Safety Alert

From the International Association of Drilling Contractors

ALERT 06 – 41

CONFINED SPACE – UNAUTHORIZED TANK ENTRY

WHAT HAPPENED:

The Derrickman and Assistant Driller (AD) were working outside the sludge tank in an effort to clear a blocked main flow line to the tank. The flow line was heavily plugged with barite and could not be cleared using only the high pressure washer from the top, therefore the original plan had to be modified. The AD had the Pumpman operate the high pressure washer while the Derrickman entered the tank to use a rod to clear the blockage. Once the blockage was cleared the Derrickman attempted to exit the tank and slipped on the mud at the bottom of the tank and fell against the ladder impacting his chest causing severe bruising. As a precaution he was sent ashore for medical examination, he was certified fit and returned to the rig on normal duties.

WHAT CAUSED IT:

The direct cause was mud making the tank floor slippery resulting in a slip hazard.

In addition:

- No PTW was in place despite the task having shifted from Routine to Non-Routine. Although the Pumpman and Derrickman enquired, they did not call a Time Out for Safety (TOFS) when the AD informed them they would not bother with a permit.
- No JSA had been reviewed or made prior to starting.
- No gas-test had been carried out as required for tank entry.
- No formal LOTO process followed, the breakers were tripped however without securing means.

Contributing Factors

- Inadequate planning, JSA production / evaluation, and review of procedure.
- Complacency. Proactive safety precautions bypassed in order to expedite the task.
- Hurried exit of the space as IP knew he was contravening policy by being inside tank.
- Lack of positive & effective supervision by AD.

CORRECTIVE ACTIONS: To address this incident, this company did the following:

- Ensure that tank entry procedures are respected and correct protocol is adhered to.
- Use of JSA and associated documentation to be emphasized.
- Supervisors must lead by example, corner cutting is dangerous and not a precedent that should be set.

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.

Issued December 2006