

# OCIMF Regional Marine Forum

Contractor Injured during Buoy Deployment

Jerry Higdon

Date: March 15<sup>th</sup>, 2018

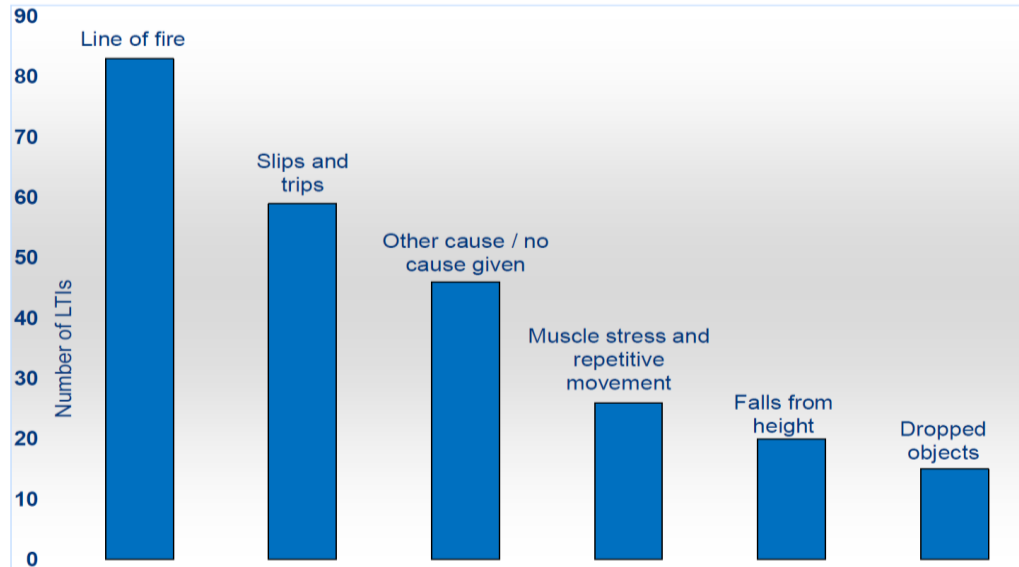


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- Most common direct causes of LTI's.
  - Slips and trips
  - Dropped object
  - Falls from height
  - Muscle stress/repetitive movement
  - Line of fire

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## DIRECT CAUSES OF LOST TIME INJURIES MOST COMMON CATEGORIES 2016



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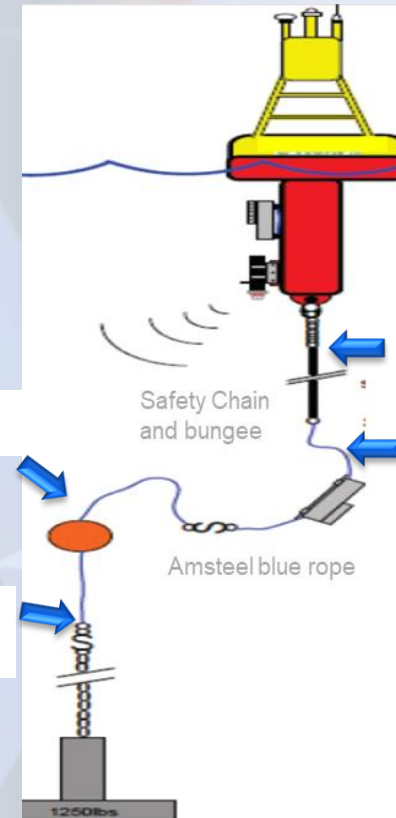
## General Overview of Equipment:

- The Telemetry Buoy acts as a relay point which takes oceanographic data and feeds it back to the offshore installations.
- This equipment is supplied by an oceanographic and weather forecasting contractor.



150m of amsteel blue rope past swivel then to hard ball float;

15m amsteel blue rope connected to 4m of 1/2" galvanized chain by swivel/shackle arrangement.



A safety chain and bungee (20m in length 5m SS chain/15m of rubber bungee);

50m of amsteel blue rope with sinker and swivel attached by 5/8" shackles;

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Rope removed from Starboard Propeller

Shackle that struck IP

12000lb Anchor

WINCH ONLY

Deck crew monitoring mooring.

PROFILE

MAIN DECK

The Telemetry Buoy was deployed over the ships side from the main deck.

Vessel was operating in DP mode with heading into the wind. Moving fwd. both props engaged

AC. OX. DECK STORE FOC ENGINE ROOM GEN. ROOM STORE CHANGE ROOM SURVIVORS RECEPTION HOSPITAL LAUNDRY DECK STORE UP DOWN

ENG. RM. VENT CO<sub>2</sub> ENGINE ROOM STORAGE DECK STORE UP DOWN

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RECEIVED AT 11:00 AM 15/03/2018

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## Consequence:

- LTI—The Injured Person (IP) suffered lacerations behind the left ear(believed to be from the hard hat when it fell off), bruising and swelling on face and left hand; the potential severity for this event was assessed to be serious. The IP was sent ashore as a precaution, was treated at a local hospital and released the same day.

## Underlying Causes:

- Vessel did not move away from the buoy. Instead, the buoy was allowed to drift alongside the vessel with mooring rope in the water
- Snag hazard risk was a focus during deployment; not risk of prop entanglement
- Contractors not aware of all the hazards that were present. Deck crew or bridge team recognized this during the work scope.
- Inexperienced (these were not sea going personnel), not aware of safe haven locations on deck.
- Safe Job Analysis /Tool Box meeting did not cover risk with deployment/entanglement/line of fire. Only discussion that took place on line of fire was the last minute risk assessment by deck crew, contractors were not present at this meeting.

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## Underlying Causes (Con'd):

- Over-reliance on existing contractor procedure and Risk Assessment for the work scope/not vessel or task specific (Procedure was developed for over the stern deployment not a side deployment).
- Vessel crew believe the deployment process and risk assessment belonged to the contractor.

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## Additional areas of discussion:

- Design of Buoy – Hazard Recognition and Analysis.
- Planning of the Operation – Application of Risk Management Processes
- Vessel Operating in DP – Was this the correct set up for the vessel for this scope?
- Environmental Conditions – Did weather play a factor?

## Root Causes:

- **Lack of job planning** - No vessel specific risk assessment and job procedure created for deployment. Crew and contractor were following generic JSA and Procedure form deployment – over the stern vs. actual side deployment.
- **Roles & Responsibilities** not properly defined for all steps of deployment.
- **Risk** to personnel during back deck operations not adequately assessed. Equipment hazards.
- **Procedures** provided in company Safety Management System (SMS) did not give adequate guidance to shipboard staff when working with client or third party contractors.

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## Corrective and Preventative Actions:

### Corrective:

- Contractor to develop a detailed description of the equipment including all potential hazards for Buoy.
- Development of vessel specific SJAs for tasks regarding buoy deployment and other marine ops and services support equipment offshore (as required).

### Preventative:

- Improvements to existing OSV Operator's SMS regarding guidance to crews on requirements and expectations when working with contractors and Third parties.
- Ensuring roles and responsibilities are clearly defined during tasks – who's doing what and where and when.

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## Lessons Learned:

- There cannot be an over reliance on generic risk assessments and procedures.
- Vessel policies for back deck operations must ensure that personnel who are not required on deck clear the area before work commences. Personnel who must be present need to be fully versed on all the hazards and understand actions to take in the event of an emergency.
- SMS procedures for contractors must be well documented and give clear and concise instructions to vessel management on how contracted work onboard the vessel is to be carried out (this includes third party contractors).

# Thank you

