

IMCA Safety Flash 09/08

May 2008

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 Loss of DP Position Caused by Incorrect Gyro Heading

An incident has been reported to IMCA in which a DP Class 2 shuttle tanker lost its position during a DP offtake operation due to sudden and simultaneous loss of all position reference systems. Investigation disclosed that loss of DP position reference systems was directly caused by incorrect gyro heading, corrupting all offset calculations in the DP model.

Root cause of incorrect gyro heading was found to be erroneous GPS signals to all gyros over a short period of time.

A corrective action in the form of more stringent criteria for acceptance of position reference systems into the DP has already been established.

Furthermore the gyro manufacturer is about to upgrade the software to include rejection of erroneous GPS latitude/speed compensation data.



2 Abrasion of Metal Casing

A member has reported a case of serious abrasion on the metal casing of the flame arrester on an oxygen hose. This was discovered during routine replacement of the securing Jubilee clips on the oxygen hose flame arresters.

Where the hose had been left coiled on its storage brackets and had been able to swing freely back and forth with the movement of the vessel, it was noticed that this had resulted in the abrasion of the underside of the metal casing of the flame arrester. The resulting wear on the metal was sufficient to reveal the O-ring inside the arrester, as can be seen in the photograph.

This rendered the arrester useless, and it is evident from the photograph that oxygen would now be able to leak freely past this area and into the atmosphere, thereby enriching it and making it more readily combustible should fire or a cause of ignition occur.

It is not uncommon for lengths of oxy/acetylene hose to be stored in 'out of the way' places, ready to be uncoiled and used on an occasional basis and, as a consequence of this, defects may only be noticed when the equipment is eventually needed.

Jubilee clips may be considered inappropriate for such hose connections as they can easily corrode and, due to their small size, do not provide an adequate sealing effect. Members are recommended to check all such hoses and arresters for wear and damage: this equipment is sometimes needed in a hurry and should always be in a serviceable condition.

