

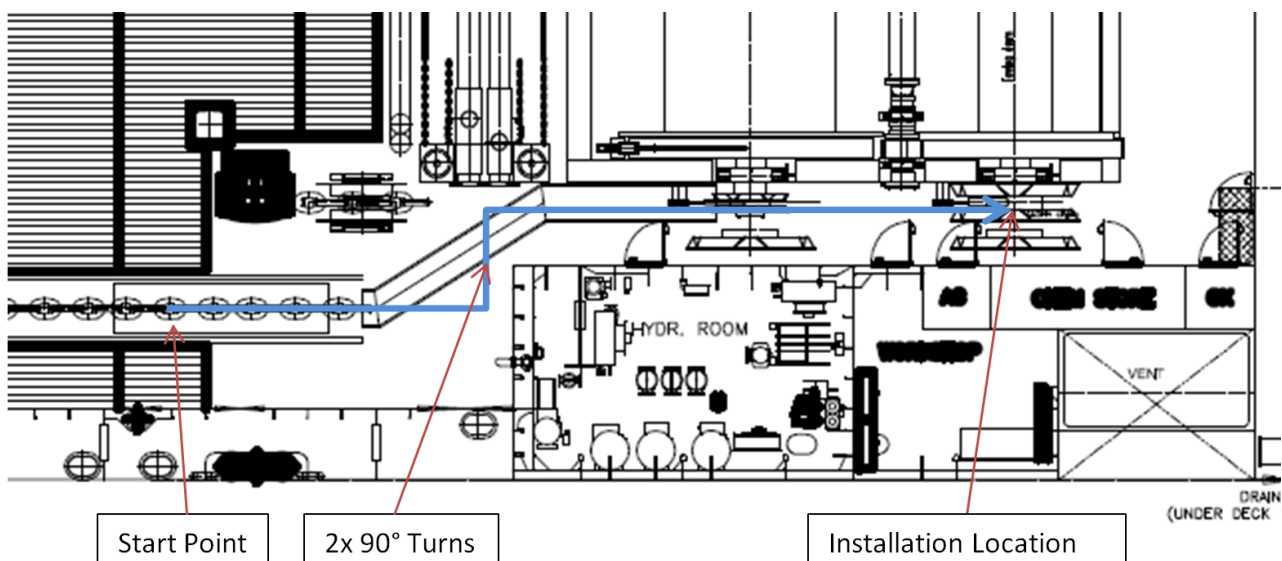
Marine Safety Forum – Safety Flash 15-16

Issued: 4th May 2015

Subject: Fatal incident during change-out of chain wheel (gypsy) on AHTS vessel

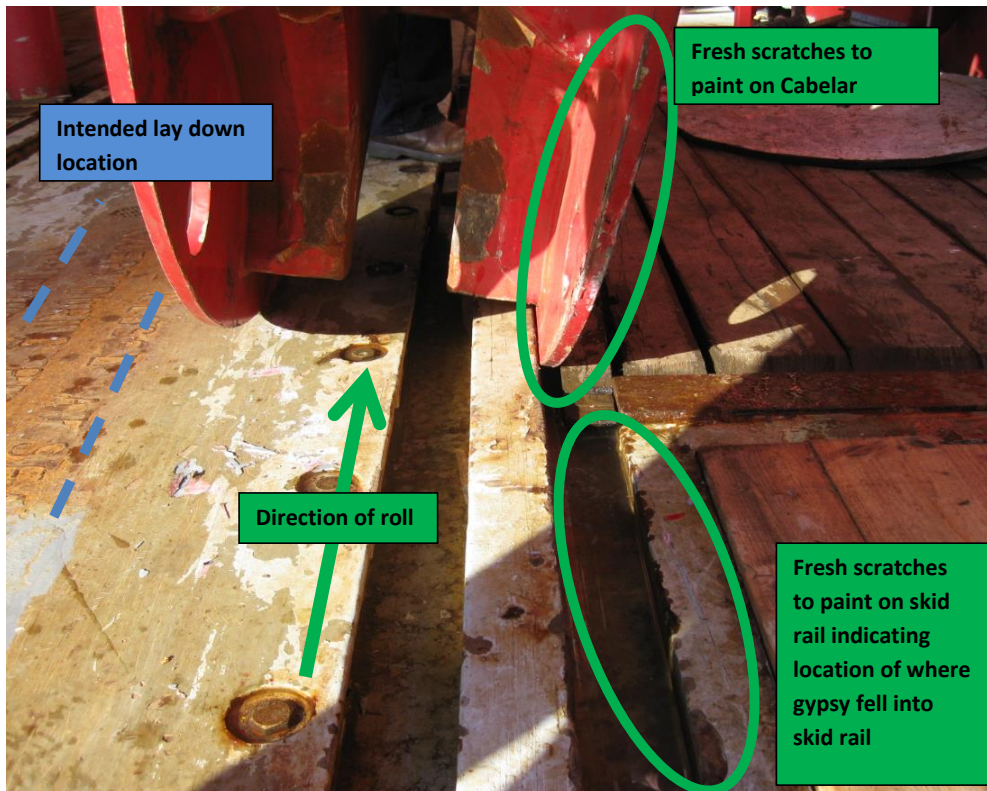
A member has reported an incident in which one crewman died and another received minor injuries when a gypsy or chain wheel fell over whilst being moved, resulting in two crew members being trapped between it and a cargo rail bulwark. The incident occurred when a vessel was mobilising for a project which required the use of an 84 mm chain wheel or gypsy. At the time the starboard side forward winch was fitted with a 105 mm unit. This was removed and stored on the main deck. Installation of an 84mm unit then started.

The crew disconnected the gypsy from the crane without checking its final landing position. Therefore, they did not see that the rims of the gypsy wheel were on each side of the skid rail for the chain lifter. Immediately after disconnecting from the crane, the crew started to roll the gypsy. This resulted in the starboard rim dropping into the gap in the rail causing the wheel to tip beyond balancing point. It fell over and pinned two crew members against the bulkhead. This resulted in one fatality and one first aid case.



Plan view drawing of the intended route for the installation of the gypsy

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Showing the cause of the gypsy wheel tipping over (the term “cabelar” is used as well as “gypsy”)

Investigation noted the following:

- ◆ The immediate causes were:
 - Gypsy rolled into skid rail causing it to tip over;
 - Lack of risk management;
 1. Failure to identify hazards and risk.
 2. Failure to comply with safe working practices.
- ◆ Contributing factors:
 - Inadequate design review for this particular mode of operation conducted by vessel;
 - Gypsy was not handled in the intended method as established when vessel was designed;
 - Insufficient lifting or handling appliances for handling and changing the gypsies.
- ◆ Root Causes:
 - Inadequate monitoring and verification of organisational performance;
 - Weaknesses identified in the design review processes;
 - Lack of effective implementation of risk management.

The lessons drawn were as follows:

- ◆ Gypsies should not be manually handled or rolled;
- ◆ Monitoring and verification of worksite performance was found to be inadequate.

The actions taken were as follows:

- ◆ Company-wide instruction forbidding free-rolling of these heavy items;
- ◆ Technical task force to evaluate a safe method for the installation of gypsies in the short and long term and review change- out methods across the fleet;
- ◆ All vessels to review and re-risk assess current methods for handling gypsies and submit risk assessment for approval.

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