

Marine Safety Flash

A16-32 (15th September)

Crew member injures back handling raptor link

Incident Overview

The AHTS vessel was alongside a MODU receiving the first Permanent Chaser Pennant (PCP) for connection. As the PCP was being passed down to the vessel that the AHTS crew observed the PCP was not fitted with a (pig) chain tail thus requiring a connecting link with a larger end than planned / prepared.

The OOW stopped the job and contacted the rig requesting a chain tail to be installed as per the rig move procedure and GOMO. The OOW was advised by the MODU that they were unaware of the requirement and did not have the equipment to enable the chain tail to be installed and requested the job proceed without the chain tail.

The vessel's crew completed a risk assessment to consider their options. A Raptor link was offered by the prelay mooring provider. In consultation with the Mooring Provider Rep, it was decided a Raptor Link would be the best option in order to connect to the PCP wire. The 1st half of the Raptor Link was placed into the PCP socket and the 2nd half was passed through the vessels 5 link chain. The crew members involved had difficulty making the connection between the two halves of the Raptor Link. (Each half of the Raptor Link weighed approximately 75kg's. The struggle to make the connection was due to the awkward angle of the PCP socket in the Shark Jaws) and that the connecting link could not be sat on the deck.

The incident occurred when the bottom half of the Raptor Link that was being manoeuvred by the Injured Party (IP) and another crew member shifted slightly causing the IP to take the full weight. The IP heard a noise from his back and felt pain. The IP continued to work to make the connection. The IP continued to work through the day with pain, taking on lighter duties, the incident was reported to the OOW toward the end of the IP's shift when the pain continued to worsen.

Future connections were completed using a lighter easier-to-handle pear links, and with greater utilisation of crane robotics.

Marine Safety Flash



Key Findings

- The lack of a chain tail being available from the rig led to a deviation from the Ships procedure, rig move procedure that resulted in the Raptor Link being used for the first PCP connection.
- The lack of an easily manoeuvrable tail chain resulted in the PCP socket being on an awkward angle in the shark jaws for connection to the vessels chain; it also required a connecting link with a larger end and not the kenter shackle normally used. This created additional manual handling risk.
- The decision was made to use a Raptor Link; this was a large, heavy shackle (connecting link, it is not a shackle) that required precise alignment. There were other lighter, easier -to-handle shackles on board that were not used for initial connection, however were used for following connections post incident.
- The additional weight of the Raptor Link was not specifically discussed in the risk assessment prior to use. General manual handling was discussed in the pre -job toolbox.
- The starboard rail crane had recently been repaired, however had not been commissioned back into service and was not available for use at the time of the incident. Through discussions during the investigation the investigation team believes there may be room to explore the optimisation of the use of the manipulator arm on the crane further across the fleet.
- The incident was not reported immediately to the OOW as the crew member attempted to work through the pain to get the task / shift completed.

Recommendations

1. On AHTS vessels, update the Risk Assessment for Receiving PCP from Rig to ensure;
 - a. that Rig has chain tail available
 - b. the lightest, easiest to use, connecting link should be used that meets the MBL required for the job
 - c. Use of cranes or mechanical means to avoid manual handling exposures as far as practical
2. At next Safety Meeting please review with the crew regarding incident notification – reminder that OOW should be notified immediately when an incident occurs as the delay in this circumstance delayed treatment and may have worsened the injury.

Marine Safety Flash

Figure 3 Diagram from the rig move procedure showing chain tail assembly



Figure 1 Actual Raptor Link

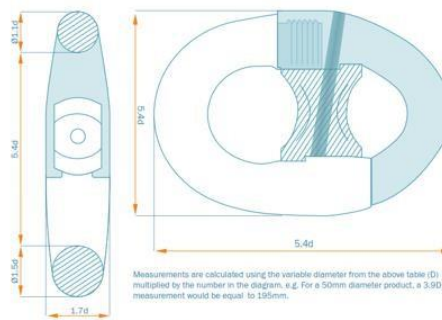


Figure 2 Raptor Link Diagram

