IMCA Safety Flash 11/19

May 2019

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 info@imca-int.com

Any actions, lessons learnt, recommendations and suggestions in IMCA safety flashes are generated by the submitting organisation. IMCA safety flashes provide, in good faith, safety information for the benefit of members and do not necessarily constitute IMCA guidance, nor represent the official view of the Association or its members.

1 Fatality and Multiple Injuries: Flash Fire Incident Onboard Pipelay Barge

What happened?

During pipelaying activities on a pipelay barge, Injection Moulded Polypropylene (IMPP) equipment at a coating station got stuck. Pipelaying activities were stopped and repair operations were started. The crew started to dismantle the machine to investigate the problem. It was discovered that the piston was stuck inside the Polypropylene accumulator chamber. Whilst trying to pull out the stuck piston, a vapour cloud blew out from the accumulator chamber. The cloud ignited, resulting in a fire in which fourteen persons were injured. The fire was extinguished by the barge crew.

After medical evacuation, one of the injured crew members subsequently died at the hospital.

What actions were taken?

- Injured personnel were treated in the barge clinic and then evacuated to the local hospital for immediate treatment and stabilisation;
- A dedicated air ambulance was organised to transfer the injured persons to specialised centres abroad within the following two days;
- An investigation team was appointed and mobilised on-site;
- The barge operations were stopped, and the barge was towed alongside.

Our member notes that this incident is still under investigation, but confirms the following general recommendations:

- Be aware that Polypropylene should always be kept within the temperature range specified in the safety data sheet;
- Check that the IMPP equipment has a reliable integrated control system to monitor the Polypropylene accumulator chamber temperature to prevent overheating;
- Heating of the system should only be carried via the integrated control system;
- The range of repair operations that may be conducted by the user should be established in consultation with the manufacturer.