TDI Brooks	**Fleet Incident Report and Lesson Learned**	**FIR # 2** **Distribution Date: 27 Feb 2015** **Action Item Due: YES**

Incident Report: A-Frame failure on Brooks McCall

What Went Wrong

On January 26, 2015, clients and the Brooks McCall crew were conducting test lifts of the Pelagic ROV using the BMC's stern a-frame. The a-frame was cycled completely inboard while suspending the ROV approximately 12 inches off the deck. The starboard hydraulic ram failed and began to leak. The transferred load to the port side ram sheared the pin connecting the ram to the a-frame and dropped the ROV to the deck, causing several thousand dollars of damage to the ROV.

What was done to correct it at the time

Hydraulics were quickly shut off and the spill contained to the deck with SOPEP gear. No injuries resulted.

The Near Miss: What could have happened

Witnesses state that before the incident, the clients were working on, around and under the ROV while it was suspended. Had they been in the near vicinity when it fell, severe injuries or death could have resulted. No one exercised STOP WORK authority because they thought the client had a right to work on their own equipment in whatever way they wanted.

What could have prevented the incident

An incident investigation determined that no JSA had been conducted, even though this was a non-routine activity. Employees were very experienced field personnel, but did not think the JSA was required because it was not a paid job, just activity at the dock side in our own yard. The load tests for all lifting gear on board were expired. The a-frame was being used in a capacity which we had not used or tested for before and no MOC had been conducted to evaluate if the a-frame was capable of handling this task and if doing so would increase risk.

The Real Root Cause

Far too often there is a mindset that there are three separate levels of HSE and Safety Awareness

Level 1: High safety awareness when we have an exacting client watching our every move
Level 2: Moderate safety awareness and casual approach when no client is aboard
Level 3: No safety awareness or following of TDI safety procedures when no TDI office or client rep on site

This mindset has been a part of the company since its creation, and will not be easy to change. The fact is, that while clients and regulations drove us to create our Safety Management System initially, its true purpose is to protect our workers from injury and to prevent accidents. **It is your safety program, meant to protect you and your shipmates.** It is essential that we operate at the highest level of safety awareness at all times regardless of the nature of the task being performed.

The incident at the Brooks McCall with the dropped ROV had the potential for severe injury or a fatality. It is the responsibility of all TDI personnel to be situationally aware and take the necessary steps to prevent incidents such as this. The near miss described here could be a hit the next time it happens.

Actions you need to take to prevent a similar incident on your vessel:

It is the workers' direct supervisor who is responsible for the safety of his crew and therefore conducting JSAs.

- **Management-** It is management's responsibility to provide the leadership, training and tools necessary to allow TDI personnel to operate in a safe manner.
- **Supervisors** - Make sure your crew recognizes the risks and plans mitigations **before** starting the job by conducting and documenting a JSA, ensure your crew understand their roles and use the proper PPE.
- **Crew**- Insist your supervisor conduct a JSA before doing any non-routine activity and STOP WORK if you are not clear on your role or responsibility during the activity or if you see unexpected hazards.
- **Everyone** - Realize that safety is safety, regardless of your location, client or lack of client.

Actions you need to take

Department	Responsible Person	Action to Take	To be completed by date
All	Captain	Conduct a safety meeting and review this Fleet Incident Report with the all persons on board. Have them **come up with three recommendations** to prevent something similar from happening in their vessel.	**7 March 2015** Send scan of the sign in sheet for this meeting and **include crew comments and the three recommendations in the meeting notes** to **HSE@tdi-bi.com**.

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Approvals

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