IMCA Safety Flash 09/12

September 2012

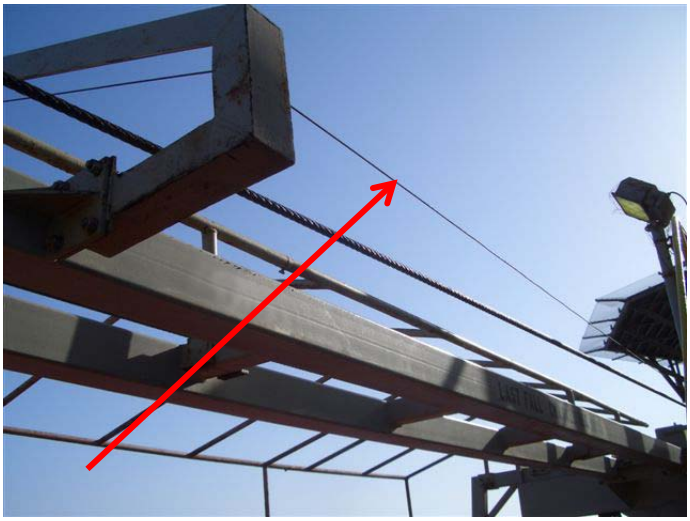
These flashes summarise key safety matters and incidents, allowing wider dissemination of lessons learnt from them. The information below has been provided in good faith by members and should be reviewed individually by recipients, who will determine its relevance to their own operations.

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

1 Inadvertent Lowering of Lifeboat

A member has reported an incident in which a lifeboat was inadvertently lowered to sea. The incident occurred during an unrelated lifting operation to move a steel plate. This was taking place during high winds, and one of the tag lines being used caught on the port lifeboat release wire, releasing the gravity brake and causing the boat to be lowered to sea. The lifeboat did not disconnect from the falls and was winched back up to the davits without damage. There were no injuries to personnel.



Cable release wire that was fouled by the tag line, pressure applied and caused de-activation of gravity brake

The outer sleeve of this tagline created a snagging hazard

Investigation revealed the following:

- The hazard created by the high wind was not fully recognised, and the opportunity to call a time out was not taken. The potential to snag the lifeboat release wire had not been recognised during the risk assessment;
- Although the taglines in use were of the tangle free type, the textile covering of the upper body of the line had become loose and retracted causing a snagging point to occur. This caught the release line and deactivated the brake;
- When the brake drum was opened for inspection, a large amount of oil residue was found on the brake lining, having seeped past the seals from the adjacent oil sump. The oil sump was overfilled beyond the manufacturers' recommendations. The oil on the brake linings reduced the efficiency of the brake to reset when the counterweight was reapplied.

The following actions were taken following the incident:

- Deeper consideration of all conditions during risk assessment. For example, how did the controls to manage the steel plate introduce other hazards in this event?
- Inspection of tag lines to ensure they were fit for purpose, and holding of spares onboard;
- Review of lifeboat maintenance particularly with regard to the gravity brake;
- Checking oil levels were correct and that personnel understood the use of level plugs.

2 Near Miss: Cement Tank Hatch Failure

A member has reported an incident in which the hatch on a cement tank failed under pressure. The incident occurred when the cement tank was being pressurised to verify the integrity of the system prior to loading dry bulk during a forthcoming port call. Following the pressurisation of the cement tank to approximately 4 bar, a loud bang was heard and the cement tank pressure was rapidly lost.

Fortunately, no one was present within the cement room at the time and there were no injuries. This incident was considered a high potential near miss. Had any persons been in the cement space at the time of the incident, the potential for a serious injury was high.

Cement tank hatch

Nuts replacing dogs

Showing personnel access restricted by dogs

Our members' investigation revealed the following:

- The original cement tank hatch securing dogs had been removed and replaced by nuts. When this replacement had taken place was not known;
- It was discovered that the most likely reason for the change of the securing dogs with nuts was to provide greater clearance for personnel access between the cement tank hatch and the pillar;
- Although the cement tank hatch thread bar was 27mm, the diameter of the nuts was 30mm and, although of a differing size, it was still possible to secure these 30mm nuts on the 27mm thread bar;
- The change had not been properly documented or dealt with through a "management of change" process;

Our member reported that a thorough investigation of this high potential incident is currently being undertaken and that the detailed findings from this investigation will be revealed in due course.

3 LTI Hand Cut During Cutting Operations

A member has reported an incident in which a welder badly cut his hand using a hand-held circular cutting tool. The incident occurred when a sub-contractor welder was cutting off an air vent in preparation for further welding work. Shortly after he started work, there was a loud shout and the chief mate rushed to him to find out that the welder has cut his palm all the way to his two fingers. First aid treatment was administered before he was taken to hospital for surgery. It was confirmed that two of his finger bones and veins were broken and cut off respectively.

Our member's investigation noted the following:

- The welder had been through job hazard analysis (JHA) training on the morning of the day of the incident;
- The welder was rushing to finish the job;
- The welder replaced the blade in his cutting machine but was distracted and failed to fix back in place the blade protective guard.

Cutting machine (with blade guard fitted)

Hand/arm following treatment

4 Near Miss: Potential Fall When TMS Protection Gate Came Loose

A member has reported a near miss potential fall and dropped object incident in which a protection gate on a Tether Management System (TMS) was almost lost. The incident occurred when crew were working on the top on of an ROV, using cut-out holds on the TMS protection gate itself. The two dogs on top of the protection gate became dislodged from their receptacles; whilst the gate was still secured by bolts and 'R' clips at the bottom, it fell into the inside of the TMS. The personnel working managed to hold onto one of the main load bearing posts of the TMS. Full harness and fall arrestor equipment was being used and a permit to work for working at heights had been issued. There were no injuries or damage to equipment.

Further investigation revealed that when downward force was applied to the gates via the cut-outs, the gate became dislodged.

Members are encouraged to make a careful check of this kind of TMS protection gate to ensure they are secured by the top pins. If they tend to come out while downward force applied, then the top pins should be changed immediately. The top pin which is secured to the gate can be modified such that it won't dislodge easily.

TMS protection gate showing "cut-outs" which are used as foot-holds.

Bottom of TMS protection gate showing fixing brackets with bolts and 'R' clips which remained secured

5 MODU Mooring Line Failure

The Marine Safety Forum (MSF) has published the following Safety Flash regarding an incident in which a MODU mooring line failed. The line was one of eight mooring lines for the MODU, which was involved in drilling at the time. The MODU moved some 12m and tilted 2-3 degrees but was restored to the correct position using thrusters and ballasting.

The report can be downloaded from www.marinesafetyforum.org/upload-files//safety-alert-notice/msf-safety-flash-12.31.pdf