DRILLSAFE MEETING
PERTH SEPTEMBER 2005

FALL FROM PERSONNEL BASKET

Actual Level 2 / Potential Level 4

Development Driller 1 – Gulf of Mexico

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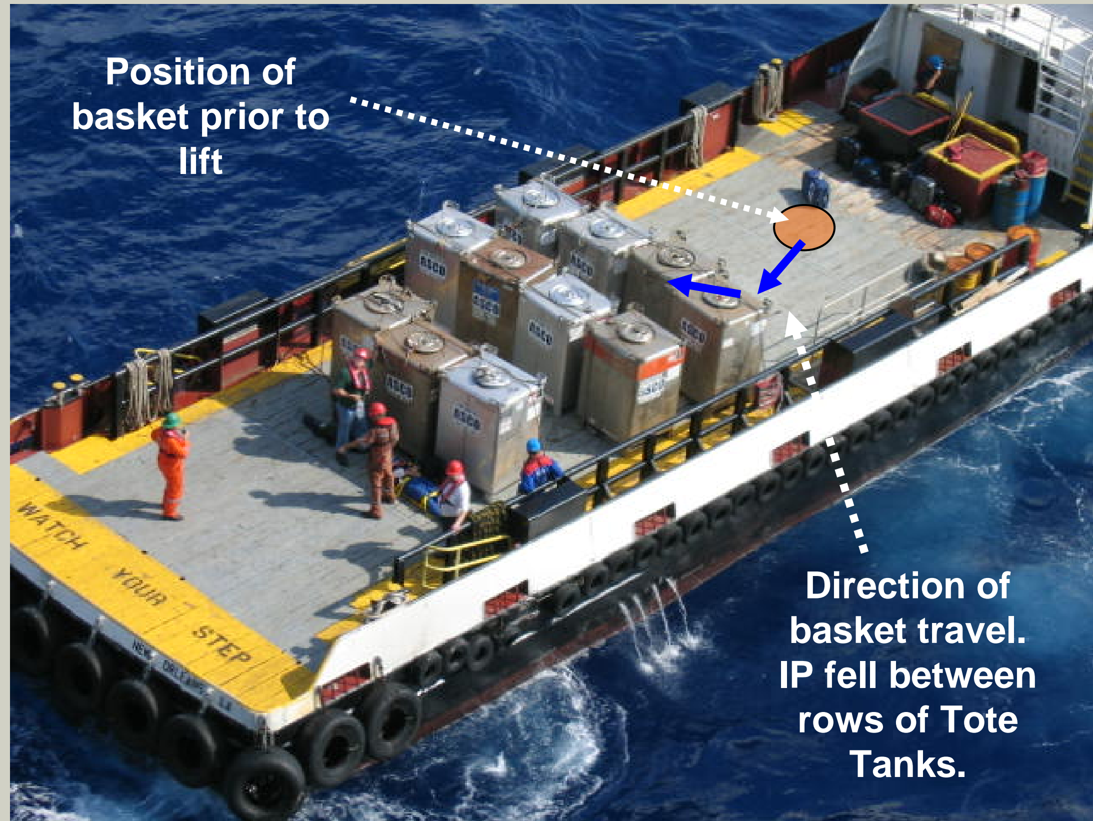
The Incident

- What
  - IP fell approximately 3m from a Billy Pugh basket as it made contact with a tote tank on the deck of the supply vessel
- Where
  - Development Driller 1 (DD1), sheltered waters – Gulf of Mexico
- When
  - 21 July 2005
- Outcome
  - Lost Time Injury: Bruising to shoulder and back (no broken bones)

Incident Visuals

Type of Billy Pugh Involved



Incident layout

Incident Description

- Supply vessel arrival at DD1 – the personnel transfer basket was suspended from the crane in preparation for impending transfer activity
- Decision made to not provide experienced banksman from DD1 to supply vessel
- Vessel Captain requested the basket be landed on the deck between the tote tanks and the vessel superstructure (~7 meter space)
- Basket landed on vessel deck and personnel repositioned it so that it was in the centre of the 7m space
- 4 personnel donned lifejackets and prepared to board basket
- The vessel began to drift from station (not recognised by the Captain). The crane operator did recognise drift-off and attempted to compensate by booming down / coming up on the hook (this was not communicated to the vessel)
- As the 4 personnel boarded the basket, it began to move across the vessels deck towards the tote tanks and one side of the rope supports collapsed

Incident Description

- The vessel rolled / dipped in the swell and the basket was lifted from the deck and swung towards the tote tanks. This was exasperated by the fact the carne boom tip was not directly above the basket
- The crane operator, in an effort to prevent the basket from striking the Tote tanks, came up on the basket
- The basket struck the outermost Tote tank and spun, striking the next inboard tank on the deck before clearing the tanks and stopping ~3m from the deck
- The IP was dislodged from the basket by the impact with the Tote tanks / movement of the personnel basket.
- The IP fell onto the top of the Tote tanks, rolled off and then fell between the two rows of Tote tanks, striking them with his head and back before landing on the deck
- Basket transfer was completed with the remaining three personnel
- DD1 medic / trauma team members transferred to vessel.
- IP stabilised, transferred to DD1 and then medevac'd to hospital

Key Learnings

- High number of basket transfers may have led to a sense of routine operation and therefore diminished hazard appreciation (note: personnel being transferred had limited basket / offshore experience)
- Ineffective change management - Crane operator adjusted boom/hook to account for vessel drift. This was not conveyed to the Vessel Captain (nor did the Captain recognise)
- The crane's hands free loud speaker / bull horn was inoperable - only had hand held radio (difficult to operate crane and use radio)
- Vessel deckhand's radio was inoperable due to dead battery
- There was no experienced Banksman / deckhand on the vessel to supervise the basket transfer
- Failure to recognise hazard of congested deck
- JSA excessively detailed for pre-task meeting/deck review meeting (13 pages) and failed to recognise "congested deck" as potential hazard
- JSA reviewed on rig only and not with basket passengers

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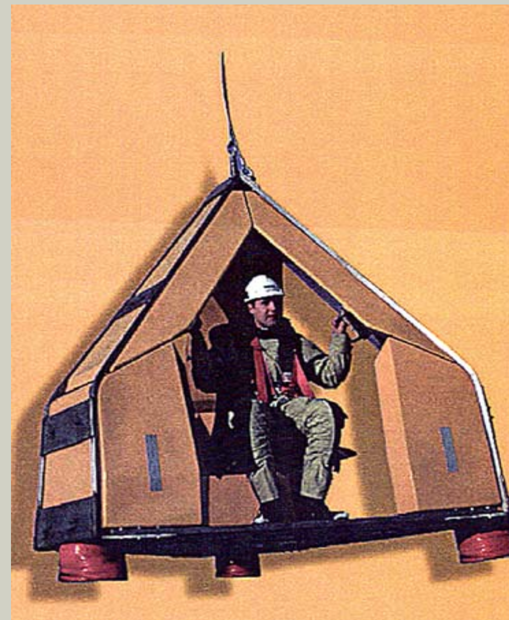
Closing Comments

- Treat all basket transfers as non-routine and conduct by exception
- Basket transfers should be subject to a thorough risk assessment and tight controls
- Ensure all equipment and personnel competencies are capable to perform the task
- Reinforce the requirement to, and actively support people for, stopping the job if circumstances change
- Identify newer / safer baskets

Billy Pugh X904



Frog

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