



# Safety Alert

From the International Association of Drilling Contractors

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ALERT 02 – 12

## FATAL INCIDENT – MAN LOST OVERBOARD

### WHAT HAPPENED:

The individual and three other persons were working to relocate the 30” diverter housing from the main deck to a stump cart inboard of the port side cantilever beam. To facilitate this movement, the cart was placed outboard of the main deck, part way out to the Texas Deck. After placement of the diverter on the cart, it was necessary to secure the diverter with two chains and load binders prior to moving the cart inboard. The first chain was deployed without incident; however, a ‘cheater’ was required to set the load binder on the second chain. A 2” steel tube 40” long, weighing 11 pounds was tossed to the individual. He failed to catch it cleanly and was struck by the tube, causing him to lose his footing and fall to the deck of the cart. While attempting to stand he rolled over the outboard edge of the cart and fell to the sea. Search and rescue efforts were unsuccessful.

### WHAT CAUSED IT:

The Safety Management System was not functioning as required wherein established procedures are followed and documented to be able to confirm that these established procedures are followed. Additionally, the behavioral training provided to both the supervisors and crewmembers, disappointingly was also not evident. The following direct and indirect causes support this conclusion:

- Failure by the individual to attach a fall protection inertia reel or safety lanyard to his harness as required.
- Failure by the individual to wear a flotation work vest or lifejacket.
- Failure by deceased to observe the requirements of a work permit he obtained to conduct the task. The permit included:
  - Alerting the standby boat to the work to be conducted over water and having it move from its location 1.25 nautical miles away to within close proximity of the rig.
  - Review of applicable job risk analysis and HSE policies.
  - Failure to conduct a toolbox safety meeting with co-workers prior to commencement of the task.
  - Disregarding advice from co-workers to secure his safety harness and wear a personal flotation device.
  - Disregarding a request from co-workers to take a “time out for safety” to review necessary safeguards and procedures.
- Failure by the rig supervision to properly manage the permit to work and follow up on the activity.

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

- Instructed supervisors that they must fulfill their obligations with respect to checking that the provisions as set forth in the permit are actually in place at the worksite. They must:
  - Establish a mandatory, formal handover meeting between the OIM, Senior Toolpusher and Night Toolpusher prior to commencement of the night tour, with a specific requirement to review permits to work.
  - Eliminate the use of break over type load binders in favor of ratchet type binders to eliminate the need for the use of “cheaters”.
- Employees were re-instructed to:
  - Review and observe all applicable work practices, job risk assessments and Health Safety and Environment policies.
  - If a time-out is called by any crewmember, all persons engaged in the activity must observe the request. If a supervisor fails to respond to a time out request, any individual is empowered to immediately report this to the senior supervisor aboard the rig. In addition, individuals are encouraged to notify the Designated Person Ashore and use the “Safety and Environmental Concern Card” system for any safety or environmental issues.
  - If a co-worker disregards advice about at-risk behavior the job must be stopped and the next level of supervision notified.

**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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