ALERT 03 – 31

FALL OVERBOARD RESULTS IN A FATALITY

WHAT HAPPENED:

A roustabout onboard a jack up drilling rig fell overboard. He was recovered from the water shortly afterwards by a Fast Rescue Craft that was deployed by the stand-by vessel. CPR was given while the Fast Rescue Craft returned to the stand-by vessel. Further attempts to revive him onboard the stand-by vessel were unsuccessful. Following consultation with the shore-based doctor the employee was transported to shore. On arrival he was pronounced dead.

Overview of events: This report is prepared to document and disseminate the facts relating to the incident as known to the investigation team.

1. A temporary deluge system was rigged up to provide water-cooling against radiated heat generated by a well test flare.
2. Four days later at approximately 18:00 hours, the well testing operations were complete. At 18:30 hours the deck crew was prepared to rig down the fire hoses.
3. Shortly afterwards, the night Toolpusher gave instructions to the Crane Operator to dismantle and stow the temporary hoses that had been rigged up for cooling purposes.
4. At approximately 18:50 hours, the deceased and his immediate supervisor started to dismantle the hose protecting No. 2 lifeboat (see attachment 1). A fire hose, supplied from a fire hydrant on the starboard helideck stairs was hung between the stairs and No. 2 lifeboat. The fire hose terminated with a nozzle connected to the hose by a positively latched coupling which requires the use of both hands to disconnect. The nozzle/hose arrangement was then connected to the davit by a long tie wrap (3 tie wraps looped together) fastened to the inboard box girder.
5. The main body of the hose between the fire hydrant and the nozzle lay over open water and hung with a “belly” in the hose.
6. From this point onwards there are no eyewitnesses to the exact sequence of events who can say how or why the deceased fell overboard. His supervisor was the last person to see him at which time he had one foot on the rung of the vertical ladder at No. 2 lifeboat. The vertical ladder is adjacent to the handrails at the rig’s perimeter. The hose was found hanging from the fire hydrant and disconnected from the nozzle secured to the lifeboat davit.

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

• Distributed and communicated this safety alert
• The risk of falling overboard is well recognized in the offshore industry. This incident highlights the need to remain ever vigilant.
• Conducted a review of all rigs/installations to identify areas where the potential for similar incidents exists.

IADC Note See IADC Alerts: 98 – 19, 01 1 24, 02 – 13, 03 – 27, and IADC APRG Section 4.2
Attachment 1

No. 2 Lifeboat, showing the original position of the hose.

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.