HAES 001/08
Fall from height – Double MTI

HIGH ARCTIC ENERGY SERVICES P.N.G.

SAFETY ALERT

What Happened

Two Floorman were working in the sub base approximately 4 metres above the ground removing the Bell Nipple from the top of the Blow out Preventer (BOP). The flow line had been disconnected from the Bell Nipple but was still attached to the winch on the drill floor when it was raised unexpectedly. The flow line flange knocked the Bell Nipple from the BOP seating and it fell to the ground. The Floorman had moved from one side of the Bell Nipple (v-door) to the other side (draw works) where they had just connected a soft sling to secure the Bell Nipple. One Floorman (#1 in picture below) had attached his shock absorbing lanyard to the Bell Nipple (approx 300 kg) and he was pulled down and fell to the ground. The other Floorman (#2 in picture below) was knocked off balance and fell backwards the extent of his shock absorber lanyard before coming to rest suspended upside down with the unused work platform stopping his fall any further. His lanyard did not extend far enough to activate the shock absorber. Both workers were standing on the BOP Lifting Bracket. Both workers received soft tissue injuries and returned to work the next day.

This incident had the potential to result in a double fatality

'ELIMINATE ALL WORK RELATED INJURIES'

How did it go wrong?

- The winch line connected to the flow line was supposed to have been disconnected.
- The original plan was to use two winch lines to remove the Bell Nipple. One through the mousehole and one through the rotary table. One line was ready but not connected in the mousehole. The Driller changed the plan to one winch. The winch operator said his was to use two winches.
- Neither worker was connected to the fall arrestors (Sala blocks). There are two on each side of the sub base fitted to the underneath of the rig floor.
- Lanyards used were not secured above head height and in one case was connected to an insecure anchor point (Bell Nipple).
- All four studs that attach the Bell Nipple to the BOP Annular had been removed before it had been secured.
- No procedure was available for this job.
- No JSA/JHA was used for this task.
- Brief pre job discussion inadequate for the task being undertaken and potential risk
- Lack of adequate and / or specific instructions during the task, particularly just before the incident.

Learning/Corrective Actions

- Procedure to be developed with sequential steps particularly the restraining of all equipment before unbolting or removing it.
- Ensure all provided safety devices are used (in this case fall arrestors)
- Processes to be put in place to ensure adequate and thorough Pre Job meetings are planned as part of the job, including the communication of hazards and why controls are necessary to prevent an accident.
- Ensure all instructions given during a job are specific, understood and recorded.
- Outline Supervisor expectations to ensure that jobs are undertaken safely
- Reinforce to the work force that they are empowered to STOP THE JOB when safety controls or precautions are bypassed.
- Ensure fall protection is secured to a suitable (stable) and approved above head height anchor point.

PLEASE GIVE THIS ALERT THE WIDEST POSSIBLE DISTRIBUTION AS IT IS LIKELY THAT OTHER COMPANIES AND FACILITIES MAY BE SUSCEPTIBLE TO THE SAME PROBLEMS.

HAES Safety Alert 001/08

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