

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 Trapped Pressure Release Incident

A member has reported a trapped pressure release incident in a dive system transfer chamber. The incident occurred onboard a diving support vessel undergoing commissioning of its saturation diving system following a dry dock. The system was compressed to an equivalent internal depth of 333 msw and then returned to ambient surface pressure.

A saturation diver entered the dive system transfer chamber, less than an hour after the system had been returned to surface pressure, and decided to flush the toilet system as there was a strong smell of sewage. On operating the bulkhead valve to evacuate the holding cylinder no movement of the contents was heard, so the diver assumed that there was no pressure in the system and opened the ball valve next to the WC. In doing so he inadvertently operated the valves out of sequence. The external ball valve had not been checked and was in the closed position. Trapped pressure inside the holding cylinder was then released into the chamber via the WC, back-flushing the contents of the holding cylinder – raw sewage – into the chamber with it, covering the diver. The force of the trapped pressure, which could have been as much as 30 bar, was sufficient to lift the toilet seat and fracture it.

The diver – following a shower and change of clothes – visited the medic, who confirmed no medical action was required.

2 Serious Injury During Pipestalk Rolling Operation

A member has reported an incident that occurred recently during planned, routine pipe stalk rolling operations at a spool base. The incident resulted in serious injuries to one person.

At a fabrication facility, lengths of pipe are welded into 1 km long pipe stalks, which are stored on pipe racks prior to spooling onto a pipelay vessel. The pipe stalks can, where required, be repositioned by rolling them across the pipe racks. This is a routine operation, involving a minimal amount of lifting at the mid-point of the pipe stalk to induce a rolling momentum.

The injured person was assisting with planned pipe stalk rolling operations when he became entangled in a tag-line that subsequently trapped and held him against the rolling pipe stalk. He was carried over the top of the rolling pipe stalk and crushed between that pipe stalk and the one adjacent to it.

As a result, he sustained fractures to both legs and serious internal injuries. First aid was administered on site and he was immediately transported to hospital.

Investigation into the incident noted the following:

- ◆ Although only a minimal amount of lifting at the mid point of the pipe stalk was involved, this activity had not been recognised as a lifting operation and, therefore, the appropriate level of control and supervision had not been applied;
- ◆ There was evidence that, while a safety management system was in place, the procedures and risk assessments used to control the work had not been adequate;
- ◆ The task was being carried out by competent, experienced personnel, who had completed the task without harm many times before. Nevertheless, there was evidence that the personnel involved were unaware of the risk assessments and procedures in place and worked to custom and practice, rather than to procedures.



The company has noted the following lessons to be drawn from the incident:

- ◆ Tag-lines are useful, often essential, attachments to assist in controlling a load. However, all personnel should be acutely aware of the potential risk of snagging or entanglement of themselves or other equipment when using tag-lines and ensure that they position themselves safely away from the load;
- ◆ The same level of compliance with procedures; and awareness and control of risk should be applied to routine work as to higher risk, and non routine activities, particularly where lifting operations, however routine or low-level, are involved.