WHAT HAPPENED:
While maneuvering the BOP trolley work platform, the platform operator intended to move the platform closer to the riser, but inadvertently activated the wrong lever on the control panel. This action released the work platform securing pins, dropping the platform into the sea. Two personnel were on the platform when it was accidently released and were restrained by their Self Retracting Lifelines (SRLs) and retrieved without injury. *(Images on Pages 2, 3)*

CONTRIBUTING FACTORS:
The control panel is of poor ergonomic design, with the securing pin retraction and trolley travel control levers being of similar look, size and design and housed together in a bank of levers. In addition, the orientation of the panel is such that the operator is facing the opposite direction (to the controls) when looking at the work area. To sum, the design of the working platform did not eliminate the risk of platform dropping to sea, thus prevention measures were reliant on operational procedures.

Similar incidents had occurred in the past, with transferred learnings driving procedural changes, but more robust engineering solutions to the platform design and control panel not fully implemented. Thus, risk mitigation was focused almost exclusively on procedures at the lower end of the hierarchy of controls, rather than on elimination via a more fit for purpose design solution.

The investigation also identified that the incorrect procedure was being followed at the time of the incident with several critical controls missing and that the process of effectively communicating procedural change was inadequate.

All personnel involved in the task were utilizing the required PPE for working over water, including correctly anchored SRLs, which prevented personnel from falling to the sea when the platform released. There were no injuries sustained during the incident.

LESSONS LEARNED:
Following this incident, an engineering solution has been designed that prevents the trolley platform from falling in the event the platform securing pins are inadvertently released. It is recommended that all members review support mechanism on any similar platforms to ensure the design is such that accidental release of pins will not result in an uncontrolled drop of the platform.

Until engineered solutions have been implemented across the fleet, rigs are recommended to review procedures, work plans, work tempo and task-based risk assessments to ensure sufficient risk controls are in place. Simple interim measures should include the installation of a manually operated isolation valve, capable of being locked out, to prevent inadvertent functioning of the platform securing pins.

The correct use of PPE, including SRLs and anchorage external to the platform, prevented injuries in this high potential event. Please share this incident to reinforce the criticality of correctly using PPE any time personnel are required to work over water and while at height.
A Safety Alert can consist of any type of health, safety & environment (HSE) notification or Near Miss/Near Hit alert. Proactive Alerts on jobs well done are also encouraged.
A Safety Alert can consist of any type of health, safety & environment (HSE) notification or Near Miss/Near Hit alert. Proactive Alerts on jobs well done are also encouraged.