IMCA Safety Flash 13/13

September 2013

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

1 Near Miss: Un-noticed Expiry and Deterioration of Carbon Dioxide Absorbent Material

A member has reported a near miss incident in which carbon dioxide absorbent material expired and deteriorated beyond usable condition. This was discovered when a saturation diver reported an acidic taste in his mouth during a lock-out.

Our members' investigation revealed the following:

- The reclaim tower was found to contain CO_2 absorbent with an acidic odour;
- 27 drums of CO_2 absorbent had recently been received onboard the vessel as part of a field transfer of materials;
- The drums were stored in a shaded area behind the dive complex;
- The crew taking delivery did not check the condition of the material when it arrived, believing that the sender had already checked it prior to delivery;
- 23 of the 27 drums of CO_2 absorbent received were found to be discoloured and had an acidic odour;
- Some of the containers did not have labels attached: some were past their "use by" date, and some were still in date;
- The caps of the containers did not seal correctly, exposing the material to salty moisture, extreme heat and high humidity (tropical environmental conditions);
- While there was guidance in company manuals on the quantity of CO_2 absorbent to be used per man per day, there was no company guidance on the correct handling and storage of CO_2 absorbent.

Figure: Showing the discoloured CO_2 absorbent material (note flecks of stained or off-white pellets).

Figure: Showing good CO_2 absorbent material (note white pellets).

Our member took the following actions:

- All CO_2 absorbent material found to be discoloured or expired was immediately removed and replaced with fresh supplies of in-date absorbent material;
- Guidance on the correct handling and storage of CO_2 absorbent, including guidance on delivery inspection, was prepared and issued;
- Guidance on the management of materials that have a shelf life, and are subject to expiry dates, was prepared and issued.

The following lessons were learned:

- Packaging deterioration can occur during the transportation, handling and storage of absorbent material. Once seals have been compromised and moisture enters storage drums, the shelf-life of the material will shorten dramatically. This is particularly so if the material is stored in high-temperature/high-humidity locations;
- Some CO_2 absorbent drums are supplied without expiry dates from vendors. These should not be accepted;
- On receipt from the vendor, expiry dates should be checked to ensure there is a suitable shelf life remaining (recommend a minimum of 1 year);
- Whenever materials subject to shelf-life are transferred from a marine-base to a worksite, or from worksite to worksite, expiry dates should be checked;
- If any transferred goods are due to expire within six months, then the recipients should be specifically informed;
- No items that have exceeded their expiry dates should be used;
- Care should be taken that expiry dates are tracked, and that replacement stock is ordered ahead of expiry;
- Care should be taken to use consumables in order of their expiry (i.e. use the oldest first);
- Any items that exceed their expiry dates must be clearly marked as expired and returned to the appropriate marine base for disposal.

2 Bunkering Hose Cut by Propeller

The Marine Safety Forum has published the following safety flash, regarding an incident in which a bunkering hose was damaged because it sank and fouled the propeller.

The safety flash can be downloaded from www.marinesafetyforum.org/upload-files//safetyalerts/msf-safety-flash-13.20.pdf

3 Crewman Injured Whilst Changing Out Crane Wire

The Marine Safety Forum has published the following safety flash, regarding an incident in which someone was injured while changing out the wire on the crane. The injured person was directly in the way of the crane wire when it spring back owing to stored mechanical energy, and suffered a small cut just above the eye.

The safety flash can be downloaded from www.marinesafetyforum.org/upload-files//safetyalerts/msf-safety-flash-13.21.pdf

4 Spillage of Oil-based Mud

The Marine Safety Forum has published the following safety flash, regarding an incident in which an amount of oil based mud (OBM) was spilt onto the deck of a newly commissioned platform supply vessel (PSV).

The safety flash can be downloaded from www.marinesafetyforum.org/upload-files//safetyalerts/msf-safety-flash-13.22.pdf

5 Dropped Object Near Miss: Wind Sensor

A member has reported an incident in which part of a plastic fixed unit wind sensor weighing 0.8kg dropped 10m to the top of the bridge roof. The wind sensor fell from the top of the aerial deck to the top of the bridge deck. At the time of the incident there were no works taking place on the ROV deck or on the roof of the bridge; there were no injuries. Weather conditions at the time were gusting southerly winds at 11m/s or 21.3 Knots, and the vessel was heading into the wind.

Use of the "DROPS calculator" for this dropped object showed that the potential had it actually hit a person was for a major LTI.

Our member took the following steps:

- Ensured that all vessel departments have a robust DROPPED Objects inspection regime in place;
- Ensure all equipment at height is in a planned preventative maintenance program;
- Check fixed unit equipment to ensure that integral fixings are in place (if possible check securing means).

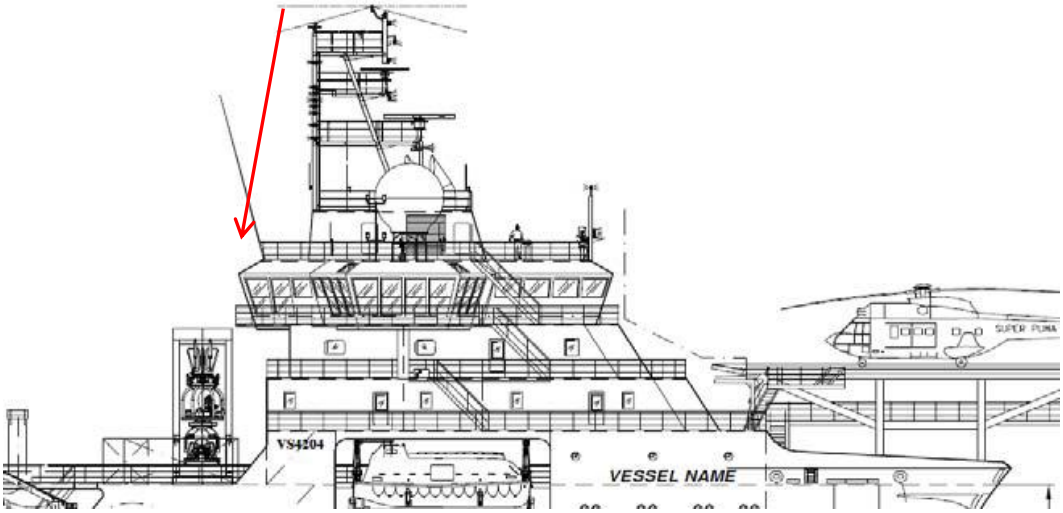

Figure 1 - Showing where wind sensor fell, from the top of the aerial deck to the top of the bridge deck

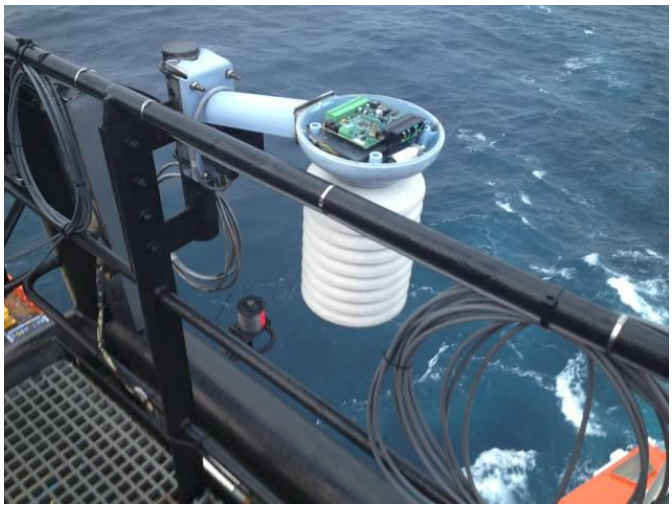

Figure 2 - showing wind sensor in situ without it's lid

Figure 3 - Showing the lid of the wind sensor (weight 0.8kg)

Member's attention is drawn to the following IMCA material which may be of assistance:

- IMCA SPP 04 - *Avoiding dropped objects*;
- IMCA SPC 12 - *Avoiding dropped objects*.