

## IMCA Safety Flash 05/09

April 2009

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](mailto: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](http://www.imca-int.com/links). Additional links should be submitted to [webmaster@imca-int.com](mailto:webmaster@imca-int.com).

### 1 Fire in Vertical Lay System Moonpool

A member has reported an incident in which there was a fire in the moonpool of a vertical lay system (VLS). A vessel had been involved with the recovery of redundant/damaged 10" flexible flowlines to on-deck storage reels, and 'wet storage' (on the seabed) was being prepared for a previously recovered section of 10" flowline. (This flowline section had been flushed of hydrocarbons in January 2008.)

Following the recovery of the flowlines to deck, the vessel made several transits totalling approximately 12 kilometres over a 19 hour period. Work was approved to remove some gouges on the VLS moonpool doors utilising a pneumatic grinder. A highly experienced, and competent, boilermaker proceeded to grind out the gouges on the moonpool doors with the grinding sparks directed down and into the moonpool water.

A fire started on the water within the moonpool centraliser and then grew to an above deck height of more than two metres. The person conducting the grinding was using body harness/fall arrest equipment as the moonpool doors had been opened slightly to give him better access. When the fire started, he experienced difficulty in escaping from the area as the fall arrest unit prevented the pay-out of the cable. Fortunately a nearby colleague freed him from the fall arrest cable and they both escaped from the fire area without injury.

The fire alarm was raised and the fire was extinguished within 25 minutes of the alarm being sounded with no persons injured or harmed.

The following were noted:

- ◆ The moonpool area, including the area below the VLS doors, was visually checked prior to the grinding, but nevertheless nobody observed or identified the presence of flammable liquids within the moonpool;
- ◆ At the earlier onshore hazard identification and risk assessment, the presence of 'inhibited seawater' containing very low hydrocarbon levels had been identified, however a fire risk or accumulation of flammable hydrocarbon products within the confines of the moonpool had not been considered as a potential hazard;
- ◆ The concentration of hydrocarbon levels found within the 10" flowline was inconsistent with the hydrocarbon levels expected ('flushing fluid' consisting of hydrocarbon < 30mg/ltr (flushed earlier in 2008)). It is possible that there may have been localised concentration of oil in the intervening period through gravity separation of fluids of different densities and/or reintegration of oil trapped in the interstices of the rough bore pipe carcass;
- ◆ The application of the permit to work, risk assessment and associated process were not sufficiently robust or effective and several management system improvements have been identified/implemented;
- ◆ Competency of the onboard personnel resulted in the fire teams responding very quickly and bringing the fire under control in a timely manner.

### 2 Personal Locator Beacons on Helicopters

Further to recent helicopter accidents in the UK Offshore Sector, the UK Civil Aviation Authority (CAA) has stopped the use of passengers' personal locator beacons (PLBs) when on helicopter flights for the UK offshore oil and gas industry.

An explanatory note from the CAA is attached, together with an announcement from Oil & Gas UK. Further enquiries should be as directed to [bhallbauer@oilandgasuk.co.uk](mailto:bhallbauer@oilandgasuk.co.uk) or to [philip.wiggs@imca-int.com](mailto:philip.wiggs@imca-int.com)

Press release:  
ISSUED BY OIL & GAS UK  
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## REINSTATEMENT OF SAFETY BEACONS A PRIORITY, CONFIRMS OIL & GAS UK

Finding a technical solution that will allow personal safety beacons to be safely reinstated for all helicopter passengers flying offshore is a matter of priority, oil and gas industry body Oil & Gas UK confirmed today (19 April).

This was one of the key helicopter safety issues discussed at the first meeting of the industry's Helicopter Issues Task Group in Aberdeen on Friday (17 April).

Bob Keiller, CEO of PSN and chairman of the task group, said: "Reinstating these beacons, known in the industry as Personal Locator Beacons or "PLBs", is being dealt with by an industry workgroup which was set up by Oil & Gas UK soon after an offshore helicopter ditched in the North Sea in February. At Friday's meeting, the Helicopter Issues Task Group agreed that the momentum must be maintained on this work and even accelerated where possible so that we can get PLBs back in use as quickly as we can."

Following the ditching of the helicopter in February, the preliminary investigation by the Air Accidents Investigation Branch (AAIB) revealed that when the PLBs worn by the passengers were automatically activated during the ditching, they interfered with the long range rescue beacons fitted to the helicopter and life rafts. This interference resulted in these main aircraft beacons being shut down, which could have seriously hampered search and rescue operations if the incident had occurred at night or out of view of the offshore platform.

As a result of the AAIB findings, the Civil Aviation Authority (CAA) instructed helicopter operators in the UK that all PLBs had to be switched off for the duration of offshore flights because of the risk of inadvertent activation and subsequent risks of interference with aircraft safety systems.

The PLB workgroup, involving representatives from the manufacturers, helicopter operators, PLB users and the Health & Safety Executive, is meeting tomorrow (Monday, 20 April) to identify the various options for a possible technical solution.

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For further information, contact:  
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### Note to Editors

1. The Helicopter Issues Task Group was established by leaders of the UK offshore oil and gas industry immediately following the North Sea Flight 85N helicopter tragedy of 1 April. It held its first meeting on 17 April, 2009.
2. It set up to act on behalf of the industry as a communications focal point for sharing information, advice and learning across the industry and with other stakeholders on matters arising from this and previous helicopter accidents.
3. The group is chaired by Bob Keiller, CEO of PSN and currently involves representatives of the companies directly affected by the recent fatal accident as well as Grampian Police. At the first meeting, It was agreed to invite all offshore helicopter operators, the trade unions and representatives from the oil and gas workforce to future meetings.
4. Oil & Gas UK is the leading representative organisation for the UK offshore oil and gas industry. Its members are licensed by the Government to explore for and produce oil and gas in UK waters and those who form any part of the industry's supply chain.

## **Passenger Personal Locator Beacons (PLBs)**

### **Briefing for Offshore Passengers:**

As you may be aware a recent incident involving an offshore helicopter has highlighted some concerns about passenger PLBs.

The UK Civil Aviation Authority (CAA) has discovered that passenger PLB's may interfere with the long range rescue beacons that are fitted to the helicopter and life rafts. This could impact the effectiveness of search and rescue operations.

As a result, the CAA has instructed that all PLBs must be switched off for the entire duration of your flight.

In order to have a common approach, the industry has agreed to stop the carriage of all PLB's onboard oil and gas related helicopters until a technical solution to the problem can be found.

PLB's can still be used offshore onboard platforms but will be transported offshore either as freight or, if onboard helicopters, will be stored securely in the unarmed position.

An Industry Workgroup is looking at medium and long term solutions to the issues, and will work to resolve this issue as quickly as possible.

Thank you for your attention.