

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 Failure of ROV Lift Umbilical Winch Brake - Update

In the Safety Flash 09/01 we gave an update on the design problem found in a Macartney Cormax unit manufactured by Norlau (see Safety Flash 08/01). A member advises that they have determined with the manufacturer of the winches that the hydraulic motors were inadvertently supplied without two check valves being fitted (although the circuit showed them being in place). The manufacturer will be refitting all of the members' winches with replacement motors. The member understands (but cannot sure) that the manufacturer will be advising all other users of these winches about the problem. The member is continuing to operate the winches in slow speed until each motor has been replaced.

2 Dead Man Anchor Supplied Unfit for Purpose

A clump weight was sent to a member's dive ship with the intention of it being used as a dead man anchor (DMA). The offshore manager correctly rejected the weight as not being fit for purpose for diving works on the grounds that it was unstable because of the limited steel base of the weight, in relation to its height.

This type of weight or 'pill' is part of a much bigger 50 tonne DMA, which is used for wire initiation. Its main frame holds four pills and is lowered to the seabed empty; thereafter each 11 tonne pill is inserted into the main frame. The steel frame on the bottom of each single pill is used for transportation purpose only and is not intended to act as sub-sea stability for the weight itself, which is lifted from the transport frame before being deployed on the sea bed.

The member advises that under no circumstances should this type of weight or other types which have an inadequate base size to height ratio, be used as a DMA; and that inspection of equipment to ensure its fitness for purpose is essential during the planning phase of a project.

3 Vessel and Port Security

A member has sent a safety notice that was passed to him from a major oil company which is of interest to all members.

Two stowaways were found on board a construction vessel that had sailed from the Shetland Islands to the Hoton Field. It is understood that the two persons initially arrived in Lerwick by stowing away in a container on another ship coming from Denmark. They realised that they were not on the British mainland and hoped to get there by stowing away on the construction ship, not realising that it was destined for an offshore field. They were discovered in a rigging container and were subsequently disembarked and handed over to the authorities in Peterhead.

The potentially more serious aspect raised is that the two persons could have been terrorists with a mission involving an offshore installation. This could have resulted in a what is described as a very high incident profile, particularly following the recent events in the USA.

The company concerned may be producing guidelines to issue to diving/construction contractors concerning container security/search, ship search/security and security controls when mobilising/demobilising personnel to a ship during port call.

Whilst this was understood to be an isolated incident, the company advises taking reasonable steps to prevent any unauthorised people embarking on ships. Bearing in mind that sub-contractors and suppliers may send containers to their ships, they also thought advisable to contact marine agents in all the ports in which they operate to make them aware of the potential threat. They request making in-house logistics and stores personnel aware of the need to secure containers whilst awaiting transfer to ships and confirmation from their regional managers that this has been done.

Similarly, their ships' captains are told to make their crews aware of the need for extra vigilance whilst in port and when they are conducting their usual search routines.

4 Near Miss Incident Lowering Concrete Mattress

A member reports a diving near miss incident when a concrete protection mattress was being moved into position.

A concrete flexible protection mattress was being deployed by ship's crane whilst divers were ready to receive it on the sea bed. The procedure demanded that the mattress should be lowered some 60 m offset horizontally from the divers' position, stopped 10 m from the seabed awaiting instructions before moving the load towards the divers. Visibility was about three to four metres.

During the lowering operation, crane operators changed over and after it was lowered to the prescribed depth, the diving supervisor gave instructions for the mattress to be shifted horizontally toward the divers' position.

The divers noticed the mattress when it was about two metres away from them but already in partial contact with the sea bed instead of about 10 m off bottom. Nobody was injured.

On investigation, it was established that during the crane operator shift change, the first operator had failed to zero his meter when the load was at the water surface and the replacement operator had not questioned the validity of the meter reading showing the length of wire deployed, having assumed that it had been zeroed. As a result the load contacted the sea bed when the operator expected it to be more than 10 m up.

The member posted the following reminder in the ship's cranes and recommended that similar ones be posted beside control panels on all cranes capable of subsea operations in the fleet.

Please remember the following rules when deploying loads to the sea bed:

- ◆ Before lifting the load off deck, check with dive/shift supervisor regarding the lateral position and initial depth at which the load is to be deployed;
- ◆ Always zero the load or hook at the surface of the water and report when completed to dive/operations control;
- ◆ During lowering, inform control of the depth of the load every 10 m until it reaches 10 m above the seabed when lowering is stopped;
- ◆ Act only on dive/operations control instructions for further crane movements;
- ◆ Change over of crane operators shall not take place during the lowering or lifting of a load.

5 Insecure Crane Lighting

A sodium floodlight is reported to have fallen from a crane boom. On investigation, the floodlight mounting bracket was found to be cracked and the pad eye weakened and this gave way. The floodlight swivel arrangement was also found to be worn. No serious injury was sustained on this occasion.

The member instigated inspection of all boom lighting fixtures. Ancillary fittings such as these can be overlooked in crane maintenance.

6 Reaction Brackets on the Divex SLS System Backpack

Attached please find a caution notice recently received from Divex concerning the above.

DIVEX CAUTION NOTICE



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Caution Notice No. DVX003/2001
Divex S.L.S. Mk IV
Part Numbers D323 & D325
Reaction Brackets

FOLLOWING INVESTIGATION OF A REPORTED FAULT ON AN SLS SET WE HAVE IDENTIFIED A POTENTIAL PROBLEM RELATED TO A REACTION BRACKET THAT MAY CAUSE A FAILURE IN THE ACTIVATION OF THE S.L.S. Mk IV.

Divex wish to advise all users to check the gauge/thickness of the reaction brackets on the S.L.S. System Backpack. There is a concern that a bracket(s) with a gauge/thickness of less than 1.4mm **may** be in Service.

ANY REACTION BRACKET THAT HAS A THICKNESS OF LESS THEN 1.4mm SHOULD BE REPLACED.

Reaction Brackets are available as spares from Divex.

FAULT IDENTIFICATION METHOD:

a) Visual Inspection:

- Ensure the metal has not become twisted, bowed or damaged.
- The reaction bracket should be at a 75-degree angle to ensure proper activation, any angle less than 75 degrees may be an indicator that the activation bracket has begun to bend and that the gauge/thickness may be less than manufacturers current specifications.

b) In the event that the bracket is damaged or of the wrong gauge/ thickness:

- The brackets must be changed.

NOTE: Only a trained S.L.S. Technician should carry out repairs and maintenance on the S.L.S. Mk IV

- Do Not Re-Crimp or re-use the reaction bracket if it has been removed from actuation cable assembly, Part No. C2937, or deformed. The bracket must be a Divex manufactured Bracket, Part No. D323 Right hand bracket, Part No. D325 Left hand Bracket.

After re-assembly the backpack should be donned and activated to confirm smooth actuation of the counterlung cables. This does not require the system to be dived.

For further information contact Kathleen Scanlan on the above telephone or fax number. Alternatively e-mail to safety@divex.co.uk

SIGNED _____

G.Gilbert, For and on behalf of Divex Ltd.

DATED: 11th September 2001