IMCA Safety Flash 02/05

February 2005

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) 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

Other Sources of Safety Flash Information

IMCA is currently assembling a set of links to other sources of safety alerts, which will be added to our website at www.imca-int.com/safetyflashes including such sites as:

- SADIE (Step Change) – http://step.steel-sci.org/SADIE/main_sadie_fs.htm
- Marine Safety Forum – www.marinesafetyforum.org/safety-alerts-notices.asp
- OGP safety zone – http://info.ogp.org.uk/safety/

Input from members and others would be appreciated to help extend this resource – please e-mail Philip.Wiggs@imca-int.com

1 Fatality – Fall from Height

We have received information on a fatality which occurred when a person fell from a high voltage transmission tower whilst wearing the appropriate PPE (fall arrest system).

The full incident investigation is incomplete, but information available from the preliminary investigation indicates that the cause of the incident was the failure of the fall arrestor lanyard. Early indications are that the stitching on the harness side of the lanyard failed when it took the load of the person's weight.

The lanyard was a SALA Zorba twin elastic lanyard (tieback 2 metre H186 alloy hook), product number Z622035E. The lanyard appeared to be in good condition and was approximately two years old. While the investigation is pending, the company involved has withdrawn this make of equipment from use.

The company's own procedures, as is also required under some regulatory regimes, required personal fall protection equipment (PFP) to be visually inspected prior to each day's use. In addition, lanyards and fall arrest systems were required to undergo an annual inspection by a competent person and had to display a legible information tag. Any such equipment showing signs of deterioration or damage, regardless of its degree, was to be taken out of service and destroyed. Out-of-date equipment was to be taken out of service until re-inspected by an appropriately qualified person.

The company issued the following instructions in light of the incident:

- construction inspectors and supervisors to review this flash/the incident at their next safety meeting;
- all PFP equipment to be inspected as set out in the company's procedures, with such inspections documented and records made available for audit;
- the specific make and model of lanyard to be withdrawn from service pending further investigation and analysis.

It has been noted that the lanyard did not carry a US-domestic product number and was not commonly used by US contractors.

Further outcomes from the investigation are to be communicated in due course.

2 Vertical Lay System Dropped During Quayside Mobilisation

A member has reported a high potential incident (HIPO) which occurred during the recent mobilisation of a vertical lay system (VLS) at the quayside. Fortunately, no one was injured. However, the VLS was damaged and some less serious damage was sustained to the vessel.

It is understood that the bottom section of the VLS, weighing approximately 265 tonnes, had been made ready for loading onto the vessel, using a permanent quayside crane. A fifteen minute test, with the load suspended on the crane had been successfully completed and loading operations commenced. As the load was in the process of being lifted onto the vessel, the load was seen to drop. It struck the starboard wing wall of the vessel and fell outboard onto the quayside.

The incident is currently subject of a comprehensive investigation and at this early stage it is impossible to state with any certainty what the causes of the incident were. However, key lessons learned will be shared with members through a further IMCA safety flash when the investigation has been concluded.

3 Fire at Sea

IMCA has been advised of a fire on a vessel which destroyed a substantial amount of diving equipment.

The photographs demonstrate the level of heat generated in a short time frame, but are quoted as not demonstrating the real potential this incident had to have developed into a major disaster. A 50l air cylinder was exposed to the heat and several 40 gallon oil drums were stored within meters of the scene. It is not difficult to imagine the conflagration which may have ensued had the fire not been contained in time.

According to the incident report, the fire, which began in a rubbish basket (approx 2m x 2m), was extinguished in 15 minutes. It is not certain what the ignition source was, but either a hot welding rod or a cigarette butt is suspected. Contributing factors have been noted and include an overflow of rubbish and strong prevailing winds. Congestion in the area is apparent by the evidence of the photo on the left.

Recommendations by the vessel safety department are:

- the basket be modified into a burn basket;
- no overflow of the basket contents and immediate incineration of combustible waste;
- electrodes to be disposed of in metal containers, not in the rubbish basket;
- no throwing of cigarette butts into the basket.

The company involved has noted that good housekeeping is always a prerequisite at work and even more so on a vessel. It is not simply the moment which needs to be considered, but also the follow-on effects when things go wrong. Fact-finding in this case is still ongoing but this alert has been sent with the intention of prompting vigilance and as a warning of the potential consequences if rigorous standards are allowed to slide or are not adhered to.

4 Securing of Loads

An incident has been reported to IMCA which, although relating to a road incident, provides an important reminder in relation to the securing of loads.

During transportation of five empty skips between a shore base and terminal, the top-most skip was blown from the top of the stack and landed on the road. No injuries occurred and no vehicles were damaged, but evasive action appears to have been taken by third party vehicles on the road to avoid the skip. There was the potential for multiple permanent injuries or fatalities and for damage to property.

The skip was lifted back onto the truck, secured to the other skips and to the truck with a strop and the journey was recommenced.

On arrival at the terminal the incident was reported to the site management and the local police. An investigation was then initiated, which identified the following likely causes:

- The skips were stacked five high, one on top of the other, significantly above the height of the truck cabin;
- There was high wind loading – the wind increased during the journey to approximately gale force, with gusting;
- The skips had been inadequately secured to the truck, with no strops used.

It was noted by a member that the skips were reloaded on one lorry and the journey was resumed in much the same manner, albeit with an extra strop attached.