

These flashes summarise key safety matters and incidents, allowing wider dissemination of lessons learned 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](mailto: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](http://www.imca-int.com/links). Additional links should be submitted to [webmaster@imca-int.com](mailto:webmaster@imca-int.com)

## 1 Fall from Height

One of our members has reported a fatal accident that has recently occurred on board one of their vessels. A rigger fell whilst undertaking maintenance activities in one of the vessel columns.

Before entering the column a Permit to Work (PTW) had been raised, and personnel carrying out the work had been briefed on the requirements of the generic risk assessment. Two employees had been assigned to the task in hand, one entered the column and the other remained in attendance at the top. Fall arrest equipment was utilised to descend 15 metres onto an intermediate work platform. Upon arrival at the platform he disconnected the fall arrest equipment. He subsequently fell from a height of 3 metres sustaining fatal head injuries.

A full investigation is ongoing, however, in the meantime the company involved has issued the following instructions to its vessels:

Before any HAZARDOUS activities requiring a PTW for tank/confined space/column entry and working at height (over 2 metres) are commenced a task specific risk assessment shall be performed on board the vessel and submitted to the Safety Department and Operations Department for review.

When conducting a risk assessment the following shall be considered:

- a) Designated Area Supervisor involved in all aspects of the work;
- b) Suitability of personnel for task. (e.g. physical/medical condition, size constraints);
- c) Atmospheric testing (prior to every entry and during work activities);
- d) Type of harness and fall arrest capabilities (In all cases where egress is from above full body harness are preferred);
- e) Access and egress (Inclusive of emergency egress);
- f) Equipment required;
- g) Emergency/Contingency Team to be assigned and briefed (BA sets stretcher etc readily available);
- h) Communications with sentry;
- i) Number of personnel required to enter;
- j) Environmental conditions (Lighting, temperature, surface conditions);
- k) Full briefings (including emergency response teams);
- l) Any Hazards not identified by generic risk assessment.

## 2 Overloading of Survival Craft

We have received the safety alert below, issued by the US Minerals Management Service.

# Safety Alert

**MMS**

U.S. Department of the Interior  
Minerals Management Service  
Gulf of Mexico OCS Region

Safety Alert No. 192 revised  
January 29, 2001

Contact: Jack Leezy  
504-736-2503

## Water Survival Craft

The MMS is revising Safety Alert No. 192 by changing the seat widths as reflected in the report. The revised Safety Alert follows.

The Minerals Management Service (MMS) and the United States Coast Guard (USCG) have examined a report of a study conducted by an offshore operator of their survival craft payloads. This study looked at the manufacturer's design standards for several models of covered survival craft (lifeboats) used on the operator's offshore facilities. During this examination, the operator discovered that some of their survival craft were rated by the manufacturer to accommodate more personnel than the operator could properly seat within the unit. This was confirmed during several field trials. The operator concluded that this occurred because the "average" worker on their offshore facilities was larger than the approved design standard used to build the survival craft. The personnel weight standard used for the design of survival craft is 165 pounds with a seat width of 17 inches. Although this standard may be appropriate for the offshore industry in other areas of the world, it may not be appropriate for personnel working in the GOM. The operator's study concluded that the average offshore worker at their facilities weighs 210 pounds and has a seat width of 21 inches. Therefore, the difference in weight and width of the design standard and that of the personnel in the offshore industry in the GOM could have an effect on the seating capacity, stability, buoyancy, and structural adequacy of the survival craft. To accommodate the larger personnel at their GOM facilities properly, the operator chose to reconfigure some of the seating, as well as de-rate the overall capacity of selected survival craft.

The operator examined this same issue with respect to life rafts, but did not observe a similar problem.

Operators are advised to be aware of these potential overloading situations on survival craft caused by the larger size of the average GOM offshore worker. **For more information, operators are urged to contact their nearest Coast Guard Officer in Charge of Marine Inspections.**

—GOMR—MMS—

Visit our Safety Information Website:

<http://www.gomr.mms.gov/homepg/offshore/safety/safety.html>

### 3 Recall of Divex LP Helmet Bailout Whips and Interstage Hoses

Further to earlier advice on these products, attached please find the recall notice issued by Divex.



## **DIVEX SAFETY NOTICE**

### **URGENT URGENT URGENT**

**Divex Ltd.**  
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### **Safety Notice No. DVX001/2001**

### **RECALL OF DIVEX LP HELMET BAILOUT WHIPS AND INTERSTAGE HOSES**

Further to our Safety Notice No DVX003/2000 dated 8th Dec 2000 Divex Ltd have been made aware of an LP hose failing during operation. As detailed in our previous safety notice DVX003/2000 the user had subjected this hose to a 20kg load test. The hose passed the test and then went on to fail during operation.

### **DUE TO THE ABOVE DIVEX LTD HAVE NO ALTERNATIVE BUT TO RECALL ALL LP HELMET BAILOUT WHIPS AND INTERSTAGE HOSES SUPPLIED TO CLIENTS SINCE AUGUST 1999.**

Since 1999 all LP hoses supplied by Divex have a Divex label. Divex Ltd is aware of the impact this may have to our clients operations but as a responsible manufacturer we have to put safety ahead of all other considerations. We have performed extensive testing on LP hoses over the last month but have been unable to replicate the failure. For this reason at this time we cannot offer replacement hoses. Divex Ltd are however making every effort to seek alternative suppliers of hoses who meet the standards required which should assist in meeting clients immediate needs. We are also carrying out a complete review of hoses to ensure that when we commence manufacture we are using the best possible design and materials. This is not of course an overnight process but is being given our topmost priority.

This very unusual situation has arisen despite the application of rigorous Type Approval and routine manufacturing tests. These include load testing to 1000N, leak testing to 42 bar and burst pressure testing in excess of 100bar. All hoses have additionally been subjected to routine tests of 200N load and 42bar leak.

At this time we are undertaking cyclic pressure tests of 0-21 bar. These tests will more than simulate the breathing pattern seen through a hose. The hoses tested to date have shown no failures after 1000 cycles. They have also been subjected to an axial load whilst under pressure with no adverse effects. Burst tests on hoses have shown that they are passing the requirement to withstand 100 bar and typically bursting at 120 bar. The hose is physically bursting with the hose ends remaining intact. We are sure that when these facts are reviewed by you our dilemma and yet correct decision in recalling the hoses will be understood.

### **Please mark all returned hoses for the attention of Kathleen Scanlan Quality Manager Divex Ltd**

Divex apologise for the inconvenience caused to our valued clients by this problem but believe this is the correct course of action until we have established the exact cause of failure. Once established we will immediately issue a further statement.

SIGNED \_\_\_\_\_  
G.Gilbert, Senior Manager, Safety and Personnel

DATED: 31<sup>st</sup> January 2001