Safety Alert

From the International Association of Drilling Contractors

ALERT 08 – 32

FATALITY – HIGH PRESSURE AIR RELEASE

WHAT HAPPENED:

A fatality occurred when two employees working on a floating MODU, were in the process of disconnecting the "U" tube of the number three tensioner from the isolation valve. This was being done in an effort to initiate repairs to the damaged marine riser tensioner (MRT). While removing the last bolt of the isolation valve flange, the internal parts of the valve blew out and struck the injured employee in the head and face. It was later discovered that they were actually dismantling the valve body because they had misidentified the flange as a separation point for the line. The employees had inadvertently released the 400 psi of air on the 3 inch line and the internal parts of the valve.

WHAT CAUSED IT:

- The subsequent investigation revealed that the crew assigned with the task of preparing the tensioner for removal did not have full knowledge of the valve assembly and the necessity for completely venting pressure on pressurized lines.
- A false sense of security was created by the lack of pressure on the downstream vent valve on the number three tensioner.
- Pressure was left on the line in the event that a quick charge was needed to put the number seven tensioner which was paired with the number three, tensioner into service.
- This job was planned to be broken down into three phases. At the completion of each phase the job was to be stopped and the next phase was to be planned before going forward. This three phase process did not occur.
- The crews were into phase two when the incident occurred and there was no stoppage of work or phase planning between phase one and two.

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

- Instructed rig personnel that when they are working on pressurized lines and/or pressure vessels, regardless of the product contained the pressure is to be vented before the work begins and isolating valves are to be tagged-out .
- Instructed supervisory personnel to discuss this alert with all employees offshore and in the various yards.
- Thee company plans to issue further recommendations in the forms of Tech Alerts, addendums to this alert and changes to systems affected.

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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