

## IMCA Safety Flash 10/08

June 2008

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](mailto: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](http://www.imca-int.com/links). Additional links should be submitted to [webmaster@imca-int.com](mailto:webmaster@imca-int.com)

### I Unsecured Object Fell and Injured Crewman

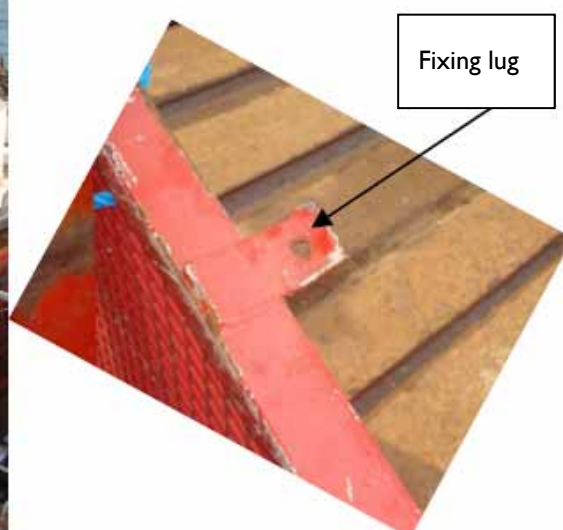
During routine offshore operations, a piece of unsecured grillage stowed on deck toppled and struck a member of the deck crew on the foot. The impact was severe and caused multiple fractures to the metatarsal bones of his foot and serious lacerations. The injured crew member was medivaced to a local hospital where he is currently being treated.

At the time of the incident the weather was flat calm and the vessel was in transit. The deck crew was involved in setting up a rigging arrangement on the over-boarding chute whilst technicians were carrying out fault-finding on other equipment. Four members of the deck crew were on their way to collect rigging equipment from the rigging container. To reach the container the crew had to pass between a deck tigger winch and a heavy piece of grating which had been removed from the top of the equipment being investigated by the technicians. This piece of grating was stowed upright against the plough guards on deck.

Whilst passing between the tigger and the plough guard the grating was disturbed and fell, striking the foot of the injured party. The grating was fitted with fixing lugs, one of which severely impacted the foot, penetrating the safety boot and caused the injuries.



Grating and approximate positions of crew at the time



Fixing lug

This incident occurred during routine deck activities when the level of hazard awareness and attention to detail was perhaps not as high as it would be when the vessel was fully operational on project construction work. This highlights the need for the same level of awareness, attention to detail and communications during routine work as there is during project construction operations.

The following points were noted:

- ◆ The grating was an obvious obstruction and partly blocked a frequently used access route to storage and working areas;
- ◆ It was left completely unsecured and incorrectly stowed;
- ◆ Three people attempted to walk round the obstruction without identifying the potential hazard – the fourth became the injured party;
- ◆ An obvious hazard went unchecked and subsequently caused an accident.

## 2 Dry Suit Inflation Installation on to a KM 37 Helmet

The practice of installing a dry suit inflation whip with modified fittings onto a KM 37 side block has been reported to IMCA.



Kirby Morgan Dive Systems Inc has advised the following.

- ◆ The modification to the side block assembly of the KM 37, shown in the photograph above, is not recommended;
- ◆ The leverage on the brass fitting is extremely high giving a high potential for breakage;
- ◆ The fitting at the bottom of the side block is a 3/8" straight thread fitting with an O-ring seal which is not designed to sustain this kind of leverage.

Members are reminded that an in-line valve is not deemed necessary by the helmet manufacturer, as long as a good quality and suitably approved inflator hose is used or the KMDSI restrictor adapter PN# 555-210.

## 3 GPS Antenna Problems

A member has reported a serious failure of a vessel's GPS positioning equipment. When approaching the work area, which was close to the shore, the vessel experienced a complete failure of all its GPS receivers (eight receivers from four different manufacturers/suppliers).

Following extensive fault-finding which isolated the problem to the area of the vessel bridge, it was discovered that one GPS unit was causing the failure of all the other units. The receiving antenna for the unit had failed and had become a transmitter, the signal from which subsequently blocked all the other GPS receivers mounted nearby. The close proximity (<1m) of this damaged antenna unit to two other GPS antenna units may also have caused damage to the internal electronics of these units.

Members are warned to be aware of the potential hazard posed by a faulty GPS antenna and that all GPS antennae be separated by at least two metres where possible.

## 4 Fire Watches for Surface Welding and Burning Operations

A member has reported a number of incidents during welding and burning operations which had the potential to result in injury to personnel or damage to equipment or vessels.

Members are urged to consider the following fire watch precautions when carrying out hot work operations:

- ◆ A suitably competent Fire Watch should be designated;
- ◆ The Fire Watch should be provided with suitable fire fighting and safety equipment dependent on the type and area of operations;
- ◆ The Fire Watch should be shown the area of operation and all adjacent areas;
- ◆ The Fire Watch should be made familiar with all fixed and temporary fire fighting and safety equipment in the immediate and adjacent areas;
- ◆ It is of particular importance that the Fire Watch is provided with clear and unambiguous instructions on the procedure to raise the alarm in the event of a fire. This may require the Fire Watch to be made familiar with the nearest active fire alarm activation point and be provided with direct communications to the bridge;
- ◆ The immediate and adjacent areas should be inspected prior to welding or burning operations to ensure that good housekeeping standards are in force. Clean and tidy areas in the vicinity of the work areas may help to avoid any fire related incidents;

The Fire Watch should be in place prior to commencement and throughout the duration of the welding or burning operations. The Fire Watch should remain in force on completion of the operations until all involved are reasonably satisfied that the requirement for a full time watch can be dispensed with.