Near Miss Incident Report

NMI/	75/	2011
	(reference number to be filled in by AM)	*(year to be filled in by AM)*

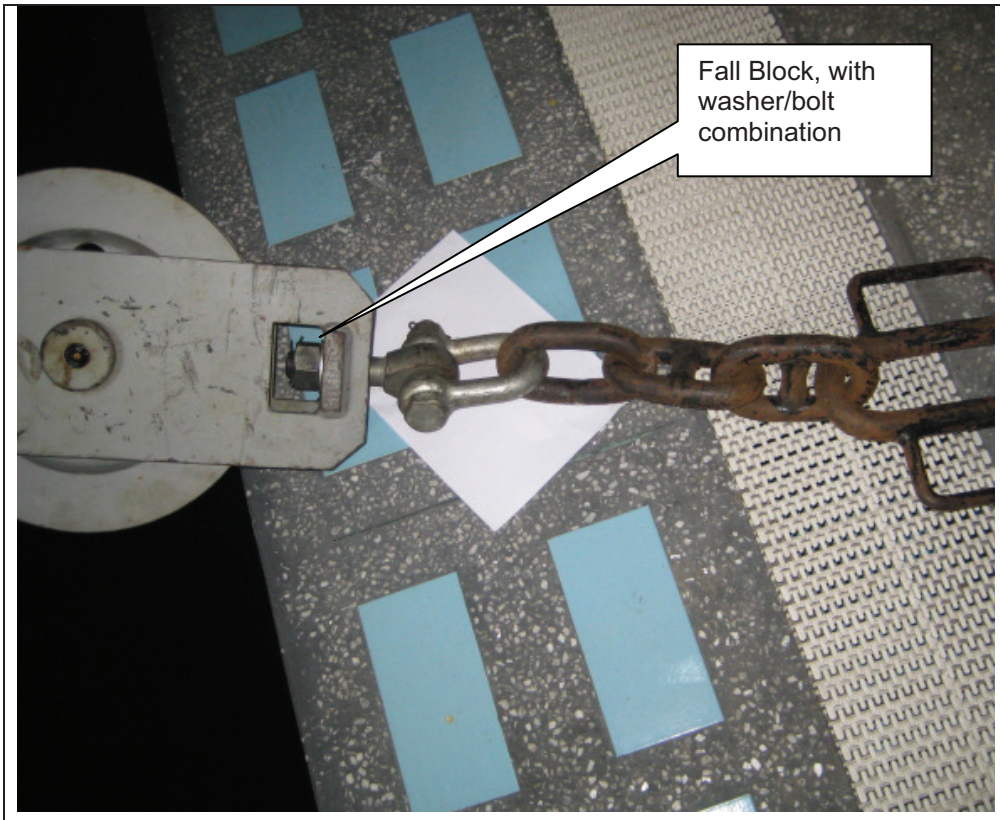
Date of the NMI:	October 4, 2011
Location:	UOTC (Yangon)
Time of the NMI:	11.30AM
Reported by:	Training Centre Supervisor: Aung Zaw Oo
Witnessed by:	----

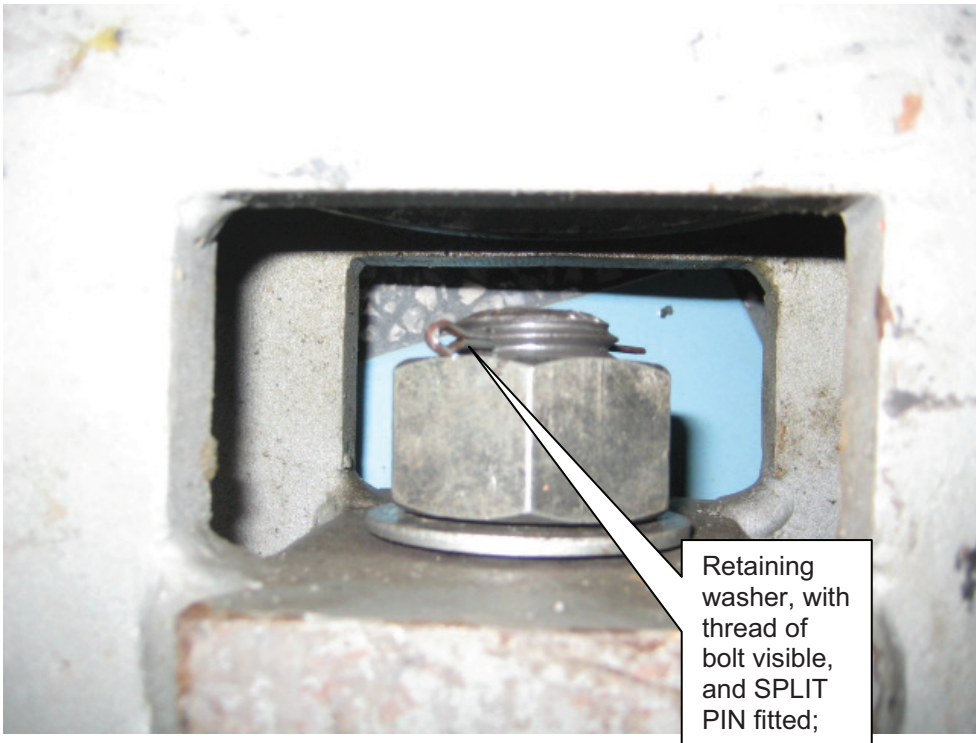
Circle or highlight categories of POTENTIAL "Impact" versus POTENTIAL "Severity" for this NMI:

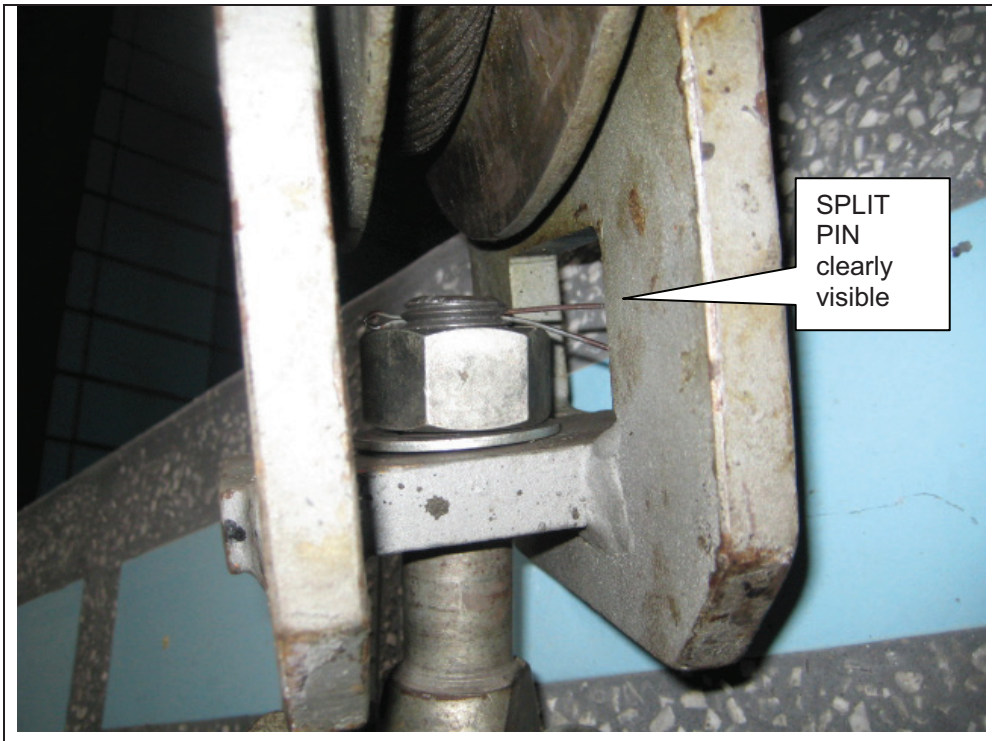
		POTENTIAL Impact				
		Health & Safety	**Assets**	**Commercial**	**Environment**	**Public/ Reputation**
POTENTIAL Severity	**Negligible (1)**	Negligible injury or health implications	Minor equipment damage	Negligible down time;	Negligible loss of containment requiring minor or no response	No public disruption
	Slight (2)	Minor injury / MTC, headache, dizziness, nausea, mild rash	Equipment damage requiring minor repair (Could cost up to 5,000 USD)	Short duration of down time;	Slight loss of containment Trace spill less than 1bbl. Minor response	Minimal public disruption
	Moderate (3)	LTI / serious injury or ill health	Equipment damage requiring extensive repair (Could cost 5,000 upto 25,000 USD)	Moderate down time;	Minor spill less than 50 bbls, limited short duration response	Disruption to small community (Local)
	Major (4)	Single fatal incident, dangerous infectious diseases	Fire, major damage to equipment (Cost could exceed 25,000 USD)	Significant downtime;	Intermediate spill 50 > 500 bbls, significant response required	Disruption to large community (National)
	Catastrophic (5)	Multiple fatalities, long term chronic / terminal illness	Explosion, major fire, equipment permanently damaged (Cost could exceed 50,000 USD)	Long term downtime;	Major spill greater than 500 bbls, extended duration, full scale response	Disruption to extended community (International)

Detailed description of the NMI:

During launch of the TEMPSC during routine lifeboat training, Supervisor in attendance heard cracky intermittent noises. After lifeboat was launched, Supervisor stepped on the foredeck to investigate further. Upon closer inspection of the forward Fall Block, it was noticed that the split pin on the bolt was missing, and the bolt had nearly came out of the retaining washer.


Fall Block, with washer/bolt combination


Retaining washer, with thread of bolt visible, and SPLIT PIN fitted;



Upon dismantling of the block, two fragments of the broken split pin were found in the body of the bolt:

Had the bolt come out of the retaining washer, it would have resulted in the TEMPSC dropping and falling down by the head (with the aft wire/fall block still connected), either on the pool deck or in the water. With passengers onboard, this could have resulted in significant (multiple) injury and/or fatality(s).

Initial Actions taken:

TEMPSC taken out of service, and barred from further use. Notified Director Offshore, and investigative assembled.

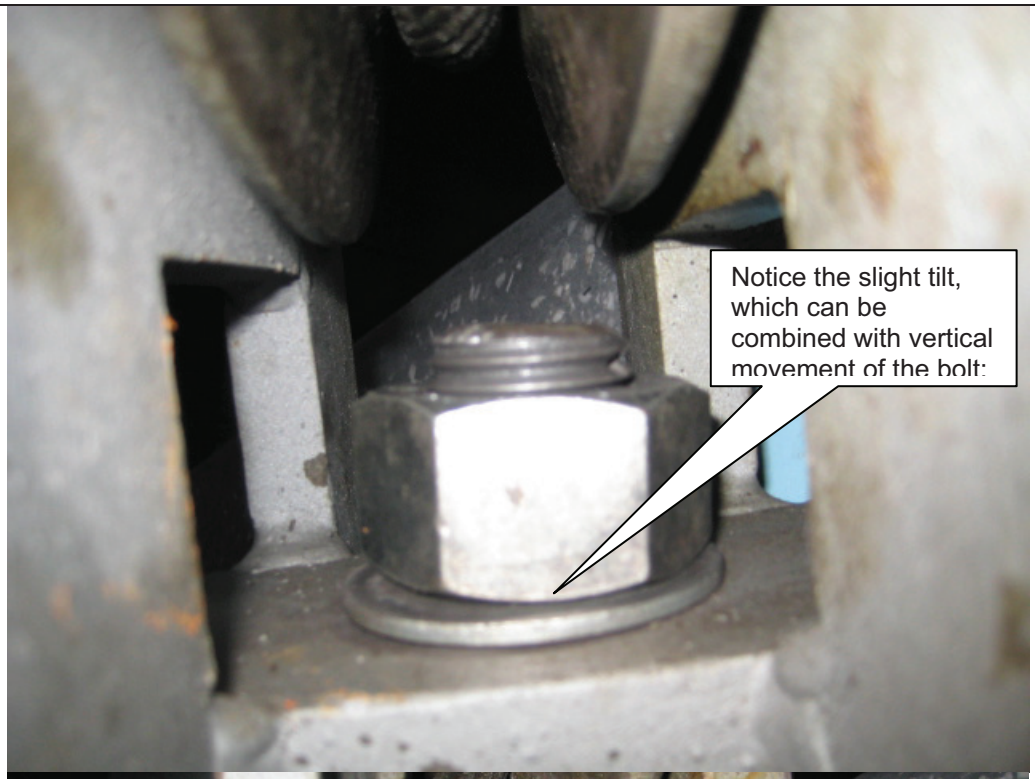
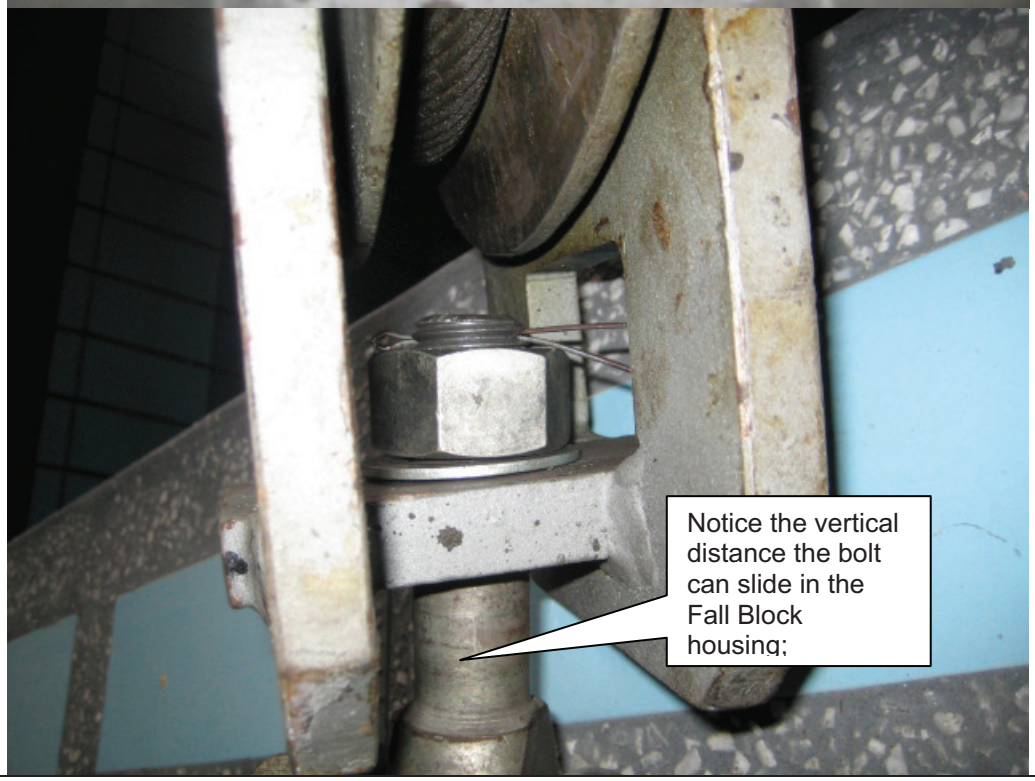
Sourcing new original split pin, and in the meantime temporary split pin installed.

Composition of the Investigative Team

	Name	Position
1	**Paul van Empel (Team Leader)**	D/O
2	Aung Zaw	Supervisor
3	Kyaw Zin	O/I
4		

Conclusions (including Root Causes) by Investigative Team:

1	Cause of failure of SPLIT PIN cannot be established conclusively; it may be possible, though improbable, that during greasing operations on 22nd of September (quarterly maintenance routines) the split pin got damaged, and the bolt gradually came out during 6 launch/recovery operations of the TEMPSC.
2	A more likely cause is that the split pin got damaged during normal handling of the Fall Block (offload) when UOTC staff is recovering the TEMPSC. It has been noted that the Operators shake the Fall Block vigorously to check whether the lifeboat hook has closed properly. The bolt can slide vertically in the Fall Block, as well as rotate freely. Investigative team also established that bolt can tilt slightly in the housing, and it is possible that the combination of vertical/rotational tilting motion during this vigorous handling caused the split pin ends to make contact with the pulley in the Fall Block housing and disintegrate.

	 
3	It was also observed that during testing of the aft Fall Block and washer/bolt combination, that the washer is very loose and can rotate independent of the bolt. This could have resulted in the SPLIT PIN being damaged.
4	Whatever the cause, this is a NEAR MISS that could have caused serious injury/material damage, and/or loss of reputation/income. Its reoccurrence can be prevented by increasing inspection routines.
5	

Actions (to be entered in Status Report):				
	Action	**Action Party**	**Close Out Date**	**Status**
1	New SPLIT PIN (original) to be sourced, and installed;	Supervisor	1st Dec 2011	OPEN
2	PRECOURSE CHECKLIST for lifeboat operations to be updated to include new routine: Check all split pins on TEMPSC and lifeboat davits, prior launch of TEMPSC is authorized;	DO	5th Oct 2011	CLOSED
3	Consider rigging safety strops through Fall Block and Lifeboat Release Hook, to arrest fall of TEMPSC if washer/bolt combination fails. This is to be carefully considered, as the fitting of safety strop or shackle may cause damage to the SPLIT PIN;	DO/ Supervisor	5th Oct 2011	OPEN
4	Near Miss Incident to be discussed during forthcoming Safety Meeting, and all UOTC personnel to be instructed to observe new PRE COURSE checklist routines, as well as be alert for unusual noises during routine operations.	Supervisor	15th Oct	OPEN

NMI Close Out approved by: (following approval, AM will enter into Status Report)	
Date:	