Rig Move LTI
MDC Rig #151 – Raslie 9
09:45 21st November 2007

6 December 2007

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Incident Summary

Mitchell Rig #151 was released at 2am on the 21st November in preparation for a 33km move. A pre-job safety meeting was held and the rig move commenced. At approximately 9:30am, the IP climbed onto the top of a load and was stopped and asked to get down. While climbing off the load the IP caught his foot at fell approximately 2.7m to the ground, landing on his elbow. The IP was taken to the Roma hospital where it was confirmed his elbow was fractured. The IP was transferred to Toowoomba hospital for further treatment. The IP will be off work for at least 4 weeks.

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Sequence of Events

- Pre Rig Move Safety Meeting was held where crew reviewed the Safe Work Instruction for rig up and rig down.
- The IP and experienced Derrickman began to load a bolster containing flow line onto back of a trailer
- A decision was made to place the choke manifold onto the bolster containing the flow line
- Rig Manager, Derrickman and IP had a meeting to discuss the loading of the choke manifold, main point discussed was dunnage requirements under the manifold
- Derrickman climbed onto the trailer to arrange Flow line and place dunnage in readiness for choke manifold; at this stage the IP who was dedicated spotter for the loader was located on the ground
- IP climbed onto the trailer and onto of the flow line located in the bolsters to better position the dunnage (approx. 2.7m above ground level).
- The Derrickman noticed this unsafe act, and asked the IP to get down
- As the IP attempted to get down, the flow line moved causing him to fall to the ground injuring his elbow
- IP was taken to Roma hospital for X-rays and later transported to Toowoomba for surgery

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Additional Information

- IP had been a lease hand on the rig for 6 six months and was no longer working under the “green hat” system.
- A pre-job safety meeting was held and the rig move commenced.
- The IP had received the Mitchell induction including basic working at height requirements
- There was no formal load plan for the trailer being loaded
- Arrangement of dunnage on the trailer did not require working at heights

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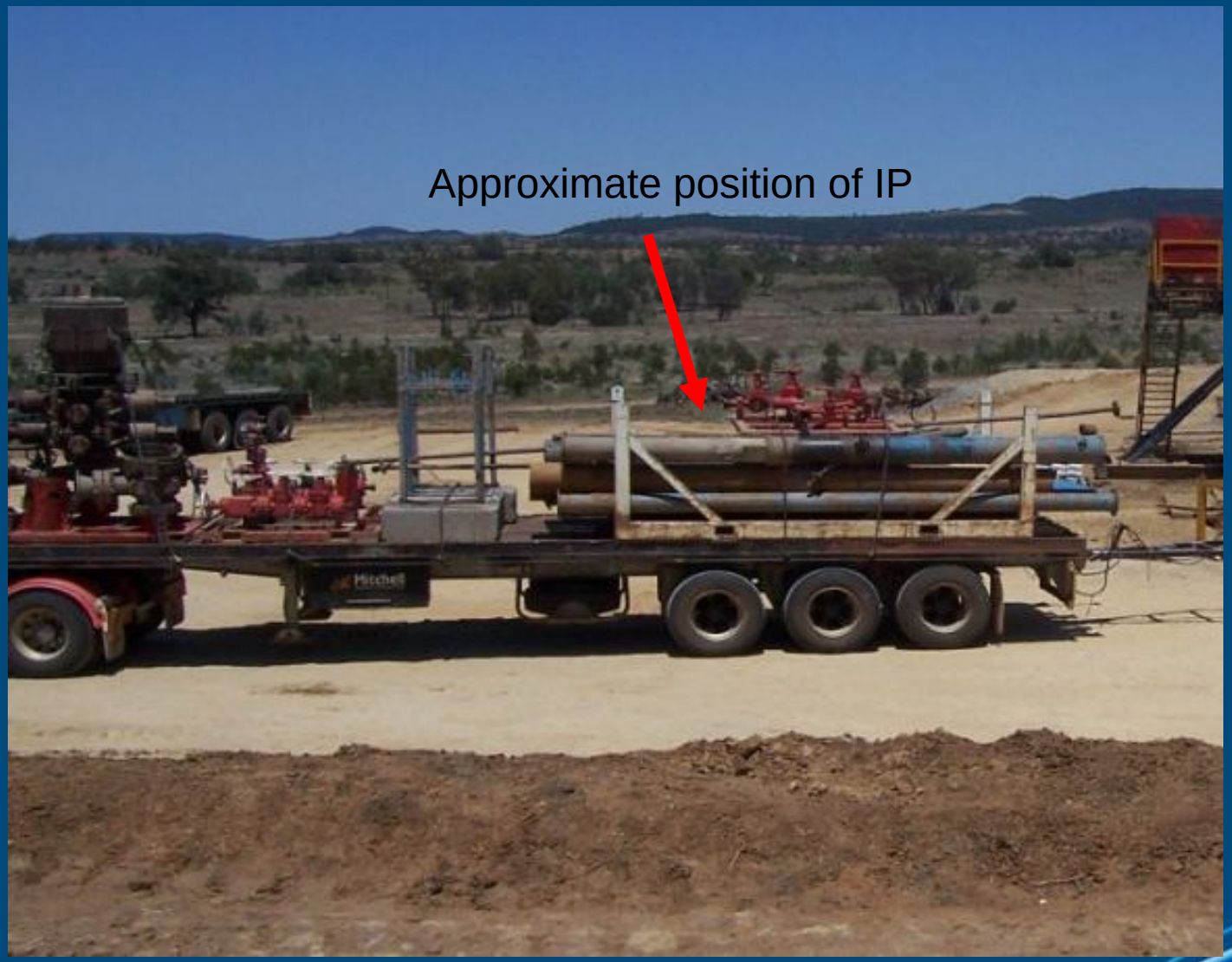
Incident Photos



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Incident Photos

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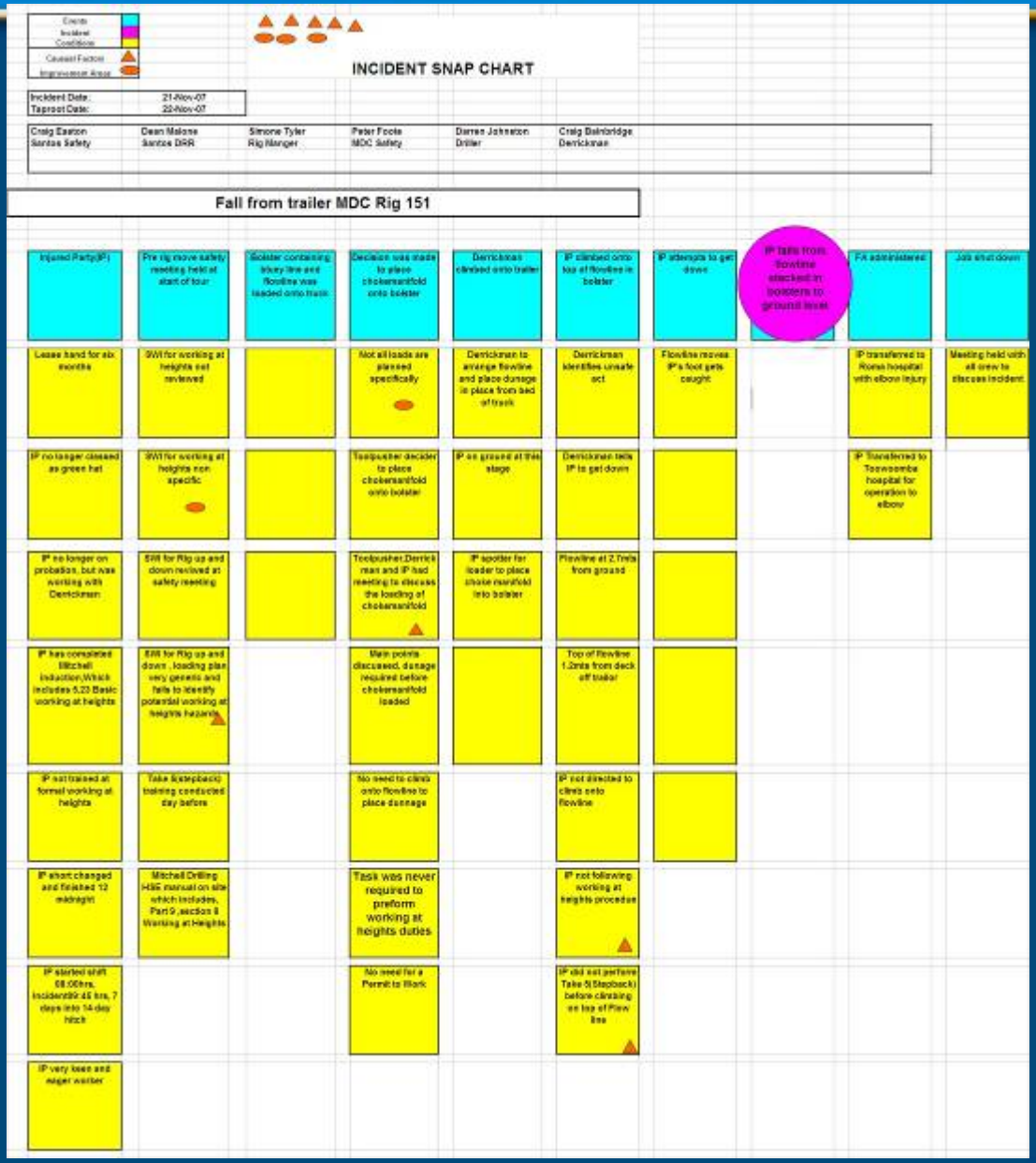
TapRoot Snapchart



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Incident Root Causes

- **Causal Factor:** Not all loads are planned specifically (i.e. load plans)

Root Cause - Management System – Standards, Policies or Administrative Controls Need Improvement

- **Causal Factor:** TP, DM and IP had a meeting to discuss the loading of the manifold, additional hazards and controls were not discussed

Root Cause - Work Direction – Preparation –pre-job briefing needs improvement

- **Causal Factor:** IP not following working at heights procedures

Root Cause - Procedures – Not Used/Not Followed

- **Causal Factor:** IP climbed on top of load without instruction

Root Cause - Management Systems – Enforcement needs improvement

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Resulting Actions

- Implement detailed rig move plan for all future rig moves
- Crews to be reinducted on working at heights requirements
- Mitchell Drilling to outline crew expectations and standards, and enforce these were applicable
- Expectation of Site Supervisors to be reinforced
  - Requirement to stop operations in the event of non compliance with safe work instruction

- Currently rolling out a Safety Leadership Coaching program (to augment previous Safety Leadership courses)
  - Improve pre-job meetings/communication
  - Improve intervention skills

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