

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 Webbing Strop Failure during Transponder Recovery

Keywords: *Lifting*

A DSV was conducting diving operations recovering a previously installed transponder array. During the transponder recovery the diver connected the transponder beacon's webbing strop (supplied with the transponder) and a separate vessel strop on the tripod stand to the crane hook.

The load was lifted off the bottom and the divers moved clear under the vessel. The crane lifted the load 10m then slewed to stern and carried on coming up. Upon arrival at surface the transponder beacon was found to be missing. Due to compliance with safe crane and diving operations, there was no personal injury or subsea asset damage. The transponder beacon was subsequently located close to original lifting position.

In the resulting investigation, the stitching on the webbing strop on the transponder beacon was found to have failed. The webbing strop had not been subjected to certification or maintenance. In communication with the supplier, the hire company stated that the webbing strop was not supplied for lifting purposes but only for general handling.

The company's immediate actions were:

- ◆ Issue of a safety alert;
- ◆ Removal of any hire company supplied webbing strops from all transponder beacons;
- ◆ All future transponder deployment and recovery operations are to be carried out with strict adherence to company procedure;
- ◆ All sites are to carry out a safety brief to make personnel aware of this incident;
- ◆ Site management are to reiterate with personnel the requirement to carry out pre-use visual inspection of lifting equipment;

The company has also noted the following longer term actions:

- ◆ Discussion with transponder supplier of suitable lifting equipment arrangements;
- ◆ Issue of a company work instruction to identify suitable lifting arrangements for transponders;
- ◆ Sharing of lessons learned with industry, through IMCA.

2 Defective Hammer Shaft

Keywords: *Hand tools*

To support a new client policy, a company was changing over to the use of fibreglass shafts for all hammers over 2lbs. One of the first to be sent offshore was a 14lb hammer. Within a short period of use, the shaft showed signs of cracking just behind the head of the hammer. Use was stopped and the defect reported.

After discussion with the supplier and the client, all fibreglass handled hammers were withdrawn and the company involved has reverted to wooden shafts.

The company involved has restated the importance of taking care in the selection of tools, noting that the latest technology may not be necessarily better than tried-and-tested equipment. It reminds personnel that good pre-use inspection remains a critical requirement not to be ignored or bypassed.

3 Fatality – Fall from Suspended Work Platform

Keywords: Fall

A man was working on the lower level of a suspended modular scaffold. He fell from the scaffold through a gap between two modular platform sections. The plywood used to bridge the gap between the two platforms was found on the floor. He fell from approximately 18 metres, sustaining severe injuries. He was taken to hospital, but died from his injuries.

The subsequent investigation noted the following contributory factors:

- ◆ the supervisor and his team had not received training concerning scaffolding procedures;
- ◆ the supervisor thought the scaffolding was safe merely because it was set up, so he authorised the person involved to go to the work location to complete previous day's activity;
- ◆ there was a lack of communication between the sub-contractor setting up the scaffolds and the sub-contractor using the scaffolds;
- ◆ the victim had not recognised a 90° tube across the platform walkway as a barrier.

4 Fire Incidents

Keywords: Fire

Fire is one of the greatest risks to vessels and everybody needs to be on constant guard to prevent fires. We have recently received the following reports of incidents involving fires.

4.1 Fire in Crane 440V Contact Box

In this incident, a contact burnt out and set fire to adjacent cables and auxiliary switches. The complete contact, damaged cables and switches had to be renewed/repared.

The company involved has reinforced planned maintenance/regular inspection schedules.

4.2 Fires involving Laundry Tumble Dryers

4.2.1 Electrical Component

In the first incident of this type, the main heater element in a tumble dryer overheated and ignited, possibly due to an insulation problem. The only damage was to other electrical components.

The defective part was replaced and all damaged areas were insulated.

The company involved has added regular inspection of insulation properties by the ETO to its maintenance regimes.

4.2.2 Lint Build-Up

In this incident, a heater element overheated due to a fault and lint ('fluff') behind the drum caught fire. The fire did not reach the vent. Due to a shortage of spare parts (the dryer was old), the dryer was replaced.

As a precaution, the vent trunking was thoroughly cleaned with any build-up of lint removed and the piping was improved to give better exhaust capability.

In this instance, the lint filters in the machine were found to be clean of build-up of lint, but the company involved has reiterated instructions to stewards on its vessels to ensure there is no build-up of lint prior to each use and to ensure that such units are never overloaded.

4.3 Fire in Equipment Space – Welding in Vicinity

During welding/burning on an adjacent wall or floor, a fire broke out in a machinery space on a vessel.

The company involved has reiterated the importance of its permit-to-work (PTW) system, along with the need to perform job safety analyses (JSAs) for all 'hot work' performed outside of designated hot work areas.

The company noted the following precautions to be included in the above:

- ◆ fire watches at the point of hot operations and in other spaces above or below that may be affected by the work;
- ◆ portable fire extinguishers and fire blankets to be present;
- ◆ combustibles to be cleared away prior to commencement of the work.