

## Uncontrolled movement of crane block and pennant during lifting operations at sea

Safety Flash Published on 23 August 2017 Generated on 14 January 2025 IMCA SF 21/17

During bunkering operations between two vessels at sea, there was an uncontrolled movement of a crane block, resulting in a pennant striking a supply vessel, placing personnel in the line of fire.

### IOGP Life Saving Rules:



Safe mechanical lifting

### What happened?

The receiving vessel's crane was positioned along the supply vessel's port side where deck crew were waiting to secure and connect the hose to the rigging. The supply vessel rolled to Port due to sea swell. This caused the crane's auxiliary hoist block to make contact with the supply vessel's ROV launch and recovery system platform, which in turn caused the hoist block and attached pennant to swing.

While swinging, the pennant and hook made contact with the work station close to where the supply vessel's deck crew were stationed. Following the incident, an **All Stop** was called. After the task was reassessed, the supply vessel proceeded to re-route the hose along the main deck. The operation was successfully completed.



### What went wrong? What were the causes?

- Before starting the operation, the following requests were made:
  - Route the hose along the main deck aft instead of the port side – rejected by the supply vessel crew.
  - Use a longer pennant to increase the distance between block and the intended load – rejected by receiving vessel crew who felt the longer pennant would increase potential swing.
  - Before transferring the bunker hose, the supply vessel requested that the receiving vessel make a heading change to reduce thruster wash as it was making it difficult to maintain station. The heading was changed, station keeping stabilised, and control of the operation was handed to the

receiving vessel's deck crew.

- The two vessels had never previously conducted bunkering operations together.
- There was minimal communication between the vessels before the job started. The only discussion was regarding the length of the hose (60 m required by receiving vessel, as opposed to supply vessel's suggested 30 m).
- There was no comprehensive planning or control of work between departments on board the receiving vessel:
  - Engine control room raised a permit to work with a risk assessment covering the operation, no deck officers or deck crew were included in the toolbox talk or signed onto the permit.
  - The permit to work was generic for cargo operations.

## What lessons were learned? What actions were taken?

- Activities involving different departments should be jointly and thoroughly planned with clearly defined roles and responsibilities.
- Operations involving crews unfamiliar with one another (as on visiting supply vessels, etc.) should be fully planned in advance.

Members may wish to review the following incidents:

- Able seaman injured when vessel moved during cargo operations
- Near-miss: ROV broke free of cargo strops during heavy seas
- Lost time injury (LTI): Crush injury – arm trapped by movement of crane block

*IMCA Safety Flashes summarise key safety matters and incidents, allowing lessons to be more easily learnt for the benefit of the entire offshore industry.*

*The effectiveness of the IMCA Safety Flash system depends on the industry sharing information and so avoiding repeat incidents. Incidents are classified according to IOGP's Life Saving Rules.*

*All information is anonymised or sanitised, as appropriate, and warnings for graphic content included where possible.*

*IMCA makes every effort to ensure both the accuracy and reliability of the information shared, but is not be liable for any guidance and/or recommendation and/or statement herein contained.*

*The information contained in this document does not fulfil or replace any individual's or Member's legal, regulatory or other duties or obligations in respect of their operations. Individuals and Members remain solely responsible for the safe, lawful and proper conduct of their operations.*

Share your safety incidents with [IMCA online](#). Sign-up to receive Safety Flashes [straight to your email](#).