IMCA Safety Flash 05/99

August 1999

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 Transponder Explosion

We have received a report of an incident on one of our members' vessels where a Simrad SHT SPT 319 transponder was retrieved from the seabed. Once on deck and during the opening procedure of the housing, to enable the batteries to be checked, there was a build-up of internal pressure. This caused an explosion of the internal casing resulting in flying debris and the subsequent formation and release of possibly toxic gases. Fortunately no-one was injured in this incident.

The contractor involved has advised its personnel to treat all transponders with care and if there is any doubt about any unit it should be put in safe quarantine until expert help is arranged. They advise that Simrad's operations manual should be referenced for safety guidelines.

2 Lifeboat Drop Test

One of our members has recently experienced an incident during a lifeboat drop test carried out on three lifeboats. One of the three lifeboats failed its drop test due to the rear door opening after entering the water.

The lifeboat was loaded to 110% load (achieved with water bags) and included three personnel. The boat was fully submerged underwater during its dive and projection away from the platform. After surfacing it was clear that there had been water ingress to the boat. Fortunately there was no injury to the personnel in the boat. The on-site supplier representative performed adjustments to the door latches in order to increase latch tightness and the boat eventually passed the test after two more drops.

The member has informed us that the supplier was Norsafe AS, Faervik, Norway, who have confirmed to them that they have no previous experience of doors opening during this type of operation. The supplier is currently carrying out an investigation to determine the cause of the incident.