

IMCA Safety Flash 09/11

July 2011

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 Failure of Fall Wire - Update to Safety Flash 05/11

Members will recall that the UK Marine Accident Investigation Branch (MAIB) published Safety Bulletin I/II regarding the failure of a fall wire which caused a rescue boat to fall into the sea, with a subsequent fatality.

Following further findings regrading this incident, the UK MAIB has published a second Safety Bulletin 2/11 (attached) on this incident. The failure of the fall wire was the result of the malfunction of a proximity switch. The incident occurred as the rescue boat reached its stowed position on the davit following a monthly drill. Hoisting was not stopped before the davit reached its stowed position. The proximity switch, that should have cut electrical power to the winch motor before the davit reached its stops, failed to function. The rescue boat and its four crew members fell nearly 29 metres into the water below. One of the boat's crew members had died and two were hospitalised.

Further information can be found at www.maib.gov.uk/cms_resources/SB2-11.pdf.

MAIB SAFETY BULLETIN 2/2011

Malfunction of a proximity switch, which resulted in failure of a fall wire with the loss of one life on the car carrier *Tombarra*



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MAIB SAFETY BULLETIN 2/2011

This document, containing safety lessons, has been produced for marine safety purposes only, on the basis of information available to date.

The Merchant Shipping (Accident Reporting and Investigation) Regulations 2005 provide for the Chief Inspector of Marine Accidents to make recommendations at any time during the course of an investigation if, in his opinion, it is necessary or desirable to do so.

Steve Clinch

Chief Inspector of Marine Accidents

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NOTE

This bulletin is not written with litigation in mind and, pursuant to Regulation 13(9) of the Merchant Shipping (Accident Reporting and Investigation) Regulations 2005, shall not be admissible in any judicial proceedings whose purpose, or one of whose purposes, is to apportion liability or blame.

This bulletin is also available on our website: www.maib.gov.uk
Press Enquiries: 020 7944 6433/3387; Out of hours: 020 7944 4292
Public Enquiries: 0300 330 3000

Figure 3

The winch was operated by a control panel sited forward of the davit. The boat was hoisted using the buttons on the control panel until the davit was near the stowed position. It was then intended that hoisting be completed manually by the use of a winch handle adjacent to the winch motor. To prevent the inadvertent operation of the winch when the rescue boat was in its stowed position, an inductive proximity sensor/ switch (Telemechanique XS7-C40FP260) was fitted on the davit (Figure 3). The switch was intended to cut off power to the winch when the davit closed to within approximately 12mm of the sensor.



Proximity switch on davit

Annual inspections of the davit system had been conducted by Schat-Harding service engineers since the vessel was built in 2006. The last service was conducted in September 2010.

INITIAL FINDINGS

The fall wire was observed to be in good condition and when tested after the accident it achieved a breaking load of 137kN. The wire parted near the lower most davit sheave as the rescue boat reached its stowed position and the winch was still hoisting under power. Although the winch motor was rated with a nominal pull of 50kN, the maximum pull that it was capable of exerting when trying to overcome the increased resistance in the system during the final stages of hoisting would have rapidly exceeded the breaking load of the wire. The proximity switch, which should have prevented this situation from occurring, was tested in situ and was found to be defective.



Water ingress into proximity switch

The switch was installed in 2006, and prior to the accident it was not tested before hoisting was commenced. Inspection identified that the switch body had been penetrated by water (Figure 4). However, detailed analysis highlighted that the switch malfunctioned due to an unrelated electronic fault. The MAIB is aware of both inductive proximity and mechanical limit switches fitted on other vessels that have also failed to operate correctly. However, none are known to have resulted in a similar accident.

The rescue boat was weighed and was approximately 450kg overweight (see MAIB Safety
Bulletin 1/2011 for further details). Although the additional weight caused the davit's SWL to be exceeded, by itself it would not have caused the wire to fail.

Figure 3

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SAFETY ISSUES

- The maximum pull of a hoist winch can exceed its nominal pull several-fold, and therefore is likely to exceed the breaking loads of other system components unless this is prevented by a properly functioning 'final stop' or safety device.
- The proximity switch fitted to the Schat-Harding SA 1.5 davit, and also known to be fitted to the SA 1.75 davit, is considered by its manufacturer to be inappropriate for use as a 'final stop' or safety device.
- The fitting of the proximity switch was not compliant with its manufacturer's
 instructions. As a result, the gland and cable entry were higher than the switch body
 and its susceptibility to water ingress was increased.
- Given the potential catastrophic consequences of the failure of the proximity switch
 fitted to the SA 1.5 and SA 1.75 davits, it is essential that owners of vessels fitted
 with these davits (over 320 vessels) are made aware of the potential limitations of
 the switches and the precautions to be taken.
- All devices (inductive and mechanical) fitted to davits to prevent overload must be maintained, tested and replaced in accordance with manufacturers' recommendations.

ACTION TAKEN

Schat-Harding has issued a Product Awareness Notice (PAN) to its customers highlighting the need to test the proximity switches fitted on its SA 1.5 and SA 1.75 davits on each occasion before hoisting operations commence, and recommends that the proximity switch is replaced every 2 years; it also highlights the need for caution when using pressure washers on deck.

RECOMMENDATION

\$117/2011 Owners and operators of vessels equipped with boat davits should:

- In the case of vessels fitted with the Schat-Harding SA 1.5 and SA 1.75 davits, follow
 the advice contained in the PAN recently issued by the manufacturer or urgently
 contact Schat-Harding¹ if a PAN has not been received.
- Ensure that all devices (inductive or mechanical) fitted to boat davit systems to
 prevent overload are tested on each occasion before a boat is hoisted and that such
 devices are not relied upon during operation.
- Follow manufacturers' recommendations regarding the maintenance and periodic testing, examination and replacement of safety devices, seeking clarification from manufacturers where ambiguity exists.
- Verify the effectiveness of watertight seals on electrical equipment fitted to boat davit systems on weatherdecks.

Issued May 2011

¹ service@schat-harding.com