

MOB fatality from multi-cat

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What happened?

A member reports a man overboard fatality which occurred from a multi-cat engaged in shallow water construction in an inshore environment. The task involved recovery and re-arrangement of a pipeline configuration, consisting of 3 x 300m sinker-pipe, which was connected to shore using 7 floating pontoons. Three separate pipes were used for dewatering a reclamation site. One of the pipes including pontoons was partly submerged. The operation took place in low light conditions during the hours of darkness

The initial plan was to re-float the pipeline with a technique using compressed air. Whilst the task was ongoing, there was a change to the plan, and it was decided to lift the floating pipeline configuration using the crane on the multi-cat. As the lift started, one of the floating pontoons flipped over the pipeline and hit the Chief Engineer who was operating the crane, causing him to fall overboard. Immediately an AB on deck jumped overboard to help him; the Chief Engineer was recovered and first aid /CPR undertaken. He was transferred to hospital but was unfortunately declared dead later that evening.

What went wrong?

During the operations, the decision was made on-site to change the plan and use the deck crane of the multi-cat to lift the pipe-line and use another workboat to place a pontoon underneath. One of the pontoons was not secured to the pipeline; this came loose, surfaced and flipped over the floating pipeline, hitting the multi-cat crane and the Chief Engineer, who was driving the crane.

- There was an unplanned change, from using the air compressor to lifting the pipeline using the multi-cat crane.
- There was no risk assessment nor Management of Change (MoC) process applied to the changed plan.

What were the causes?

Our Member's investigation identified the following root causes:

- Inadequate worksite supervision
 - Site supervisor ignored the instructions to postpone the operations after the first attempt to follow the initial plan. He changed the plan, without following the appropriate MoC process.
 - Operations were conducted in hours of darkness, against company instructions.

IOGP Life Saving Rules:



Bypassing safety controls



Energy isolation



Line of fire



Safe mechanical lifting



Work authorisation

- Unsafe Lifting Operations
 - The sunken dewatering-line was lifted using the Multi-Cat deck crane.
- Lack of Situational Awareness
 - There was no adequate (risk) assessment of the job or work area.
 - No-one involved recognised the hazardous situations and did not use **STOP WORK** authority.

Actions

Members may wish to refer to

- HSS035 *In the line of fire* video

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