



# MSF - Drops Forum

30/04/2019




TIDEWATER

RESQUE ZONE

MS MIRA  
DOUGLAS

5

6  
4  
2  
7M  
8

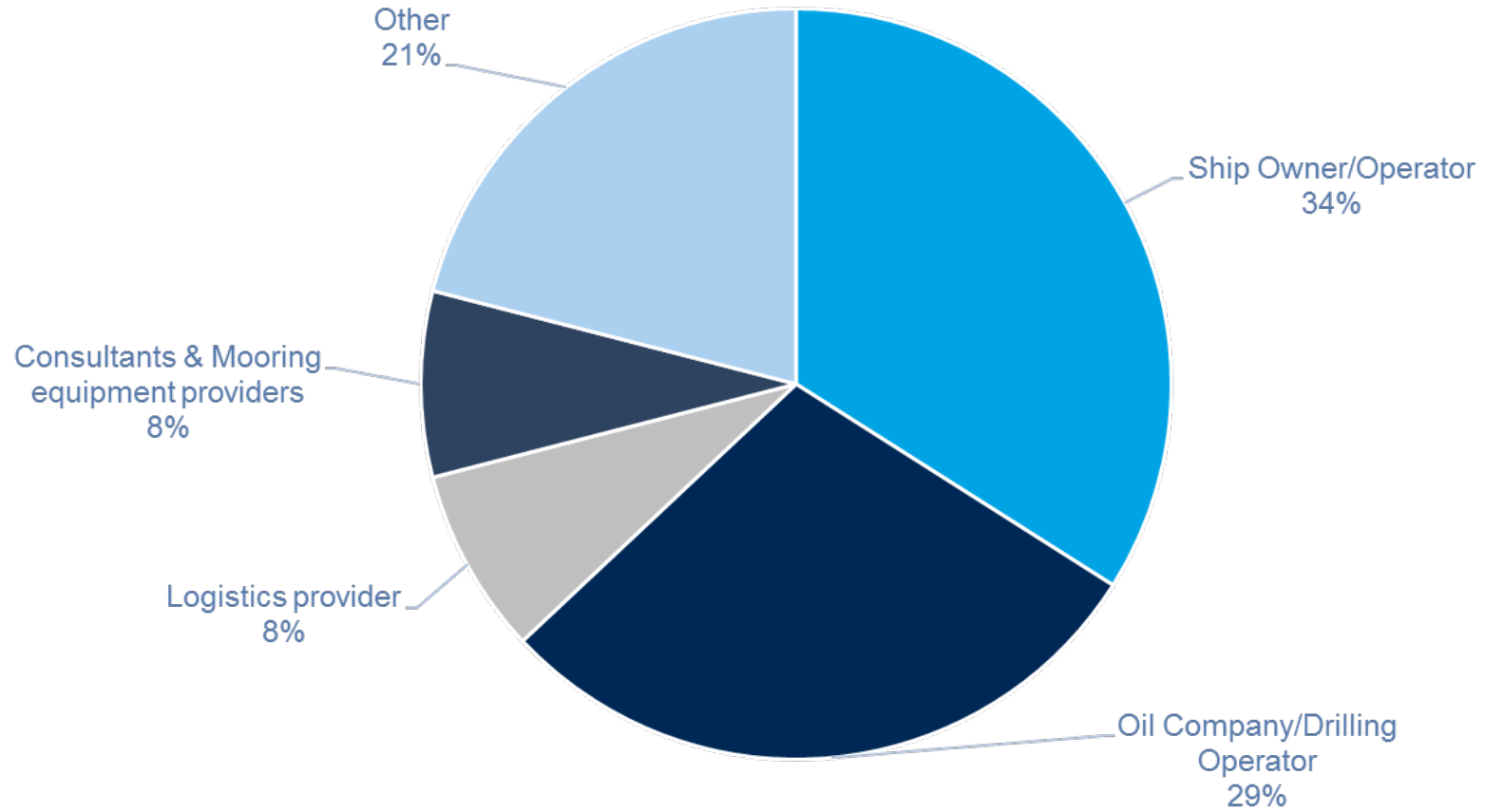


Actively promoting safety within the marine sector of the oil and gas industry

The Marine Safety Forum is primarily focused on actively promoting safety within the marine sector of the oil and gas industry.

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### Steering Group







## Safety Alert

**Number:** 19-04

**Published:** 01/03/2019

**Subject:** Potential Dropped Object

### What Happened / Narrative

A guide-base unit was back loaded from the installation with significant amounts of hardened cement attached to its underside. When the guide-base landed on the vessels deck the contact dislodged some of the cement. The AB's 'stopped the job' and unhooked the lift however they didn't raise any particular concern.

It was only when the guide-base was about to be offloaded in port that the shore side stevedores noted the hardened cement was a potential dropped object and again 'stopped the job' until the hardened cement was removed using pinch bar's and hammers prior to the guide-base being lifted from the vessel.

### Why Did It Happen / Cause

Although the vessels crew did notice the cement falling from the guide-base when it was backloaded they didn't consider the follow-on potential dropped object scenario during discharge.

### Corrective Actions Taken / Recommendations

- During cargo transfers, when and where possible, remain within safe haven areas avoiding the risk of 'potential dropped objects
- If anything falls from the cargo assess your own safety and if / when safe to do so recover / report the object
- DO NOT return the offending cargo to the installation
- Report the incident to the installation
- Discuss the incident and identify the concern to the stevedores at the pre-discharge TBT once back on shore

### Photographs / Supporting Information



## Safety Alert

**Number:** 18-23

**Published:** 26/10/2018

**Subject:** Near Miss – Potential Dropped Object

### What Happened / Narrative

During cargo operations at an offshore location, a 20ft basket was discharged from aft on the main deck. Shortly afterwards bridge team were informed by the installation crew that a yellow metal plate was found trapped inside the forklift pocket of the basket. Later that day, a picture of the plate was sent to the vessel and ships staff confirmed that the plate originated from the vessel's deck.

The plate in question was used to protect a potential trip hazard (stanchion mounting holes) when not in use.

### Why Did It Happen / Cause

A detailed risk assessment for the operation was in place and as per standard practice, the risk assessment was used as the basis of the toolbox talk for the operation. The following hazards were amongst those specifically identified:

- Trip hazards marked or removed if possible. The use of these covers was justified in removing the high likelihood of a trip resulting in personal injury.
- Dropped objects prevented by a pre-inspection of the container prior to lifting and use of safe havens when any lift is suspended.

Note that the control measures listed did not include pre-inspection of the deck. The control measure requiring a pre-inspection of the container alone failed, as it did not identify the potential dropped object. However, it should be noted that the ability to conduct a full inspection of a container prior to lifting from a vessel's deck can be impaired and may not always identify all Potential Dropped Objects, e.g.

1. Weather conditions / water on deck may not allow a full check of fork pockets
2. The orientation of a container against the vessel's rail or other cargo may impair visibility of all areas that could harbour a Potential Dropped Object

### Corrective Actions Taken / Recommendations

A spare cover plate was immediately fitted, and the trip hazard removed. Ship Staff were also able to engineer a solution so that no single motion i.e. wave action on deck could result in the plate being inadvertently shifted. Additional pins have been added which will hold the plate in place unless intentionally removed.

Furthermore, the vessel owner implemented the following preventative measures fleet-wide:

1. Update the risk assessment - add pre-work inspection of the deck as an additional control measure against the hazard of Potential Dropped Objects
2. Update 500m entry checklist to include a requirement for a positive report to the bridge that the pre-work deck inspection has been completed
3. All Safety Officers to conduct inspection of the vessel plate cover arrangements to determine if a similar hazard could occur and take preventative action where necessary
4. Conduct an additional recorded briefing for all deck crew on the lessons learnt – particularly the potential failure of the pre-lift check of the container and the new requirement for a pre-work deck inspection

### Instructions to vessel owners fleet:

- All crew shall be made aware of this bulletin and contents by displaying on noticeboards, printed copies available in mess rooms and discussing all learning points and recommendations at the next onboard safety meeting
- Any applicable points shall be actioned to reduce the likelihood of a similar incident occurring on another vessel





## Safety Alert

**Number:** 18-20      **Published:** 23/08/2018  
**Subject:** Potential Dropped Objects in Frame Pockets

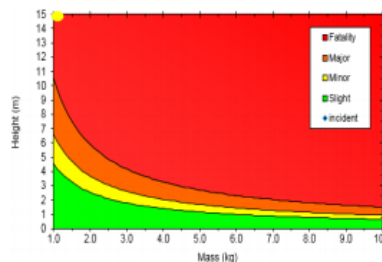
### What Happened / Narrative

When preparing a heavy lift to be discharged from an offshore supply vessel to an offshore installation the vessel's AB's were carrying out final checks which included checks for any potential dropped objects, during these checks they discovered some debris within the frame pocket.

The items were estimated to weigh approximately 1kg and the potential outcome has been highlighted using the drops calculator as shown.



Outcome Calculator	
Height	1.5 m
Mass	1 kg
Outcome	Fatality



### Why Did it Happen / Cause

Cargo checks onshore failed to spot the items before the lift had been loaded onto the PSV. This was apparently due to the lift frame positioning on the trailer which may have hampered the checks at the gantry.

### Corrective Actions Taken / Recommendations

- The potential dropped objects were removed from the pocket and the lift was safely and successfully discharged to the offshore installation.
- This alert highlights the importance of final checks on all lifts prior to discharge offshore even though there had been previous checks onshore.

### Photographs / Supporting Information



Further information and guidance on the checking of cargo items for potential dropped objects can be found in: "Best Practice for the Safe Packing & Handling of Cargo to & from Offshore Locations" available at [www.onshoreoffshorecargo.com](http://www.onshoreoffshorecargo.com)



## Safety Alert

**Number:** 18-11      **Published:** 18/04/2018  
**Subject:** Potential Dropped Object on Top of a Container

### What Happened / Narrative

While hose watching during bunkering operations, a Deck Foreman noticed an object on top of a container onboard the Supply Vessel.

### Why Did it Happen / Cause

The object was later found to be a large piece of wood weighing 1kg. With a possible fall height of 15 – 30 meters during lifting operations. There was the potential for a fatality.

The origin of the wood is not known. CCTV images were captured of the container arriving at port and prior to being lifted onto the vessel – the wood was not seen on top of the container at either of these points.

Therefore, the wood appeared on top of the container at some point between being loaded onto the boat and arriving at the installation

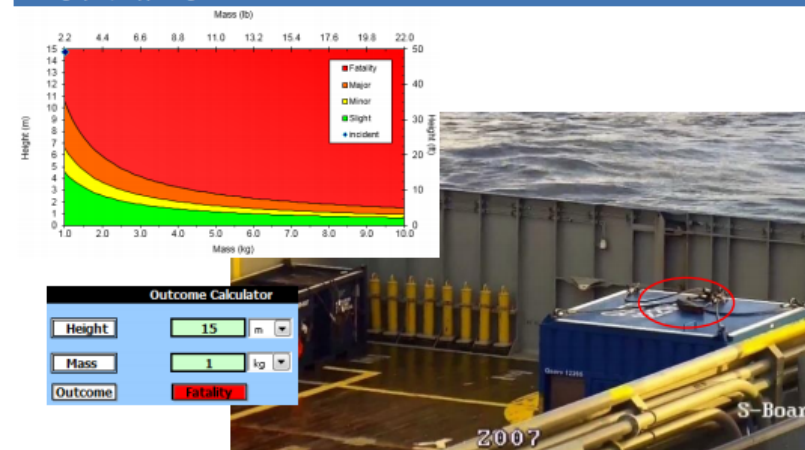
### Corrective Actions Taken / Recommendations

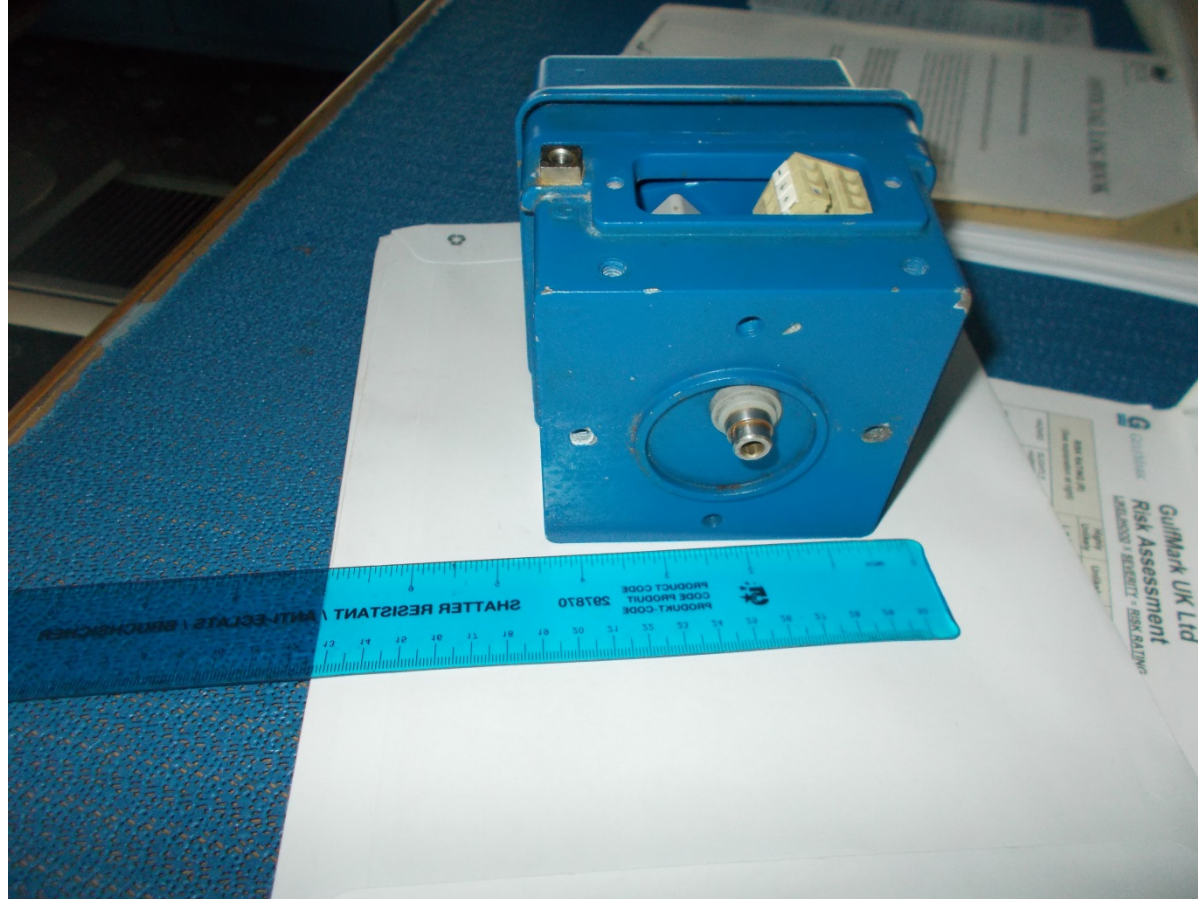
Vessel Master was contacted, who arranged for the object to be removed.

No preventative actions were taken – it was a great spot by the deck crew.

This event demonstrates the importance of pre-lift checks and good observation at all stages in the supply chain.

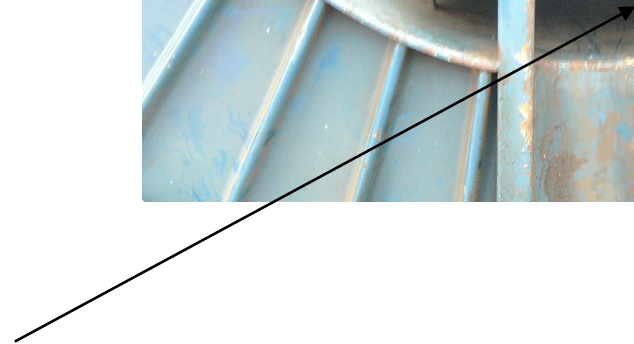
### Photographs / Supporting Information

























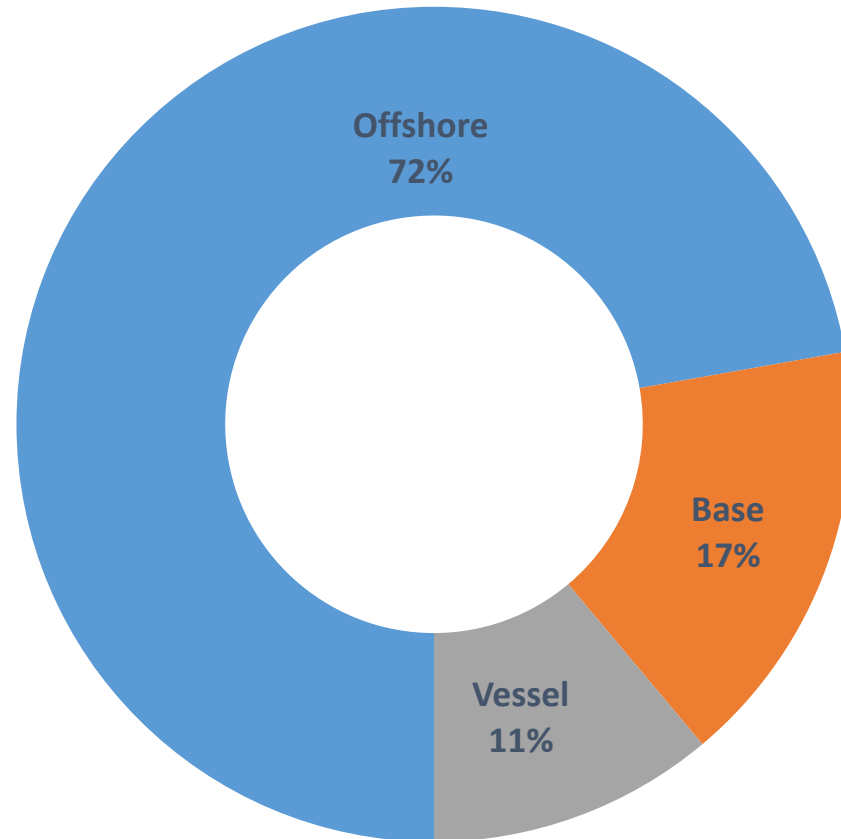








### Potential / Dropped Objects Breakdown



\*Figures are based on incident reports 2011-2018



- Checks failed
- Checked several hours prior to backload
- Checks were not stringent enough
- Not ours/didn't come from here
- Inconclusive
- No response



- Is cargo being lifted to vessels given the same level of scrutiny as lifts across your assets?
- Are those doing the checks fully aware of the potential of these items?
- Are they given sufficient time to conduct the checks?
- When you experience these incidents/near misses is your follow up robust enough to prevent re-occurrence?