

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 Offshore Telescopic Gangway

We have received the following 'safety alert' from UKOOA – the UK Offshore Operators Association:

'Recent investigations on an unplanned disconnection of a marine aluminium telescopic gangway identified a potential for a single point failure of joystick pressure control valve which could result in 350 bar hydraulic pressure being applied to 50 bar rated joysticks.'

2 Potentially Defective Ball Valves

The following information has been reported to us as a 'safety alert' received from the UK Health and Safety Executive.

'The results of recent investigations have indicated that several hundred potentially defective ball valves have been manufactured by a small UK based engineering company. The majority of the ball valves in question appear to have been supplied to the offshore industry and to date there have been no known in-service failures. They are bespoke valves often used in high temperature, high pressure applications such as gas compression. Following joint action involving police, intermediate suppliers and the HSE it is believed that most of the valves have been identified, their end users alerted and appropriate action taken.

It is believed the valves in question vary in size from 0.75 inches to 8 inches and were manufactured between late 1995 and early 1999. The company appears to have traded under a variety of names during this period, including Nixon Industrial Valves, Nixon Valves, Nixon Industrial, Valve Shop Ltd (VSL), GBV Ltd, JSF Valves Ltd, JSF Derby Ltd and from the late 1997 to March 1999, Stanton Engineering and Stanton Ball Valves.

If you purchased one of the valves specified above and you have not already been contacted you should immediately determine if any of the valves are being used on a safety related duty and if so assess the risks having:

- ◆ checked all the documentation with particular reference to any associated test certification, from the original material specification to final pressure testing;
- ◆ contacted the relevant testing house that issued the certification to verify the authenticity of the certificate and that inspection/testing was carried out.

If after completing the above actions you have doubts about the integrity of any particular valve or its ability to perform the duty for which it was specified you should contact the company that supplied the valve to you for advice. In the event of any difficulty, or if you require any further action you can telephone the Offshore Safety Division of HSE on 44 (0)151 951 3889.'

3 Joystick Controls

We have received the following information from one of our members, where that member's vessel suffered a loss of joystick control for no apparent reason, whilst working alongside a rig with a bulk hose connected.

The joystick manufacturer's engineer visited the vessel, as soon as it returned to port and thoroughly checked out the joystick panel, finding no reason for the failure in the process. Current thinking is that a radio signal caused the control failure. This is not an unknown effect, as another of their vessel's found that transmissions from a small UHF portable radio caused the same type of failure. When the portable radio's aerial was removed, the effect disappeared. Portable telephones are also known to have similar effects on the control equipment.

The member advised that persons should be aware of this potential problem and that, when working alongside an installation, a quick, clean changeover to manual control can be affected before the vessel loses position, should a similar incident occur. They advise that it would also be prudent to practise regular changeover drills, from joystick to manual, if anyone does not already include this as part of a ship's regular, emergency exercises. The problem does not appear to be specific to any single manufacturer, so they advise that everyone should be made aware of this problem.