

IMCA Safety Flash 07/05

May 2005

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 ROV Free-Fall Incident

A member has reported an incident which resulted in a work-class remotely operated vehicle (ROV) free-falling approximately 10 metres into the sea during a recovery operation. No injuries occurred and only minor damage was sustained by the ROV, but the incident could have been severe with possible loss of life or damage to the vessel if the fall had occurred at a different stage of the recovery operation, or in bad weather conditions.

The company's site investigation revealed that the fall was caused by a lapse in the procedures used to safely recovery ROVs, probably due to complacency because of the stillness of the weather and over-confidence, due to the large number of times that the process had been completed. A contributing factor to the incident may also have been the fail-safe condition of the docking device.

The umbilical snapped at the outlet to the sheave block and is suspected to have failed due to a combined over tension from both the umbilical winch and the initial movement of the A-frame inboard. A block-to-block position with the lifting wire meant that the docking device was pulled by the umbilical to a non fail-safe position and subsequent snapping of the umbilical prevented the docking device from capturing the ROV again in time to prevent its fall.

The following actions were recommended as a result of the company's investigation:

- ◆ further investigations into the design of the docking device to improve its fail-safe features;
- ◆ verification of the strength of umbilicals via destruction testing of a cut-back on a yearly basis;
- ◆ review of launch and recovery procedures to verify risk assessments;
- ◆ improved training of personnel specifically aimed at launch and recovery scenarios;

review of lifting equipment to instigate visual indicators (colour banding, flags, lights, etc.) to represent the safe working areas and warn of 'danger zone' operational envelopes.

2 Product Safety Recall – Kongsberg RPT Transponders

We have been passed the attached product information bulletin relating to Kongsberg transponder models RPT316, RPT319 and RPT324 and spare end cap assemblies which we have been asked to bring to members' attention.

PRODUCT INFORMATION BULLETIN



KONGSBERG

ISSUED DATE: 13 MAY 2005

PRODUCTS AFFECTED: **TRANSPONDER MODELS RPT316, RPT319 AND RPT324 & SPARE END CAP ASSEMBLIES**

PRODUCT RECALL

It has been identified that there is a possible safety concern on the RPT range of underwater acoustic transponders. The likelihood of a serious product safety incident is considered small, but Kongsberg is advising all customers and users that there is a product safety recall in place for all possible affected products and related spare parts as of this date.

BACKGROUND

The RPT transponder units are designed to incorporate a built-in gas pressure relief valve in the back end caps as an enhanced safety feature. This feature is intended to prevent the build up of an internal product pressure differential in the event of certain rare fault conditions.

After review of a customer feedback we have identified that there is a small possibility that the pressure relief valve on certain RPT units (and related spare end cap assemblies) may not function as designed. The failure of the relief valve to operate as intended may create an increased safety risk under certain rare fault conditions which may allow a gas pressure build up inside the unit:

- Faulty internal battery conditions
- Electrolysis from a sea-water ingress
- Ingress of pressurised helium gas (diving environment)

PROPOSED ACTIONS

All RPT units, and related spare end cap assemblies should be removed from service at the earliest opportunity, and returned to Kongsberg Maritime A.S or Kongsberg Maritime Ltd for test evaluation and possible remedial action for those products affected.

Prior to transporting any RPT products from an offshore site, or from onshore warehouse or storage, please ensure that the following additional safety actions have been performed:

- Follow procedure contained in "RPT transponder pressure relief valve verification and repair" procedure circulated on 18th January 2005.

A copy of this procedure is attached.

Once the safety procedure has been performed on all identified RPT products, please contact KMAS or KML Customer Support department for a Return Material Authorisation (RMA) number. Contact details are provided below. Once the RMA number has been provided, the units should be consigned to KSAS or KML Customer Support Department for evaluation and remedial work if required.

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PRODUCT INFORMATION BULLETIN



KONGSBERG

Kongsberg Maritime Contact Addresses:

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