

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 Corrosion of Band Securing Screw on Diver Band Mask

A member has recently reported the failure of a band securing screw on a DSI Mrk 18B band mask. During the annual return to base for a full strip-down and service of the diver band mask, the company reported the failure of one of the band securing screws, resulting in the band falling away from the mask. The dive technician was re-assembling the unit and had already inspected both screws and considered them fit for use. While tightening one screw, the head of the screw fell off.

On closer inspection, severe corrosion could be observed where the head of the screw joined the threaded section. This corrosion was not visible prior to the failure – only slight wear of the cross-head was reported. Since then, the company concerned has instigated a full inspection of all band-securing screws with any screw showing slight wear being replaced.

2 Fast Rescue Boats (Zodiac)

One of our members has recently reported an incident on one of its vessels, whereby a rigger crushed his hand between the zodiac and the structure. A similar incident was known to have happened on another company's vessel, where the rigger also received a hand injury.

The similarity between the two incidents is striking, since both involved a zodiac connecting lines, which is a routine job carried out by experienced crew.

The company concerned noted that the majority of incidents on its vessels happen when:

- i) doing routine jobs;
- ii) using experienced crew (mainly riggers); and
- iii) using standard equipment and methods.

The company has noted the following lessons learned from the incident:

- i) Be alert;
- ii) Think before you act;
- iii) Do not take anything for granted;
- iv) If necessary, perform a job safety analysis.

3 Use of Hand-Held Disc Grinders

One of our members has recently received the following information on an incident:

A fatality occurred when a worker was using an air-powered disc grinder to cut grooves into cast iron. The disc fractured and a large fragment penetrated the worker's face shield and hit his face, with fatal consequences.

Several rule-violating factors contributed to this incident:

- i) the disc installed was larger than allowed for the grinder tool;

- ii) the disc guard had been removed;
- iii) the disc was not designed for this type of cutting;
- iv) the side handle had been removed;
- v) the marked disc speed was 4500rpm, while the grinder tool could make 7600rpm.

The following lessons learned were noted:

- i) Never remove guards installed by tool manufacturers;
- ii) Only use consumables recommended for the tool by the manufacturer;
- iii) Always check if tools are fit for the purpose before use;
- iv) Ensure face shields in use are adequately dimensioned for their intended use.

4 Fork Lift Truck Operations

A recent incident on one of our members' vessels occurred when working on an internal lifting tool, using a fork lift to lift and install grippers.

The gripper fell off of the forks and hit a man on his hand, causing serious crush wounds.

The main reason for the incident was that the forks were being used as a lifting tool. The grippers were attached using a rope. The rope was not secured against slipping.

Proper slings/shackles should have been used, along with a device to prevent slipping. On a similar vessel, a shoe and tie-back device is used.

The lessons learned from the incident were:

- i) use fork lift trucks for what they are designed for;
- ii) use proper slings, shackles and securing devices;
- iii) supervisors should check on all ongoing work.