Safety Flash

11/23 – May 2023

IMCA Safety Flashes summarise key safety matters and incidents, allowing lessons to be more easily learnt for the benefit of all. The effectiveness of the IMCA Safety Flash system depends on members sharing information and so avoiding repeat incidents. Please consider adding **safetyreports@imca-int.com** to your internal distribution list for safety alerts or manually submitting information on incidents you consider may be relevant. All information is anonymised or sanitised, as appropriate.

Uncontrolled movement of spreader bar

Applicable Life Saving Rule(s)

Line of Fire

What happened

A vessel was set up alongside a barge in preparation for the subsea deployment of a 16" (40cm) spool. The spreader bar sea-fastenings were removed by the deck crew and as the crane raised the rigging, the spreader bar rotated uncontrollably causing it to fall from its supports, with the forward end landing on deck and aft end landing on the spool.

The potential for rotation was unforeseen; a rigger who was nearby had to move quickly to get out of the line of fire. There were no injuries.

Underlying causes

- The roll potential was identified by the onshore mobilisation team; however, it was not communicated to the offshore team;
- The procedure and lift plan did not detail the correct sequence for sea-fastening removal and lifting;
- There was a failure to identify and manage change requirements;
- The design / drawings presented at the risk review were not detailed enough to allow robust assessment of associated risks;
- The hazard of roll potential was not identified at design stage and was not detailed in design requirements.

Learnings

- Emphasise requirement to carry out a tool-box task before starting a task, and after a worksite inspection, so that all participants are made aware of all foreseeable hazards and implement suitable and sufficient control measures;
- Perform post-task debriefs, considering the following:
  - What went well?
  - What was different than planned or expected?
  - What could have gone better?
  - What surprised you?
  - What changes were made to address the issue or condition discovered?
  - What hazards/safeguards/issues still require follow up?
  - What would you change or do differently next time?
- Ensure sea fastening design requirements and the need for suitable technical review of full lifting operation is communicated.