IMCA Safety Flash 01/09

January 2009

These flashes summarise key safety matters and incidents, allowing wider dissemination of lessons learnt from them. The information below has been provided in good faith by members and should be reviewed individually by recipients, who will determine its relevance to their own operations.

The effectiveness of the IMCA safety flash system depends on receiving reports from members in order to pass on information and avoid repeat incidents. Please consider adding the IMCA secretariat (imca@imca-int.com) to your internal distribution list for safety alerts and/or manually submitting information on specific incidents you consider may be relevant. All information will be anonymised or sanitised, as appropriate.

A number of other organisations issue safety flashes and similar documents which may be of interest to IMCA members. Where these are particularly relevant, these may be summarised or highlighted here. Links to known relevant websites are provided at www.imca-int.com/links Additional links should be submitted to webmaster@imca-int.com

1 Anchor Drag Near-Miss Incident

A member has reported a near-miss incident in which a barge anchor was dragged approximately 300 metres along the seabed and came within metres of a live export pipeline. Following a visual survey of the pipe 100m either side of the anchor location, it was confirmed that there was no apparent structural damage to the pipeline.

The following causal factors were identified:

- Failure to identify that available monitoring information indicated a potential anchor drag;

Following investigation further causes were identified:

- Training and competence
  - There was no competency defined for the anchor winch operator position
  - There were no properly identified training requirements for the anchor winch operator position;
- Procedures
  - Anchor operating procedures were available on the vessel. However, the anchor winch operators were not aware of the location or content of the current procedure
  - The anchor winch operators were unaware of the existence and contents of anchor operating procedures which contained monitoring requirements and contingencies in the event of an anchor dragging
  - Enforcement of operating procedures in the past had not been thorough and failure to follow procedures has gone uncorrected;
- Management systems
  - Pay-out counting devices were not used as a standard operating practice despite requirement under the procedures
  - A monitoring tool had been reported as broken four days earlier; the defect had been reported to maintenance but the person in charge was not informed. The anchor winch operators continued the operation without fixing the tool
  - There was no record of any management system compliance audit having taken place on the barge;
- Safe systems of work
  - Despite one of the anchor winch operators having over 12 months' experience, the two anchor operators were the least experienced on shift at the same time.

The company involved has put the following actions into place:

- Develop competency matrix for all job roles and monitor competency;
- Implement mentoring system for inexperienced staff;
- Ensure shift schedules are properly balanced to ensure experienced personnel teamed with less experienced personnel;
- Make operating procedures accessible to the crew and ensure crew are aware of operating procedures through ongoing communication;
- Conduct safety management system audit of barge to confirm compliance with standard operating procedures;
- Ensure all crew members are appropriately supervised;
- Ensure all crew members are involved in the daily pre-start meetings;
- Ensure safety critical equipment is repaired prior to activities commencing.

2 Dangers of Medicine Abuse

A member has reported two incidents highlighting the dangers of the inappropriate use of prescribed medicine. On two different offshore vessels personnel took prescription medication that was not prescribed for them.

One of the cases was thought to be life threatening and required emergency medical evacuation by helicopter. In addition to the medical risk to the patient there was also unnecessary risk to the medical crew and significant cost incurred for the medical evacuation and onshore support.

The second case was managed by onboard medical personnel.

Both cases were considered to be unsafe acts and violations of the company's drug and alcohol policy and, as such, grounds for disciplinary proceedings possibly leading to dismissal.

The following lessons can be drawn from the incidents:

- Personnel should always report to the site medic any prescribed medications as well as 'over the counter' (non-prescription) medications being used while at work;
- Always follow dosage instructions on all prescribed and 'over the counter' (non-prescription) medications;
- All warnings related to potential food interactions and interactions with other drugs should be fully heeded;
- Never share medication prescribed for you or another person and never accept prescribed medication from another person.

3 Counterfeit Hydrostatic Release Mechanisms for Life-Rafts

Members' attention is drawn to the attached warning from the Swedish Maritime Safety Inspectorate which has been passed to IMCA, relating to the sale of faulty counterfeit hydrostatic release mechanisms for use on life-rafts.

SWEDISH MARITIME SAFETY INSPECTORATE
Ship Technical Division

Date
17 December 2008

Our reference
070206/08/22948

Your date

Your reference

Directorate General of Shipping
Joint Director General
Walchand Hirachand Marg
Ballard Estate
Mumbai 400 00
India

Dear Sir,

It has come to the knowledge of the Swedish Maritime Safety Inspectorate that someone is producing counterfeit copies of the Swedish Hammar H20 hydrostatic releases for liferafts. To an untrained eye the copies look almost identical with the original product, with Hammar's logo and address on the labels, but there is, however, one very important difference: the copies do not work.

A ship-owner has recently purchased a number of Hammar H 20 hydrostatic releases from a ship chandler in Mumbai, India. The products came in boxes marked CM Hammar AB, Gothenburg, Sweden. The ship-owner tested the releases and lowered five of them into the water; only one of the hydros actually cut the line. They contacted CM Hammar AB in order to alert the company regarding the malfunction of the releases. The company asked them to return the faulty products, and when they arrived it was discovered that the products were not manufactured by the company. The ship-owner also returned five releases still in their boxes. The company have tested them, and not one worked properly according SOLAS specification (if they worked at all) and the LSA Code 4.1.6.

The Swedish Maritime Administration is very concerned about this situation. There may be a number of ships sailing with counterfeit hydrostatic releases. It is of utmost importance to find out who the manufacturer of these products is, and make him stop production and sale. The only lead to the producer, which the Swedish Maritime Administration has, is that the products were purchased at

INTERNATIONAL SHIPS' STORES SUPPLIERS

101, 'Navratan Building' 69
P.D 'Mello* Road, 1st floor, Carnac Bunder
MUMBAI – 400 009. INDIA
Phone: 91-22-23440057
Fax: 91-22-23439719

We ask for your kind assistance in this matter to obtain, if possible, more information regarding the origin of the counterfeit products. Please, do not

Date
17 December 2008

Our ref
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hesitate to contact our LSA-expert Roland Eklöf who can be reached at his e-mail address roland.eklof@sjofartsverket.se.

Yours sincerely,

Johan Franson
Director of Maritime Safety

Cc
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CM HAMMAR, GÖTEBORG, SWEDEN

SAFETY ALERT – DANGEROUS H20 FAKE COPIES!

It has recently come to our attention that someone is producing fake copies of our Hydrostatic Release Unit, the Hammar H20. To an untrained eye, the copy is almost identical to the original product, with Hammar's logo and address on the labels. The fake might look almost like the original product, but there is one very important difference: **the copy does not work!**

We have tested several of the copies. Not a single one of them worked properly according to SOLAS' specification – **the fake H20 will definitely not release a life raft or an Epirb.** We see this as a very serious situation. There can be a number of ships at sea that are sailing with fake Hydrostatic Release Units. If any of these ships were to sink, there will definitely be no life rafts or Epirbs that will help to rescue the seafarers in danger!

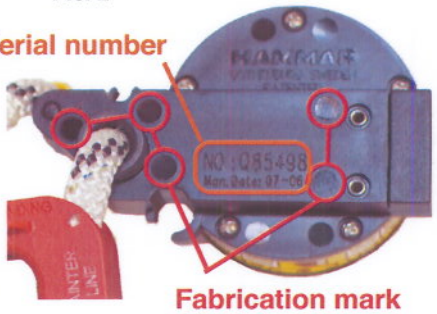
How can you quickly check that you have the original Hammar H20?

- Always purchase your products through approved distributors or authorised service points for life rafts and Epirbs
- Make sure that you receive the Hammar multilingual product manual and a raft label with each unit for life raft H20 or Hammar marking instruction for Epirb H20. *(Pic 1)*
- If you check on the underside of the Hammar H20 you should be able to find 5 (five) fabrication marks on all units produced since April 2006. Units produced before that date have only 2 (two) fabrication marks. *(Pic 2)*
- The serial number and production date can always be verified by contacting CM Hammar at info@cmhammar.com. *(Pic 2)*
- The fabrication mark on the upper side of the unit must always point directly towards the rope. *(Pic 3)*

Pic. 1

H20 unit with the multilingual product manual and raft label

Pic. 2



Pic. 3

If you have any questions regarding this matter please contact us.

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