

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 Plough Recovery Incident

An incident was recently reported to us which occurred during the recovery of a plough whilst cable laying.

The emergency plough recovery system used incorporated an Emergency Life Line (ELL). When the ELL became puckered on the stern chute during recovery a webbing strop was employed to aid its recovery, attached via a tugger winch. Unfortunately the ELL became snagged on the rudder and as it came free of the rudder it was sucked into the thruster, which in turn caused the weight to go onto the webbing strop/tugger winch wire which parted at the webbing strop. The wire on the tugger and ELL winch snatched violently inboard, injuring two men who were on the aft deck.

The contractor involved has made a number of recommendations to avoid repetition of such an incident. These include the following:

- ◆ The vessel is now fitted with a high tension slowdown facility which can be used whilst on DP
- ◆ The ELL, originally provided as an added security feature should the tow wire part, can cause excessive slack below the waterline at the stern end and therefore runs the risk of being sucked into the thruster and is to be replaced
- ◆ All lifting equipment is to be colour-coded. The incident investigation revealed that the webbing strop had never been certified or inspected during its time onboard

2 Regen Plumbing Incident

During the ten year pressure test of the regeneration plumbing onboard a member's vessel in dry dock, a cracked weld was discovered. The length of plumbing which contained this crack was removed and subjected to an x-ray, which revealed that the tube had deteriorated beyond an acceptable level. The tube was stainless steel seamed pipe and deterioration had occurred where this seam was welded. The contractor involved intends to replace all their regen plumbing with seamless tube.

3 Eureka Wire locks

An incident which involved the inadvertent release of a taut wire dump weight recently occurred on a member's vessel. The incident itself did not result in any injury, damage or loss of position. DP trials were being conducted in open water and the taut wire dropped to the seabed.

The cause of the incident was due to the wire being pulled through a Eureka wire lock. This occurrence, identified a discrepancy between the manufacturer's recommendations and guidance available on the use of these wire locks.

The manufacturer recommends the use of a single wire lock clamp to make an end termination. However, the International Rigging and Lifting Handbook (1997 edition), printed by North Sea Lifting, used by the contractor, recommends two Eureka wire clamps are fitted irrespective of the rope diameter.

The member has now issued instructions that when using Eureka wire locks, two are fitted to make a termination.

The member has also included the following in their instructions:

"The bolts supplied with the wire locks are of a high quality to meet the torque values and should never be replaced with standard bolts. In addition the bolts should be tightened to the correct torque values using the correct torque tools."

4 Loose Bolts on Turbine Engine Exhaust Stack

The following near miss on an offshore installation has been reported.

During high winds a 21m exhaust stack from one of the turbine engines on an offshore installation was seen to be moved abnormally. It appeared that the point of movement was at a joint halfway up the stack. Concerned that the top section might fall off, the installation was shut down and depressurised.

When scaffolding was erected and lagging removed, all 64 bolts around the joint were found to be loose and many bolts had come off – this is assumed to be due to vibration. It transpired that this part of the stack installed ten years ago had not been inspected since, while other parts of the stack were included on the maintenance schedule. Also the bolts used were not the ones specified in the design. These have since been replaced with bolts with a locking nut to prevent them from loosening during service.

This near miss highlights the need for inaccessible joints to be included in planned maintenance routines.