



Safety Alert

From the International Association of Drilling Contractors

ALERT 05 – 24

CONFINED SPACE INCIDENT

WHAT HAPPENED:

An incident with an extremely high potential occurred due in the large part to a complete disregard for established procedures. While the investigation of this incident has not yet been completed it is important that we share what is known so that we can all review the event and raise the awareness of the potential hazards of confined space entry.

Event: A watertight hatch was removed from a void space located at deck level in anticipation of an NDT inspection and possible welding work. In preparation for the initial inspection, two employees were instructed to clean out water and debris from the floor of the void. This particular void space was approximately 10 meters deep and consisted of 5 different levels. One employee entered the void space through the hatch at deck level while the other man remained outside of the void acting as the watchman. Communications were maintained by a call and response process at five minute intervals. After approximately fifteen minutes into the task; the watcher did not receive a timely response and reacted by entering the void to investigate. The watchman found the first employee unconscious at the top level of the void space. The watchman then left and called for help and two supervisors arrived at the scene. One supervisor entered the void wearing proper Breathing Apparatus (BA) and at the top level realized the atmosphere was oxygen deficient. He then removed his BA set and left it running next to the IP while he exited the confined space to get another BA set. The IP revived and made his own way down the ladder and out of the confined space area. After a period of recovery, the IP showed no ill effects from his collapse.

WHAT CAUSED IT & Findings:

A sign was posted as required to identify this void as a confined space / entry allowed by permit only, but the warning sign was ignored by both employees. This job commenced without the controls of any Permit to Work in place.

What can we tell from the description of events and preliminary findings?

- The employees probably identified the hazard because one acted as a watchman.
- However no testing of the atmosphere took place.
- The void was identified as a confined space but no PTW was utilized.
- The watchman entered the space on his own prior to calling for help.
- At one time we had two employees inside the void area without breathing apparatus.
- It would appear that no formal risk assessment had been carried out and consequently there was no defined rescue plan in place.

Two men arriving at the scene with one BA set between them is not an acceptable confined space rescue plan. The rescuer removed his BA set in a known oxygen deficient atmosphere. This “**At-Risk Behavior, lack of planning, compliance and Supervision**” could have resulted in a multiple fatality. On this particular job, **safety was not a choice, Safety was left to chance** and the result can be attributed to nothing more than **luck**. We are all aware of the hazards associated with confined space entry and the need for an appropriate response and rescue to be in place prior to the commencement of the task.

Proper risk assessment would have identified the need for a **Permit to Work** and permits / certificates would have required the atmosphere to have been tested prior to and during the course of the entry. JRA and PTW would have addressed other important measures like proper fall protection, lighting, notification, spot checks, available personnel and equipment required at the scene.

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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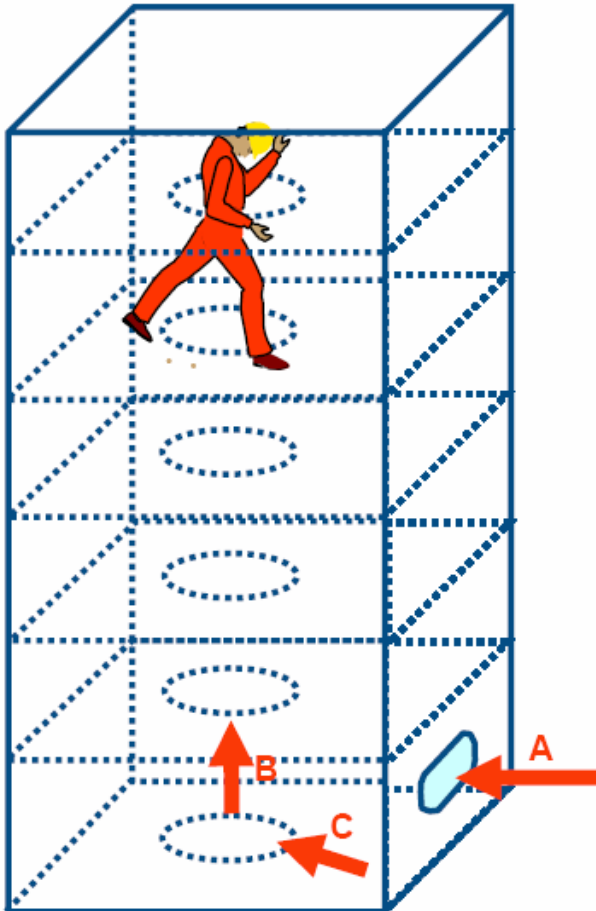
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CORRECTIVE ACTIONS: To address this incident, this company all rig supervisors to do the following:

Discuss this incident at your next Weekly Safety Meeting and ask the following questions.

- Could this happen on your rig?
- Are you sure?
- Are we always doing what we say?
- The only way to be certain is by **questioning, testing and verifying.**



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