

IMCA Safety Flash 08/13

May 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

I Substandard Nitrogen Quads Delivered to Shipyard

A member has reported an incident in which two nitrogen quads were delivered in very poor condition to a vessel in a shipyard. Following delivery the quads were inspected, and observations were made regarding the amount of corrosion around the necks and valve areas of the bottles. The nitrogen quads were immediately quarantined and removed to a safe area of the yard to await collection by the supplier.

Our member noted the following:

- ◆ The quads were delivered by a company approved supplier;
- ◆ The quads were delivered with a full certification pack.

Our member drew the following conclusions:

- ◆ The incident highlights the importance of checking ALL equipment upon arrival and before use to ensure that it is fit for purpose;
- ◆ Certification documents ought not be used as proof that equipment is fit for purpose. Always check equipment;
- ◆ If equipment is found to be in unsafe condition on delivery, this should be reported and the necessary precautions taken to ensure that the equipment is not used until the defect has been rectified or other equipment supplied;
- ◆ Suppliers should also be audited (as required) to ensure that they have suitable management systems in place to provide fit for purpose equipment and services.



Figure: Showing corrosion and poor condition of gas quads as delivered

2 Small Boat Cradle Collapsed During Poor Weather Conditions

A member has reported an incident in which a zodiac inflatable boat was dropped onto deck. The incident occurred when a dive support vessel (DSV) was at anchor outside the offshore oilfield waiting on weather. The wind picked up suddenly to 35 knots and as a result the vessel began to roll violently. This caused severe shock-load on the four securing ropes for the

cradle supporting the boat. Two of the ropes (on the seaward side) snapped, whereas the deck side ropes were still secured. The vessel continued to roll violently and the small boat cradle slid from the stand and fell on the deck. The two deck side ropes which were still securing the small boat caused it to flip/turn over during the fall.

There were no injuries and no environmental damage. The small boat sustained some damage.



Figure: Showing zodiac inflatable boat after collapse of stand

Our member took the following steps to prevent recurrence:

- ◆ The securing mechanism was reviewed and modified;
- ◆ Cargo lashing belt was introduced as additional securing means;
- ◆ Additional skirting was fabricated and installed on the platform towards the deck-side as well;
- ◆ Our member noted that appropriate securing of equipment and cargo against vessel movements should not be neglected.



Figure: Showing inflatable boat on stand after reconstruction

3 Crane Wire Parting

The Marine Safety Forum has published the following safety flash regarding the parting of a crane wire on an offshore vessel. This was partially due to the malfunction of the crane limiter switch, but also due to a failure to check that all the safety devices were functional.

The safety flash can be downloaded from www.marinesafetyforum.org/upload-files//safetyalerts/msf-safety-flash-13.11.pdf

4 Crewman Injured – No Control of Work

The Marine Safety Forum has published the following safety flash regarding an incident in which someone was struck on face and arm by debris under pressure, resulting in hospitalisation to remove particles from under their skin. It was discovered that there had been no control of work whatsoever in place – no Permit to Work, no isolations or barriers, no risk assessment or tool box talk.

The safety flash can be downloaded from www.marinesafetyforum.org/upload-files//safetyalerts/msf-safety-flash-13.15.pdf.

5 Fire Caused by Hot Work

A member has reported an incident in which a small fire was caused by hot work taking place on the deck above. The incident occurred when a repair was being performed by a sub-contractor on a steel plate in the forecastle area. The job involved using an oxy-acetylene torch to remove an old corroded plate. During this activity, the oxy-acetylene cutting of the plate caused heat transfer from the forecastle deck area to the store-man's office area (located directly below the place where the hot work was being carried out). As a result, glowing slag fell on the store-man's chair, which caught fire. There was no-one in the storeman's office at the time. The fire detection equipment in the office caused the alarm to go off. There were no injuries.



Figure: Fire-damaged chair after the event

Our members' investigation revealed the following:

- ◆ Immediate causes:
 - Fire watch location was not well planned by supervision;
 - Melt slag fell on top of the store-man's chair.
- ◆ Root Causes:
 - Failure to control and conduct of safe work (permit to work planning failed);
 - Failed check of the workplace;
 - Inadequate risk assessment (warning about the smell of smoke in the store-man's office was not investigated by the fire watcher).

Our member took the following preventative and corrective measures:

- ◆ Held discussion with all parties involved to ensure all understand their responsibilities;
- ◆ Ensured that any spaces identified as at risk of heat transfer from hot work are identified in the appropriate section of the job risk analysis beforehand;
- ◆ Raised awareness of correct identification of adjoining compartments/spaces in regard to hot work and heat transfer through bulkheads, decks, etc.;
- ◆ Double check (second pair of eyes) to identify any deck penetrations to improve spatial awareness;
- ◆ Ensure fire detection system is fully functional during hot work.

6 Counterfeit Portable Fire Extinguishers

The United States Coast Guard (USCG) has published the following report regarding counterfeit portable fire extinguishers. The USCG has become aware of counterfeits of USCG approved portable fire extinguishers ostensibly manufactured by approved suppliers serving a world-wide market. These counterfeit extinguishers present a significant safety hazard. Their capability to extinguish a fire is unproven; they may be charged with a powdery substance that is not a fire extinguishing agent, the pressure cylinder is not DOT approved, and the pressure gauge may not function or give false readings.

The USCG strongly recommends that vessel owners and operators inspect their equipment. Those suspecting that they have counterfeit extinguishers should contact the Coast Guard Office of Design and Engineering Standards immediately. Please provide a description of the suspect units, including if possible photographs showing full front, rear, and bottom views of the extinguishers, along with close-ups of all labels, and submit this information to typeapproval@uscg.mil with a copy to anticounterfeiting@us.ul.com.

Further information, including useful graphics and photographs to assist with identifying the counterfeit equipment, can be downloaded from www.uscg.mil/tvncoe/Documents/safetyalerts/CounterfeitExtinguishers.pdf.