

## MSF – Two recent dropped object incidents

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The Marine Safety Forum (MSF) has published safety alerts on two recent dropped object incidents, both of which have learning value for IMCA Members.

### IOGP Life Saving Rules:



Line of fire

### Incident 1: What happened?

A breakaway coupling became a dropped object.

It fell unnoticed to deck on a semi-submersible accommodation vessel.

Later investigation identified where the breakaway coupling had fallen from.

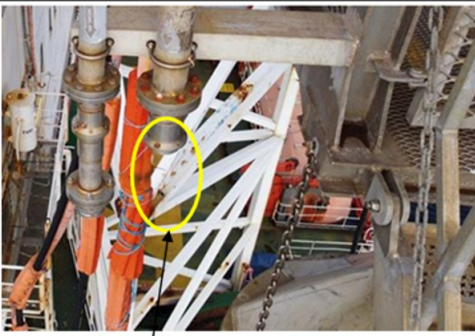
Another coupling was found with early signs of failure, with one of the breakaway studs found loose and able to be moved around freely.

### What went wrong?

The MSF notes that planned maintenance of the couplings was not aligned with OEM guidelines – it was found that the breakaway studs had been in place for longer than OEM recommendations.

Also, the vessel was in lay-up and there was no reason for the couplings to be in place during layup.

The couplings should have been removed at end of contract to remove any risk of a dropped object.



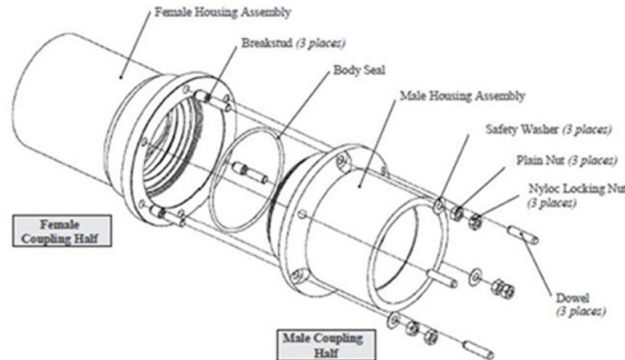
Original position of breakaway coupling



Damaged handrail

As found position of breakaway coupling

#### Exploded Assembly (Typical)



## Actions

### Actions

- Amend planned maintenance system to reflect OEM requirements and recommendations.
- Amend procedures to ensure hoses and couplings are not left *in situ* at height, when this is not required.
- Review potential use of drop net / secondary restraint.

See [Breakaway Coupling becomes a Dropped Object](#) for further details.

## Incident 2: What happened?

A barrier tape mechanism handle weighing 278 g fell 45 m from an offshore platform onto the deck of a supply vessel.

During routine supply vessel operations, a deck crew person on an offshore platform was establishing barriers for safe lifting of cargo onto the platform's weather deck.

On extraction of the fixed barrier tape, the handle was seen to eject from the mechanism and fall, eventually landing **45 m below** on the deck of a supply vessel.

Whilst nobody on the supply vessel was on deck at the time, this had the potential to have been a fatality.

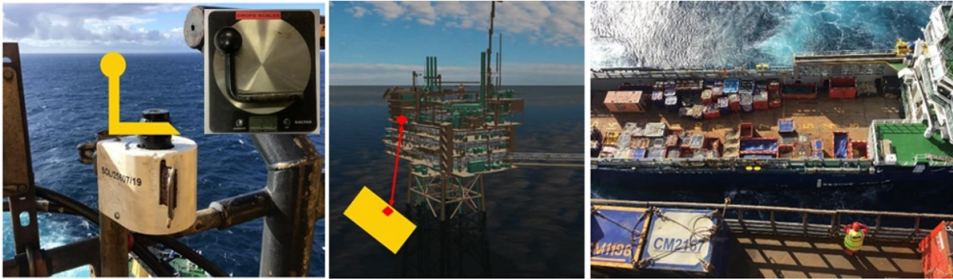
## What went wrong?

This type of barrier tape was only used by the offshore platform deck crew and was all fixed to the outboard handrails near laydown areas.

The handle was fastened with a grub screw to a round shaft with no keyway or secondary retaining mechanism.

The design is such that as the tape spools out the handle spins; this provided the lateral force to allow the handle to eject out over the handrail and down onto the supply vessel deck.

A review of other new and older mechanisms onboard found similar loose moving handles but none that would readily fall out.



## Actions

- Check if similar barrier tape mechanisms are used and check integrity of handle fixtures.
- Consider relocation away from handrails to remove the potential for rotating mechanisms to fail and fall to levels below, the sea or supply vessels.

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