

IMCA Safety Flash 08/12

July 2012

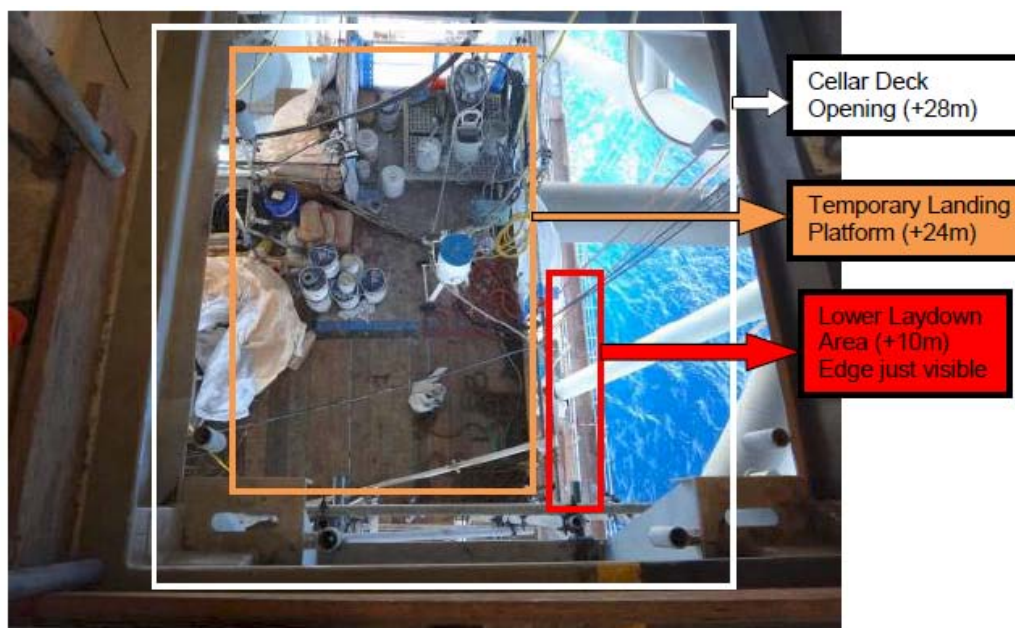
These flashes summarise key safety matters and incidents, allowing wider dissemination of lessons learnt from them. The information below has been provided in good faith by members and should be reviewed individually by recipients, who will determine its relevance to their own operations.

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.

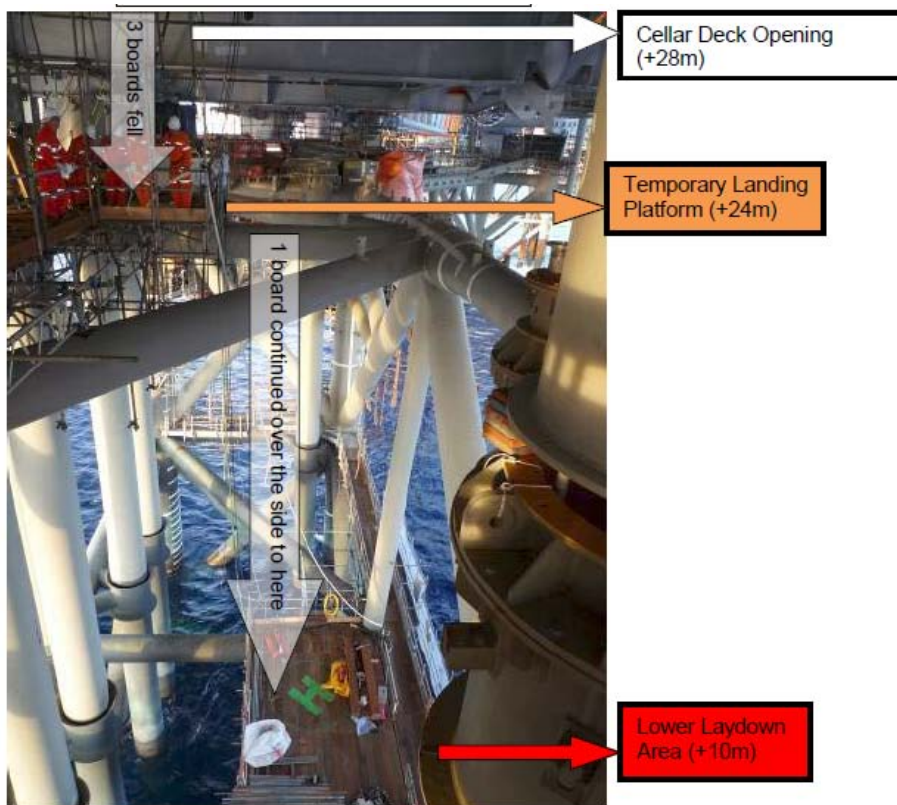
A number of other organisations issue safety flashes and similar documents which may be of interest to IMCA members. Where these are particularly relevant, these may be summarised or highlighted here. Links to known relevant websites are provided at www.imca-int.com/links. Additional links should be submitted to webmaster@imca-int.com

I Near Miss: Dropped Objects

A member has reported an incident on an offshore platform in which three scaffold boards fell 4m from one deck to another. The incident occurred when the scaffold boards were being lowered in vertical bundles of three boards through a hatch opening on the cellar deck. The crew were using a timber hitch and a half hitch on a 19mm hemp rope fed through a shackle attached to a beam clamp. Whilst lifting the bundle of three boards over the handrail of the hatch, the knot holding the boards together contacted the handrail, causing it to loosen. This resulted in the three boards falling to the temporary deck (+24m level) four metres below. One of the boards then ricocheted off and fell a further 15 metres, landing in an area where two painters were working. The scaffold plank grazed one of the painters on the arm before coming to rest. The painter was assessed by the medic, but no treatment was required.



View through Cellar Deck Opening to +24m landing



View from Sub Cellar deck +24 m level

An investigation revealed the following:

- ◆ Work preparation and risk assessment was not adequate – the HIRA controls had been ‘ticked off’ and yet not followed, and the work method was inappropriate for the volume of scaffolding being moved;
- ◆ Improper rigging practices were used – the rope was rigged over a shackle rather than using a gin wheel;
- ◆ Three boards were being lowered at once – industry practice is for two boards at once as a maximum.

The following lessons and actions were identified:

- ◆ Local scaffolding guidelines were updated to reflect industry practice of no more than two boards to be lowered at a time;
- ◆ Dropped object zones need to account for potential deflection.

2 Near Miss: Bell Umbilical Damage Incident

A member has reported an incident in which a diving bell umbilical was damaged after it was trapped between the cursor and the bell. After completion of diving operations a deck foreman was in the vessel bell garage assisting with bell recovery operations. He noticed that the white tape mark on the bell umbilical and the white tape mark on the cursor wire were not aligned as the cursor started to rise. He called an ‘all stop’ and the situation was investigated.

It was found that the umbilical was snagged under the upper guide wire slot on the cursor and was trapped between the cursor and the bell. The deck foreman advised the dive supervisor who lowered the bell back to 30m of sea water, in order to investigate the problem further. The umbilical was freed by slackening it and slowly raising the bell on the main winch. A Remote Operated Vehicle (ROV) was used to check the condition of the bell umbilical.

A slight leak was detected from damage observed to the umbilical outer sheath and a small amount of gas could be seen coming from one of the small pneumo-fathometer hoses. The divers secured the pneumo valves and the leak was stopped. The bell left 30m and internal pressure was maintained. The bell arrived on surface and was locked onto the system. All of the bell internal valves were closed and the system was bled down and the bell prepared for surfacing and sealed. All valves were secured inside the bell and the bell was recovered with the correct amount of tension on the umbilical for immediate transfer of the divers and assessment of the damage in the dry. There was no loss of integrity to the bell and the divers inside were unharmed.



View from ROV showing damaged umbilical leaking gas

During an investigation the following points were noted:

- ◆ The immediate cause of the incident was found to be that the dive supervisor did not ensure sufficient tension on the bell umbilical to eliminate the risk of it bunching, trapping and being damaged during bell recovery operations;
- ◆ Underlying causes identified were as follows:
 - loss of control: the dive supervisor lost concentration when distracted during the aft bell recovery operations/activities. Existing procedural and engineering control measures which might have prevented this were not effectively applied
 - design: the differential read-out monitor alarm indicator is a visual alarm only, and not audible also, which could go unnoticed;
- ◆ It was unclear whether or not the dive supervisor had noticed the visual alarm (red flashing bell in the screen of the differential read-out monitor) which highlights the differential selected for each dive undertaken;
- ◆ The dive supervisor was a very experienced member of the dive team, with great experience in using on-board bell launch and recovery systems, and had performed bell deployment and recovery operations numerous times in the past. On this occasion the dive supervisor believes he had become distracted and had not paid attention to the length of umbilical paid out prior to recovery;
- ◆ Experience and competence in tasks does not mean that the risks of being distracted, or losing focus, does not remain high when undertaking what may be considered “routine” tasks;

The following corrective and preventative actions were taken:

- ◆ Re-termination of umbilical;
- ◆ Installation of an audible alarm onto the differential panel read-out on the hydraulic control panel, which will enhance pre-existing warning controls of differentials when recovering dive bells;
- ◆ Bell launch/recovery risk assessments reviewed and updated with incident findings and addition hazard control measures.

3 Near Miss: Failure of Load During Lifting

The Marine Safety Forum (MSF) has published the following Safety Flash regarding a near miss incident in which a 20 tonne subsurface buoy split in two and fell 30cm back onto the trailer from which it was being lifted. There were no injuries or damage to the trailer. The only equipment damaged in the incident was the buoyancy itself.

The report can be downloaded from www.marinesafetyforum.org/upload-files//safetyalerts/msf-safety-flash-12.28.pdf

4 Platform Supply Vessel comes into Contact with Fixed Platform

The MSF has published the following Safety Flash regarding an incident in which a platform supply vessel came into contact with the leg of a fixed platform, causing some slight damage to the leg. The immediate cause was found to be mechanical failure of a relay in the engine control system.

The report can be downloaded from www.marinesafetyforum.org/upload-files//safetyalerts/msf-safety-flash-12.29.pdf