

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

1 Potential Problem with By Flex Fire Extinguishers

One of our members has informed us that the suppliers of Hy Flex fire extinguishers have advised them that there is a potential problem with their DDC fire extinguishers. Following a study of the units, it has been discovered that the M3 grub screw set into the handle, which acts as the main valve, is missing from some of the units.

While operating a faulty unit, only the handle acts on the pin, and consequently causes malfunction of the unit. Therefore all units need to be checked to ensure that the relevant screw is in place.

Should the screw be missing, then the extinguisher should either be removed from service until a replacement screw is available or a competent person should fit a compatible M3 screw to the handle and adjust accordingly.

2 Entry Procedures

On a semi-submersible drilling unit, the port-aft column was opened up to allow a team to gain entry for visual inspection of an instrument on the cross-tubular section. Access to this section was via one of the ballast tanks. Since the rig was under tow at the time and had become slightly out of trim, the control room operator started to pump seawater into the port ballast tank. On completion of the inspection and when bolting the access hatch back up, one of the team members noticed that the water level was slowly rising. The team evacuated immediately and the control room was told to cease the ballasting operation. Although a permit to work system was in operation, the control room operator was unaware that the inspection team had passed through the tank to gain access to the cross member. The seawater inlet valves were normally remotely operated from the control room but no mechanical or electrical isolations had been carried out. A full risk assessment had not been done although the inspection team had carried out a toolbox talk. Also in place was a tank entry procedure and bolted plate closure procedure.

The incident highlights the importance of the use of risk assessment and of following correct procedures.

3 Explosion during Removal of Old Resin Plugs

A near miss incident recently occurred when there was an explosion of the resin/wire plug in a 'Wirelock' ROV umbilical lifting/docking cone. Heat, applied using an oxy acetylene torch to remove the old resin/wire plug ready for re-termination, caused a build up of fumes which led to an explosion. The explosion shot the armoured strands from the cone several feet in the air.

The contractor involved has elected to ensure that where possible old resin plugs are removed from sockets by cold press techniques. Where heat has to be used, the contractor advises that heat should be applied from a low heat torch, the socket positioned to allow the fumes to escape from both ends and the work carried out in a well-ventilated location.

4 Container Incidents

Three separate incidents have been reported involving container double and personnel doors.

- i) A control van personnel door fell off whilst someone was trying to open it; fortunately the individual jumped clear as the heavy door fell to the ground. The hinges of the door had been broken during sea transit in severe seas and the door was only held in position by the rubber seal and the door closing/lock mechanism.

The contractor now ensures that all container hinges are checked prior to opening when the container arrives for mobilisation and that all hinges are regularly greased and examined as part of routine maintenance.

- ii) In the second incident a workshop/tool container door fell off its hinges. This was a result of rust causing severe wear and tear, which led to the hinges eventually breaking with the weight and the torque of the door being opened and closed.

Door hinges require regular maintenance as the elements can cause them to rust and seize up. Again this emphasises the need for hinges to be regularly greased and examined as part of routine maintenance.

- iii) The third incident occurred in rough seas and high wind. A control container personnel door swung shut unexpectedly catching a person's fingers in the door.

The contractor involved now ensures that container doors are held by suitable close/lock mechanisms in a closed position or if it is necessary to have a door held open, then it is securely held.

5 Fire

A fire occurred when paint ignited in a bulk storage area on a vessel due to welding being carried out on the main deck. The firewatcher for the area had gone off for a break whilst the welder was on his break. Welding resumed without checking that the firewatcher was in place.

The contractor involved has elected to ensure that hot work permits include statements regarding communication between the firewatcher and welding crew.

6 Anchor Handling Incident

An incident occurred on a vessel which was conducting an anchor handling operation. A sudden tensioning and de-tensioning of the tugger wire occurred, probably due to the vessel rising or falling on the swell. The second mate, who had run towards the tugger wire, was hit by the tensioned wire, thrown into the air, landed heavily and was knocked unconscious.

The contractor involved has elected to review their anchor handling operations procedures in the light of this incident. They are also to include an overview of their Safety Management System and emphasis placed on risk assessment for each task undertaken in their Safety Induction.