## IMCA Safety Flash 06/99

November 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

## I SOPEP Oil Booms

One of our members has alerted us to a problem with one type of SOPEP oil boom – type SMB40.

SPOEP oil booms are normally manufactured using blown polypropylene as the absorbing membrane, contained within an outer cover manufactured and sewn together using polypropylene. Whilst polypropylene will begin to melt at 160°C, it will not support combustion.

Type SMB40 oil booms have been found to be covered in nylon, which will burn rapidly when in contact with an ignition source.

The member involved has instructed all of its vessels to remove these booms from service and has informed us that the manufacturer has withdrawn this type of boom from offshore sale and use.

## 2 Automatic Control - Navigation Problem

We have recently had reported to us this near-miss concerning an ROV support vessel and an unmanned installation. The vessel was operating under automatic control with the platform selected in the outboard navigation computer as the target destination.

On approaching the 500m zone, the on-shift Chief Officer commenced operations to position the vessel outside the 500m zone for field arrival trials.

However, as a result of his omission to deselect automatic control, the vessel failed to respond as he had expected and continued into the platform 500m zone at a speed of between three and six knots.

The Vessel Master, who was also on the bridge, realised that the automatic control had not been deselected. He changed to manual mode and stopped the vessel short of the platform.

The vessel is reported to have come within 10-60m of the structure.

Following the incident, the vessel departed the 500m zone and satisfactorily completed standard field arrival trials prior to starting DP operations.

The company involved has noted that the incident, which occurred on the UKCS, occurred as a result of the failure to comply with UKOOA's 'Guidelines for the Safe Operation of Offshore Support Vessels', Section 3 'Way Points', compounded by operator error. A number of corrective actions have been taken by the company to prevent recurrence of this situation.

## 3 Failure of a 1/2" BSP Cap Under Pressure on Well Service Work

The following incident was recently reported to us. It occurred on an offshore installation where the  $\frac{1}{2}$ " BSP cap appears to have blown off a pressure testing manifold under approximately 1200psi of water pressure. The cap and BSP/NPT connector were rated to 45000psi. The cap was not found, so the conclusions are based on the following assumptions:

- I. The cap was not fully engaged;
- 2. It was over-tightened.

The key lessons learned from the incident were identified as:

- 1. Be aware of the ratings, tightening procedures and limitations of all pressure fittings used in a temporary pressure system;
- 2. Pressure fittings should be in good condition prior to use in particular, threads should be free of paint and debris. If in doubt, use new fittings.