

Two near misses: Loads fell from height to deck

Safety Flash Published on 21 September 2017 Generated on 24 January 2025 IMCA SF 23/17

During two recent lifting operations, loads fell from height to the deck.

What happened?

In one case the rigging crew was close to where the load landed – the incident could easily have had fatal results. No one was hurt in either incident.

IOGP Life Saving Rules:



Bypassing safety controls





What lessons were learnt?

- Investigation into both incidents showed that unapproved changes had been made to the rigging. This was highlighted as a major contributing factor to the loads being dropped.
- It was found that the Management of Change (MOC) process had not been followed and that the crews had a lack of awareness regarding the application of the MOC process and when it should be applied.
- The company's MOC process was not followed; the changes were made without engineering reviews and subsequent risk assessments.
- If the MOC process had been applied, then the subsequent checks could have prevented both incidents.

What actions were taken?

- Conduct a review to ensure that there are no unauthorised modifications to rigging or equipment (welding on ROV hooks for example).
- Equipment found to have been modified without engineering review or where the MOC process has not been followed, should be quarantined and not used until the MOC process and a risk assessment can be completed and approved.
- Particular care should be taken to ensure that modifications do not introduce further new hazards to the operations.
- Ensure that the MOC process is fully understood and applied across all worksites.

Members may wish to review the following incidents:

- Near-miss: Modification of machinery
- Welding of shackles [*“in spite of clear work instructions and procedures to the contrary, shackles and hooks at the worksite were being regularly modified by welding”*]
- Dangerous occurrence involving a mobile crane [*overload protection mechanism on the crane had been deactivated*]

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