

## IMCA Safety Flash 23/17

September 2017

These flashes summarise key safety matters and incidents, allowing wider dissemination of lessons learnt from them. The information below has been provided in good faith by members and should be reviewed individually by recipients, who will determine its relevance to their own operations.

The effectiveness of the IMCA safety flash system depends on receiving reports from members in order to pass on information and avoid repeat incidents. Please consider adding the IMCA secretariat ([imca@imca-int.com](mailto:imca@imca-int.com)) to your internal distribution list for safety alerts and/or manually submitting information on specific incidents you consider may be relevant. All information will be anonymised or sanitised, as appropriate.

A number of other organisations issue safety flashes and similar documents which may be of interest to IMCA members. Where these are particularly relevant, these may be summarised or highlighted here. Links to known relevant websites are provided at [www.imca-int.com/links](http://www.imca-int.com/links). Additional links should be submitted to [info@imca-int.com](mailto:info@imca-int.com)

Any actions, lessons learnt, recommendations and suggestions in IMCA safety flashes are generated by the submitting organisation. IMCA safety flashes provide, in good faith, safety information for the benefit of members and do not necessarily constitute IMCA guidance, nor represent the official view of the Association or its members.

### 1 Property Damage: Platform Supply Vessel Collided with Legs of Jack-Up Rig

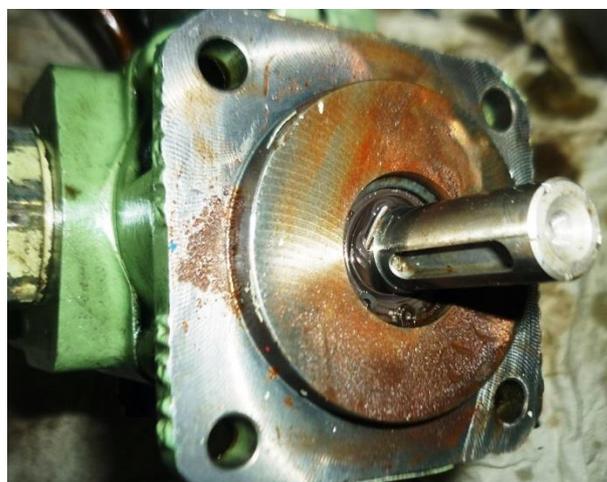
#### What happened?

A Platform Supply Vessel (PSV) collided with the legs of a jack-up drilling rig, causing some damage to the PSV. The incident occurred after transfer of water to the rig. The PSV had been ready to disconnect the hose, but the rig informed the PSV that there would be a delay. The PSV was to the windward (weather) side of the rig and the weather was “rough”, with the wind approximately 22 knots.

A little under an hour after completing transfer of cargo, but whilst the hose was still connected, the PSV starboard engine and thrusters tripped. As a result the PSV started to move astern and to Starboard. DP control was immediately transferred to manual mode. The hose was dropped in the water. Whilst pulling away to safety, the PSV made contact with the forward leg of the drilling rig.



*Dent in PSV as a result of collision*



*Damaged fuel oil pump*

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

- ◆ Procedures were not followed: Vessel working on the weather side as the jack-up rig was not geared up to receive water on the lee side;
- ◆ Equipment: Mechanical seal of fuel oil pump was damaged suddenly indicating material failure.

#### What lessons were learnt? What actions were taken?

- ◆ Better management and assessment of risk during simultaneous operations – if required, the vessel should come off and get out of the safety zone;

- ◆ Whilst material failure of items can be unpredictable, planned maintenance schedules and manufacturer's instructions should be followed for critical equipment.

Members may wish to review the following incidents:

- ◆ [Collision Between Crew Boat And Anchored Barge](#);
- ◆ [Vessel Activities Near Platforms – Two Incidents](#).

## 2 Two Near Misses: Loads Fell from Height to Deck

### What happened?

During two recent lifting operations, loads fell from height to the deck. In one case the rigging crew were close to where the load landed – the incident could easily have had fatal results. No one was hurt in either incident.



### 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].

### 3 Failure of Pipework in Fuel Tanks

#### What happened?

Water ingress into a fuel tank was discovered to be from leaking pipework. Water ingress was reported into a fuel tank from two seawater lines running through the tank. Engineers investigating a high-level alarm on the fuel tank initially thought it was due to vessel movement. But upon inspection of the pipework, a leak was found on a sea water pipe approximately 150mm outboard from the Pump Room bulkhead.



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

There was a hole of around 13mm diameter in the pipe, which had caused seawater leakage into the tank and thus, a rise in level. Fuel was transferred from this tank to the port side settling tank and shortly after starting the transfer, the port side fuel separator tripped out. The 3rd engineer went to clean the strainer and quickly realised that a large amount of water was present in the system. A check on the settling tank drain confirmed that there was water present.

The cause was failure of pipework installed on the vessel at build stage.

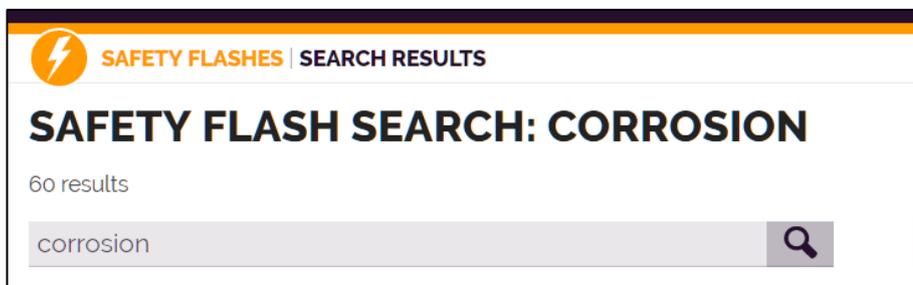
#### What lessons were learnt? What actions were taken?

- ◆ Clarification of fuel tanks on vessels if pipework lengths run through tanks;
- ◆ Inspection of pipework in tanks for integrity through visual and ultrasonic thickness baseline measurements.

Members may wish to review the following incident:

- ◆ [Huge Leak Discovered In Fresh Water System](#).

On the IMCA website, entering *corrosion* into the safety flash page search bar generates 60 results which members may wish to check for themselves.



## 4 Lost Time Injury (LTI) – Finger Laceration Due to Use of Knife

### What happened?

A crew member was working with a knife when his knife suddenly slipped and sliced a layer of skin off his index finger and part of the nail off the next finger on his left hand.

Medical treatment was received on return to port, and two weeks off work were necessary to recover from the injury.

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

- ◆ The crew member was cutting towards his free hand;
- ◆ He was wearing ANSI Level 4 cut resistant gloves at the time;
- ◆ The cause was incorrect cutting technique.

### What lessons were learnt? What actions were taken?

Always keep your free hand (and other body parts) away from the line of the cut. Gloves provide sufficient protection for regular cuts and grazes, however will not prevent a serious knife wound.

The UK HSE produce a handy leaflet on [How to reduce hand knife injuries](#).

Members may wish to review the following incident:

- ◆ [Lost Time Injury \(LTI\): Severed Tendon](#).

## 5 Crewman got Cement Dust in his Eyes

### What happened?

During the discharging of a cement tank on board a vessel, a crewman was standing in the path of a blow back of cement dust, and the dust got in his eyes. Crew were using a portable hose to investigate why the discharge line inside the tank was blocked. The hose was being held by deckhands who were assisting in the operation. There was a back pressure in the hose which resulted in the cement in the line and in the tank to blow back at considerable pressure. A deck hand who was standing in the vicinity was caught unawares and got cement dust in his eyes.

After washing out his eyes, the deck hand was unharmed.

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

- ◆ The crew were not following the correct procedures for this work;
- ◆ The crew were not wearing appropriate personal protective equipment (PPE).

### What lessons were learnt? What actions were taken?

Proper precautions should be taken with dry bulk cargo and dusts of all kinds.

Members may wish to consult [Carrying solid bulk cargoes safely](#), guidance for crews based on the International Maritime Solid Bulk Cargoes Code.

Members may wish to refer to the following incident:

- ◆ [Working with hoses and pressure](#).

