

Dropped object: first aid injury during ROV maintenance

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A tooling tray guide arm fell from an ROV skid rail slot and hit an ROV technician's torso.

What happened?

He was beneath the ROV disconnecting the securing pin. Two further technicians had pulled out the tooling tray to allow access for the injured person to clear himself from underneath. While doing so, the guide arm dropped from the ROV skid rail onto the ROV technician underneath. The estimated weight of the tooling tray was 68 Kg. He was taken to the local clinic as a precaution for a check-up, as the vessel was in port at the time of the incident.

What went wrong?

- There was a requirement to remove the tooling tray before the next project.
- The technician was required to go underneath to disconnect the securing pin from the hydraulic cylinder that connects the tooling tray to the ROV skid.
- The skid was removed whilst he was underneath, and it fell onto him causing injury.
- The risk assessment performed was not task specific.

What were the causes?

- There was a lack of communication and poor risk perception demonstrated by the ROV technicians.
- The mechanism was not designed to be easily or safely removed.

What lessons were learned?

- There is a need for the attachment design for the clevis pin to be in a position that allows for access from the main deck in front of the ROV, removing the need for personnel to be underneath during removal.
- There needs to be higher hazard/risk perception for routine tasks.

What actions were taken?

IOGP Life Saving Rules:



Bypassing safety controls



Working at height



Line of fire

- Improved the design (see image) eliminating the need for working underneath.



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