

# Marine Safety Forum – Safety Flash 15-13

Issued: 27<sup>th</sup> April 2015

Subject: Hose Incident

## Event

The vessel was engaged in a bulk transfer operation on the leeward side of the platform.

The incident involved a 2" bulk chemical transfer hose that had been passed up to the platform, and was being passed down to the vessel.

Prior to the incident the chemical transfer hose had been used to pump scale dissolver into a well. The chemical pumping operation was complete and the hose was in progress of being passed back to the vessel when the event happened.

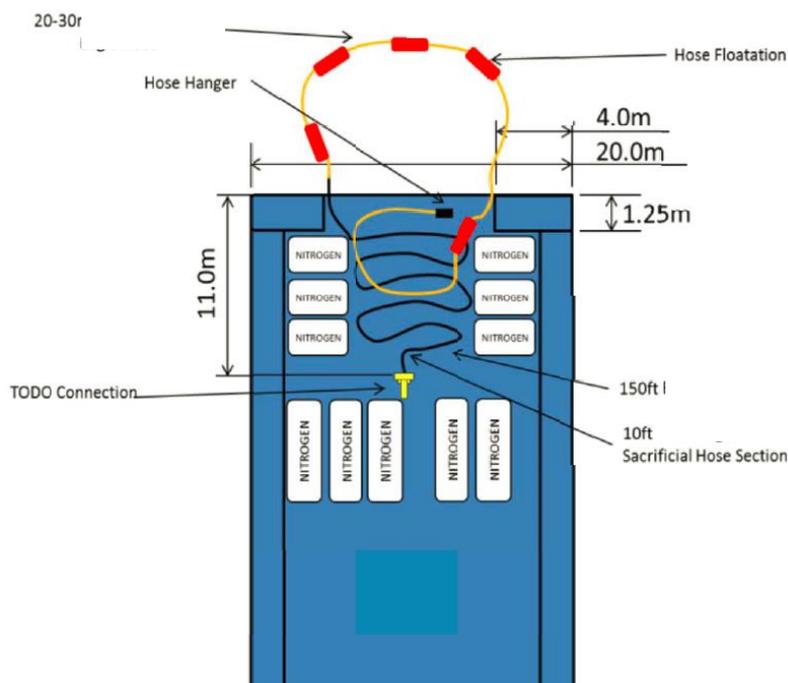
## The event resulted in the following consequences:

- 337ft (102m) of bulk transfer hose including fittings being pulled into the port azipod of the vessel
- Irreplaceable damage to the bulk hose
- Delays to operations

## Potential consequences included:

- Catastrophic failure of the vessel's port azipod
- Injury to persons on the aft deck of the vessel
- Damage to nitrogen tanks on the aft deck of the vessel
- Potential for collision through reduced manoeuvrability

Fig: Deck layout and hose position



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## **Root causes:**

### **1. Risk Identification**

- Everybody involved in the task, during planning and at operational phases both on and offshore deemed the task of passing the hose to and from the platform to be a routine bunkering operation that had been carried out many times before
- The vessel was not included in the risk assessment / HAZID during planning phase
- The vessel's deck layout had not been considered during job design or operational planning. Deck layout was only considered once the AFE was approved and the charter process completed
- Failure to manage change in operations i.e. repositioning of the hose TODO and review all necessary procedures, risk assessments when the job was changed
- Tool Box Talks didn't fully capture all tasks and risks associated with the operation offshore and only focused on the chemical pumping operations

### **2. Error Enforcing Conditions**

- The crew involved in the operation both on the vessel and the platform, failed to recognize the additional hazards associated with hose handling and STOP the job and re-asses when they were unable to fully pass the hose back to the vessel
- At the time of event the weather conditions changed, this resulted in increased movement of the vessel.
- Operation to recover the hose was carried out in the hours of darkness
- Insufficient floats had been installed on the bulk hose

### **3. Communication**

- Failure to fully include all members of the work party in TBT's and task specific risk assessments
- Communication on the vessel was poor, there were delays in establishing radio communications between the vessel and the platform, two separate radio channels were being used which lead to confusion

### **4. Procedures**

- Lacking procedures for installing floats on hoses and were also lacking awareness of industry guidance document regarding hose floatation.
- The task was carried out under a generic Supply boat operations PTW

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