

IMCA Safety Flash 03/13

January 2013

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) 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. Additional links should be submitted to webmaster@imca-int.com

I Fatality during Basket Transfer

A member has reported an incident in which a crew member suffered a fatal fall from a Billy Pugh X-800 series personnel basket during a transfer between an incomplete platform jacket and heavy lift barge. The basket started swinging and the person fell and landed on a walkway of the platform jacket, suffering serious head injuries. He was evacuated to hospital and subsequently died of his injuries.

The company's investigation revealed the following causes:

- ◆ There was no provision of an adequate landing platform for the personnel basket;
- ◆ The basket landing area being used was on a walkway grating 1.2 m in width and between two transition pieces of the jacket;
- ◆ During the lifting operation of the basket the crane barge was rolling and pitching between 1–2 degrees and the boom angle of the crane was at 31 degrees (main crane in use), a combination of factors which allowed the basket to swing when raised;
- ◆ The crane operator continued to lift the basket despite it striking the transition pieces of the jacket;
- ◆ The two tag lines attached to the basket were not used to stabilise the basket whilst it was being hoisted.

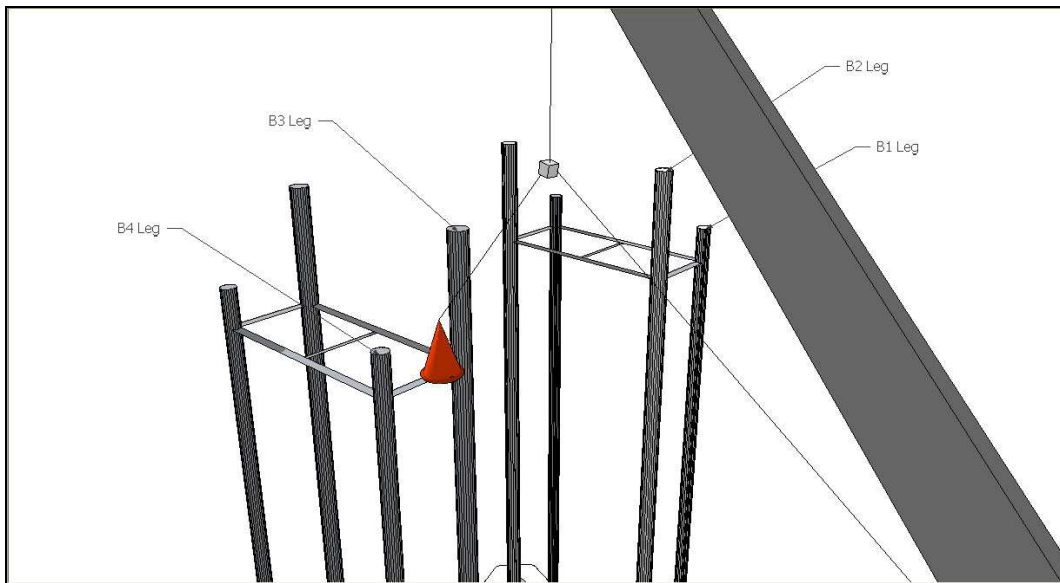
Following the incident, it was noted that all offshore personnel transfer methods involve some degree of risk. The method of personnel transfer should be taken into account when conducting assessment of risk for the project. The transfer method should be identified and mitigating factors agreed with the client prior to the start of operations. Mitigating factors should be taken into account, such as environmental limit criteria, provision of adequate landing areas and use of the most appropriate mode of transfer.

The company and its client took the following actions:

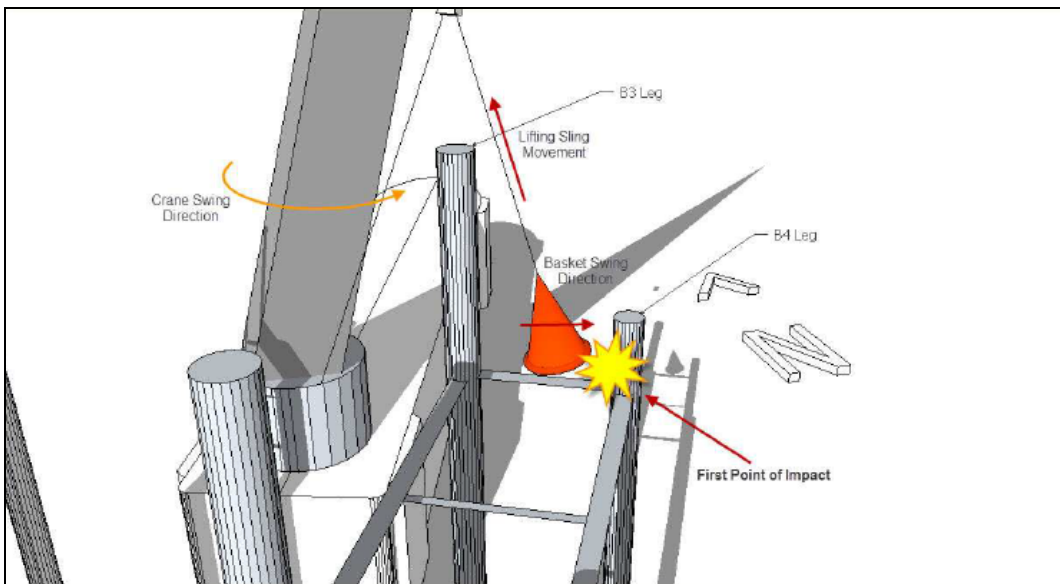
- ◆ Review the type of basket currently in use and consider an alternative which can provide impact and fall protection;
- ◆ Identify and provide a proper landing platform for personnel basket landing in the initial jacket positioning phase;
- ◆ Reinforce standard operating procedure with regards to personnel basket transfer and lifting operations;
- ◆ Reinforce the stop work policy. All personnel have the right to refuse to be transferred or conduct a transfer when they consider the situation unsafe to do so;
- ◆ Reinforce the safety awareness of personnel basket transfer by conducting more safety discussions on the subject. Personnel working on barges which use personnel basket transfer method have been reminded about the safety issues, to be more vigilant and exercise their right to stop the work if they see the conditions are unsafe to continue.

Members may wish to refer to [IMCA SEL 025 – Guidance on the transfer of personnel to and from offshore vessels](#).

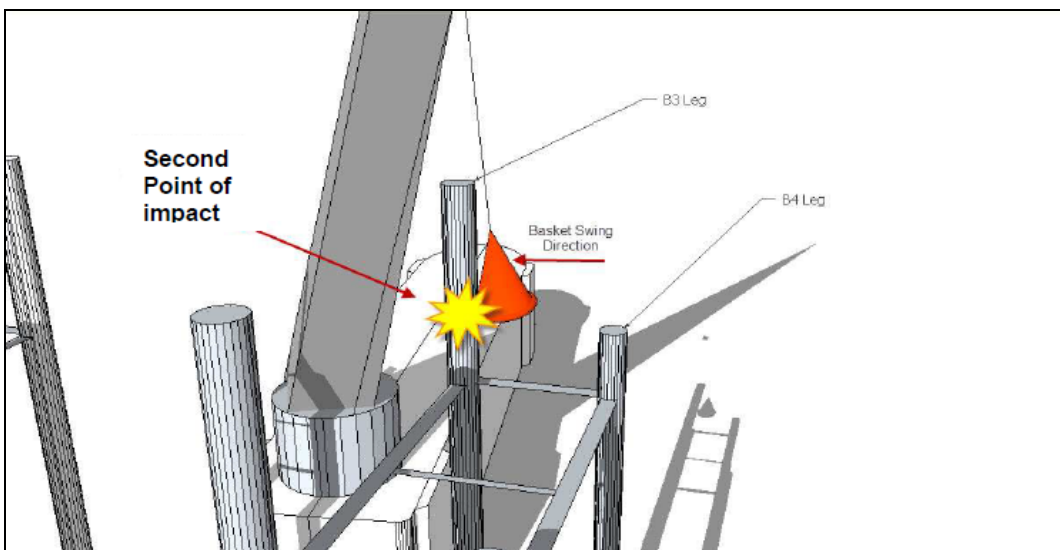
A series of sketches follows which describes the incident in more detail:



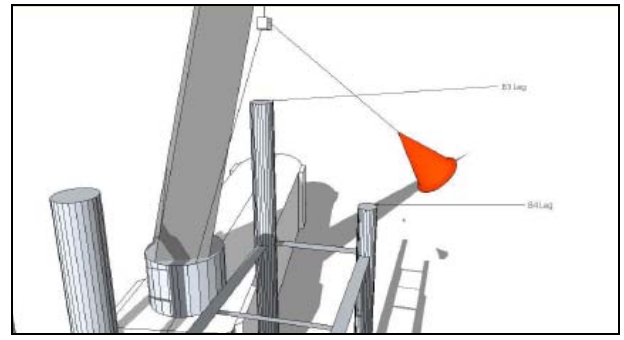
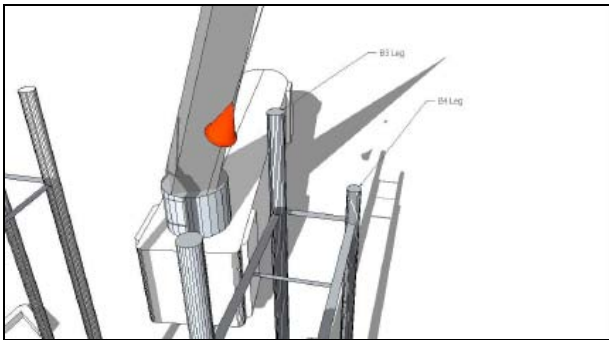
Basket landed between B3 and B4 transition piece to pick up two persons



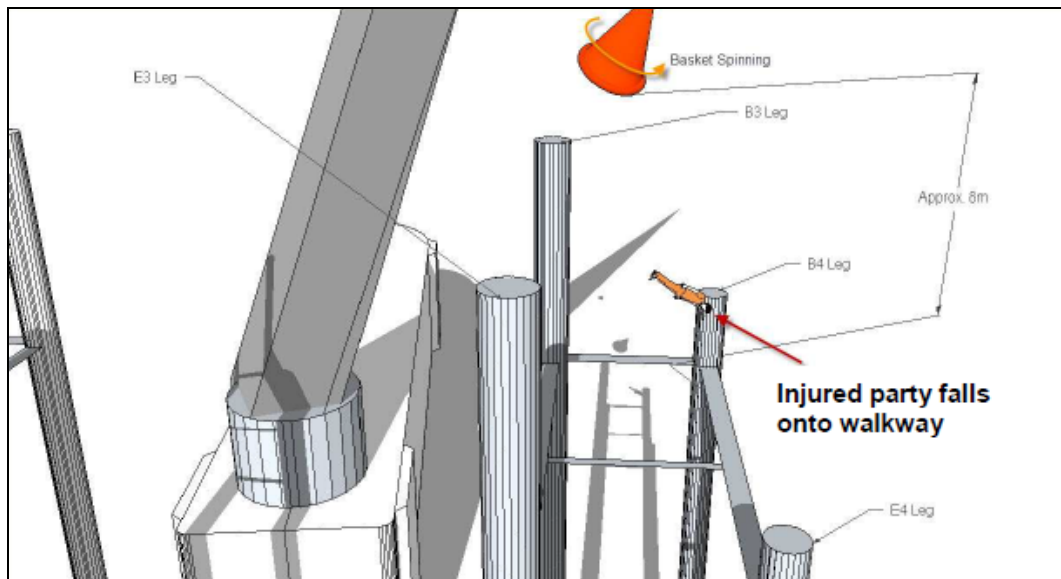
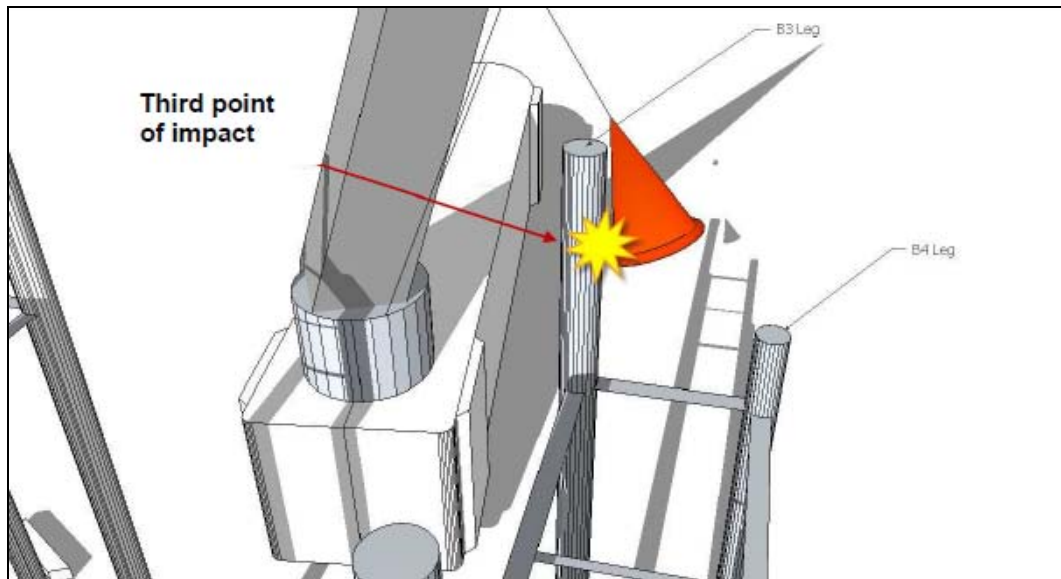
Basket begins to swing when lifted



Basket strikes platform transition



Basket continues to swing with both personnel on board



Basket continues to be raised whilst swinging and spinning, at this point one person loses his grip and falls from basket (approx. 8m), landing on walkway between B4 and E4 legs

2 Diver Emergency Decompression following Construction Barge Anchor Loss during Tropical Storm

A member has reported an incident in which a construction derrick lay barge lost all of its bow/weather anchors during a severe tropical storm. The incident occurred while the barge was in stand-by mode waiting on weather.

At the given time there were nine divers in saturation. When station keeping was lost due to the parting of the bow/weather anchors, the divers were immediately transferred to the hyperbaric rescue chamber. Given the severity of the circumstances, an accelerated emergency decompression schedule was initiated for the saturation divers, in co-ordination with diving medical specialists. The hyperbaric rescue chamber was not launched.

After a few hours, barge station keeping was regained with two anchors-handling tugs. Further to which, once matters stabilised, emergency decompression was stopped. The divers returned safely to the surface using the routine decompression profile. Post-incident medical examinations on the divers were uneventful.

A full investigation is on-going.

3 LTI: Broken Thumb

A member has reported an incident in which an employee suffered a broken thumb. The incident occurred during demobilisation works onboard a barge, where two technicians were stripping out cables and framework from within an electrical power distribution unit (PDU) container. During the final phase of the work, one of the technicians was removing a final horizontal section of 'Unistrut'. Whilst supporting the left hand side of the Unistrut section with his left hand, he unscrewed the right hand screw. Unexpectedly, the right hand screw and Unistrut adaptor (ZEB) dislodged from its fixed position causing the right hand side of that section of Unistrut to fall to the ground. As he was still supporting the left hand end with his left hand and as the Unistrut fell, his thumb was caught within the section of Unistrut, twisting it and causing a broken thumb. First aid was provided onboard, after which he was taken to hospital for further treatment.



Showing Unistrut and demonstrating how a thumb could become trapped within it

The company's investigation revealed the following:

- ◆ Risk assessments and toolbox talks were all in place prior to the incident;
- ◆ All crew attended the pre-work briefing and toolbox talk;
- ◆ Full appropriate personal protective equipment (PPE) was being worn, including suitable gloves;
- ◆ The injured person did not feel 'under pressure' to get the task done too quickly;
- ◆ The incident occurred near the end of the task;
- ◆ There was insufficient appreciation of potential risks if a section of Unistrut detached unexpectedly. Had this potential been correctly identified it is unlikely that the incident would have happened; the risk assessment was not adequate.

It was noted that although the incident occurred during the removal of a section of Unistrut this could also happen during the installation of Unistrut. Actions identified are therefore as applicable to installation as to removal.

The primary action was to ensure that, henceforth, two people should be involved in the installation and/or removal of Unistrut sections, regardless of length. The second person should provide support to the Unistrut whilst it is being secured in position or removed to prevent any unexpected movement.

4 Diving Decompression Chambers – not fit for purpose

The International Association of Oil & Gas Producers (OGP) has published the following Safety Flash regarding a number of air decompression chambers that have been identified during verification audits that contain serious safety hazards.

The report can be downloaded from http://info.ogp.org.uk/safety/SafetyAlerts/alerts/Detail.asp?alert_id=246

5 Fatal Wind Farm Accident

A fatal wind farm incident has been brought to the attention of IMCA. A crane operator working at an onshore wind farm site in Europe was killed when a blade dropped onto the cab during the installation of a turbine.



Crane cab destroyed by turbine blade landing on top of it

The turbine manufacturer noted that further updates on the accident will be provided when the root cause analysis has been carried out.

Further information is available from www.vertikal.net/en/news/story/16352/