



Safety Alert

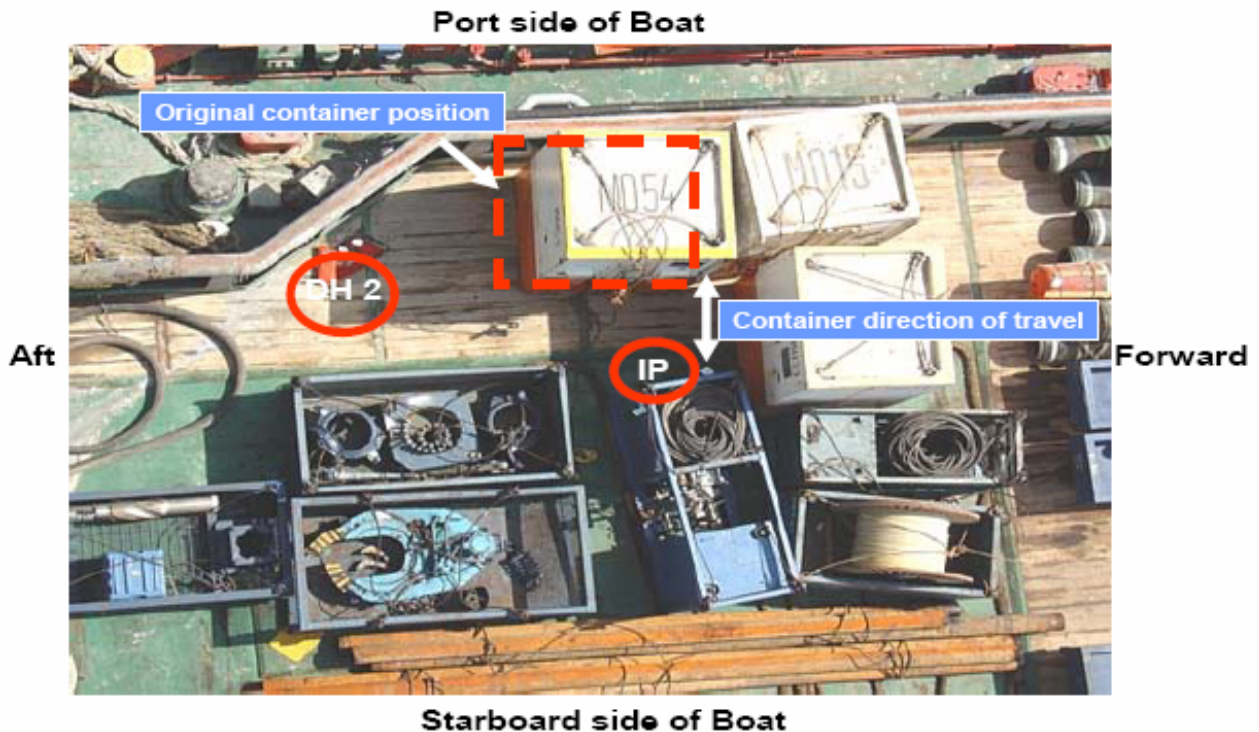
From the International Association of Drilling Contractors

ALERT 05 – 41

CARGO HANDLING OPERATIONS RESULTS IN FATALITY OF A SUPPLY VESSEL CREWMEMBER

WHAT HAPPENED:

An offshore supply vessel was moored on the port side of a jack up rig. The vessel was moored at the bow with a back down buoy system and the stern was moored to the rig using the bow and port leg ropes. The supply vessel had already worked two other rigs prior to arrival and supply boat deck space was limited. The incident occurred just after the noon tour change when the on tour crane operator resumed cargo operations. Two supply vessel crewmembers were working as riggers on the boat deck. An empty chemical container was back loaded and spotted on the deck of the supply vessel, but as the crane operator started slacking off the hoist wire so the load could be detached, one of the two riggers hand signaled the crane operator to pick up a little so the load could be repositioned (pushed) closer to the other cargo. The crane operator complied by hoisting the container approximately one foot off the deck. As the container cleared the deck it unexpectedly appeared to swing 4 feet to the starboard side of the supply vessel and trapped one of the riggers between the swinging container and a power pack basket setting on deck. The man was crushed and immediately collapsed onto the deck. The man was transported to the rig's hospital and the medic performed CPR for approximately 30 minutes however he never regained consciousness, breathing or a pulse.



The Corrective Actions stated in this alert are one company's attempts to address the incident, and do not necessarily reflect the position of IADC or the IADC HSE Committee.

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WHAT CAUSED IT:

This was a very routine job that is successfully completed on a daily basis without incident. **Complacency may have been a factor.** The investigation determined that the boom tip was properly positioned above the load as the container was lifted for repositioning. The cause for the sudden movement may have been due to the beam sea that pushed the supply vessel to port making the load appear to swing 4 feet to starboard as it was suspended above the deck. This sudden motion is what caused the container to strike the stationary basket. **What we don't plan for can kill us. Planning:** A basic generic Job Risk Assessment was reviewed during the pre-tour meeting but the riggers on the supply vessel were not part of the risk assessment. This is not an example of proper risk assessment and if it had been task specific with all workers involved, these risks would have been identified and risk reduction measures put in place. **Communication:** The crane operator had radio communications with the supply vessel captain only. It was never established which rigger was giving hand signals from the supply vessel or what exactly the riggers plans were. **Communication should have been a priority and it was not. Environmental Factors:** The supply vessel was secured with three point mooring in a beam sea and was subject to a roll of 2 degrees to port and 2 degrees to starboard. **Were environmental conditions (vessel motions) carefully considered? Time Out** was not called and the job only stopped when a man went down. **Are we Proactive or Reactive?**

CORRECTIVE ACTIONS: To address this incident, this company issued the following summary:

The planning, communication and procedures used to work cargo on this vessel were probably very similar to the many other vessels that have been worked, but with one exception, this time a man was killed. **Unsafe conditions** and **at risk behaviors** continued to add up and because nothing bad happened in the past so the job went on, business as usual. Is this how we do our business? If we allow ourselves to develop **high risk tolerance** and become comfortable working around things that should concern us, we become less likely to call **Time Out**. Something set this incident into motion and the result was a fatality. It was not identified what kind of training or safety culture the employees working on the supply vessel were exposed to or what tools they had available to manage safety on the job. What is known is the **training, safety culture** and **safety tools** our employees have available to manage safety. Regardless of who is involved we must work to our standards. If something is not right, stop and make it right. The photo above identifies the **CRUSH POINT**.

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