

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 Confined Space Incident

We have recently learnt of a tragic incident involving confined space entry. The two individuals were assigned to de-ballast 12" of water from a tank on a cargo barge. This entailed opening the hatch cover and accessing the tank to position the pump suction hose in the water. The foreman who entered first collapsed. The rigger, on seeing his colleague had collapsed, entered the tank to rescue him. The alarm was subsequently raised and both the individuals were recovered by personnel wearing breathing sets. Tragically they were found to be dead. The cause of death was oxygen deprivation. The atmosphere immediately above the water level was found to contain no oxygen.

There was a confined space entry permit procedure in place and the procedure was mandatory where confined space entry was necessary. No reason was found as to why the foreman elected to enter the tank on this occasion as he was familiar with the procedure and had used it a few days before.

The company involved has modified its procedure to require on all confined space work that the atmosphere in confined spaces be tested regardless of whether entry is necessary or not.

2 Termination of Elastic Shock Cords

We have recently learnt of a near miss where an ROV supervisor used an elasticated shock cord (bungee cord) to secure a television monitor in place. The cord was terminated with a hook-type device but the cord itself was looped back on itself and clamped with a clip.

When the cord was stretched to the second firing point, the clip failed to hold, resulting in it pulling through the hook and spinning out violently, narrowly missing the supervisor's face.

The company involved has undertaken the following actions:

1. replace, wherever practical, all bungee cords
2. if bungee cords are the only practical solution, ensure that a figure of eight knot is tied in the cord to prevent it being pulled through the hook end termination unit.

3 Near Miss with Cherry Picker Wire

While lowering a ladder using a cherry picker crane to a diver, the wire came off the drum and dropped uncontrolled to the seabed. The diver was well clear of the load at the time of the incident. The investigation revealed there was insufficient wire on the drum for the depth of water.

The company involved has initiated the following actions:

- ◆ wires to be painted to show when they are approaching the last layer on the drum;
- ◆ crane and winches to have maximum allowable working depth clearly displayed. This information is to be updated if cutbacks occur;
- ◆ drums of cranes to be adequately illuminated.

4 Information on Material Change to SL-17 Yoke

Below is copied an information bulletin received from Divex.

Change to Product Bulletin 2 of 2000: 3 Aug , 2000 (Revision of Bulletin 1 of 1999)

Subject: Material change to SL-17 Yoke

Products Affected: Yokes for all SuperLite 17 A/B and MK 21 Helmets.

DSI is replacing the existing fiberglass yoke (31), DSI Part Number 520-060, with a new yoke, DSI Part Number 520-117 (no price change). The new yoke is made of a durable black polyurethane, molded around a stainless steel core, and is slightly heavier than the fiberglass. This yoke will become standard equipment on all SuperLite 17 A/B & MK 21 helmets produced as of June 15, 1999.

The new yoke is **fully retrofittable** with the fiberglass unit it replaces and is readily retrofittable to all SL-17 A/B helmets. The only difference is that the three stainless washers, (DSI Part Number 530-530 - location number 30 on the exploded view), used on the fiberglass yoke hinge installation are **not used** on the polyurethane yoke hinge installation.

OLD PART NUMBER:
520-060

This fiberglass yoke will remain available as a special order spare part.

NEW PART NUMBER:
520-117

Note: There is no change of part number for the neckclamp / yoke assembly, 505-008 which is also now standard with the new black polyurethane yoke.
No Price Change.

