



PLATINUM EXPLORER

FATAL INCIDENT – 31ST JANUARY 2011

HSE Presentation - 022

VANTAGE

Exceeding expectations

What Happened

- Who was Injured
- How was he Injured
- What was the Job
- Pre-Incident
- The Event

What Went Wrong

- Critical Factors

What Actions Were Taken

- Action Plan

A 29 year old Indian Roustabout (R1) of 5 years offshore experience, employed by a Vantage Labour Contractor, sustained a traumatic impact to the abdomen area of his body resulting in fatal injuries

How was he Injured

He was struck a glancing blow in the abdomen by the base of a 5 ton chemical container being hoisted into the air by the crane

What was the Job

Unload chemical containers into the sack store via the sack store landing platform using the crane and fork truck

Pre-Incident

This was the second lift of this type of chemical container, the first container was unloaded without incident

The Event

Start of Shift a pre tour meeting was held in the office and a written plan was made by the Crane Operator and Chief Mate

Crane Operator explains plan to crew out on deck and shows them the sequence of loads for the Cargo Operation – (23 items of cargo)

Deck Crew are assigned their individual duties by the Crane Operator – A Banksman, Roustabout 1 (R1) Fork lift and crane assist, Roustabout 2 (R2) crane assist, Roustabout 3 (R3) Pipedeck crane assist

Deck Crew use a 1 ton sling to send 5 garbage bags down to the supply vessel, the Chief Mate assists the deck crew with this operation and then leaves to do other duties

The Event

Start of Chemical Container cargo operations – Banksman takes up position on Sky Bridge, R1 & R2 are positioned on Sack Store Landing Platform to assist crane and use the fork truck to remove the chemical pallets from the container

The Deck Pusher joins R1 and R2 in the Sack Store area and assumes the position of Fork Truck Operator

The Deck Pusher did not attend the Planning meeting with the rest of the crew at which time the duty of operating the fork truck was assigned to R1 by the Crane Operator

The Crane Operator was not aware of the Deck Pushers presence in the Sack Store area during the cargo operation

The Event

The first chemical container is landed on the sack store landing platform and unloaded using the fork Truck without incident

The second chemical container is landed on the sack store landing platform and the doors opened by R1 and R2

The Banksman notices that the 1 ton sling used on a previous lift sending down garbage bags to the supply vessel has been sent back on the crane hook

The Banksman makes the Crane Operator aware via radio that they need to remove the 1 ton sling from the crane hook – the Banksman's English is not good and the Crane Operator is unclear as to what he is asking

The Event

As all the deck crew have radio's R1 who's English is good clarifies the situation to the Crane Operator who now understands but thinks the Banksman clarified the situation and from this moment forward thinks all radio signals are from the Banksman

R1 now asks the Crane Operator to boom left and slowly lower the crane hook down the side of the container to within 2 feet of the deck

R1 and R2 go to the side of the container between it and the landing platform handrail to remove the 1 ton sling

The 1 ton sling is removed and R2 proceeds to the front of the container towards the Sack Store door

The Event

The Crane Operator was given the instruction to pick up slowly on his whip line, which he indicated he did, he said the line came tight as he was picking up the slack, then he immediately heard the command “up up up” which he complied with raising the whip line quickly lifting the container into the air.

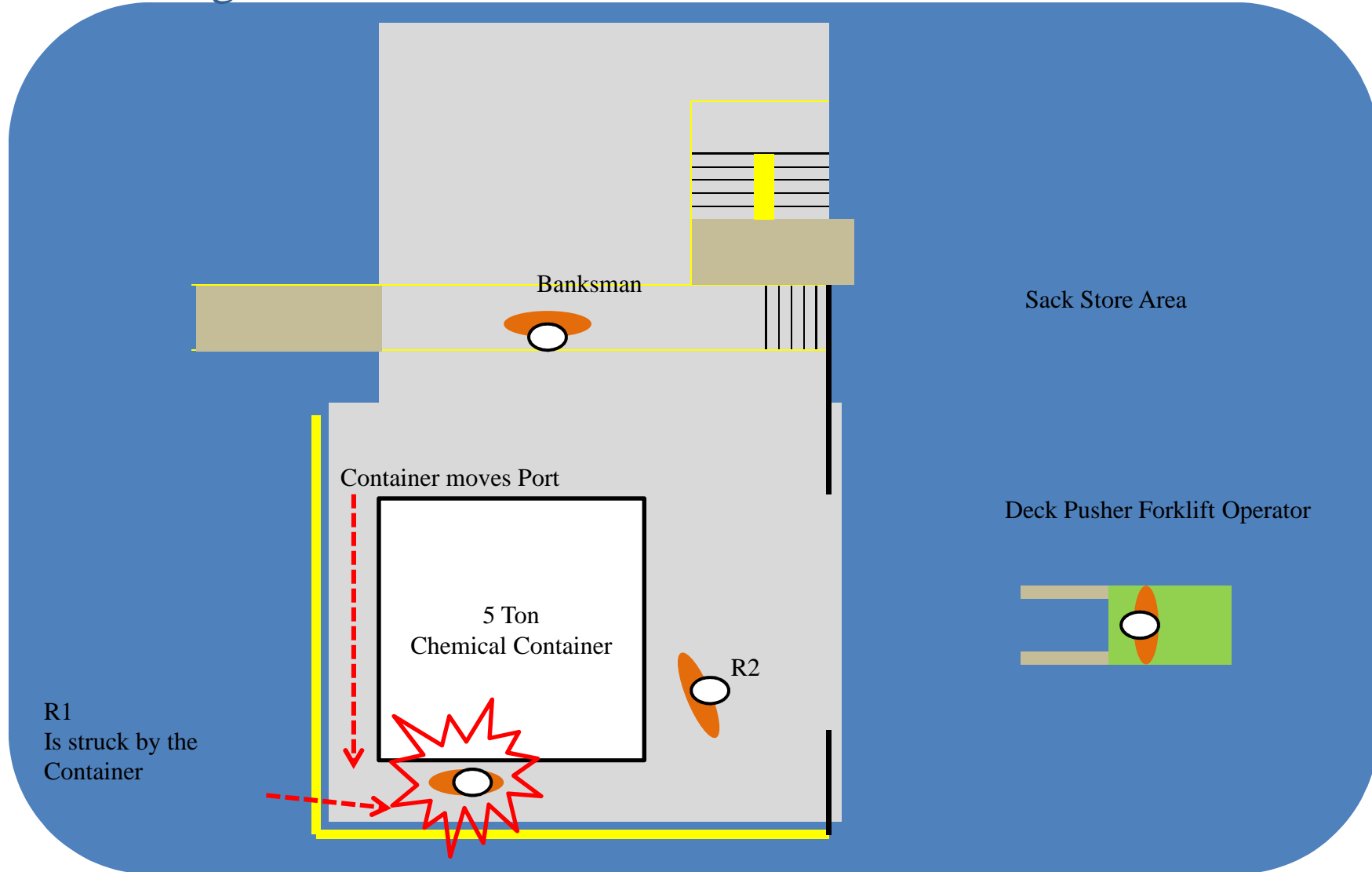
The Banksman and R2 advised they observed after the 1 ton sling was removed, the whip line was picked up quickly with the boom still off center, the whip line came tight and the container was lifted off the deck and up quickly swinging in the direction of R1 *The Crane Operator failed to use and understand the technical aids correctly in the crane, as well not looking at the boom tip camera display to identify the position of his crew prior to lifting the load quickly.*

The Event

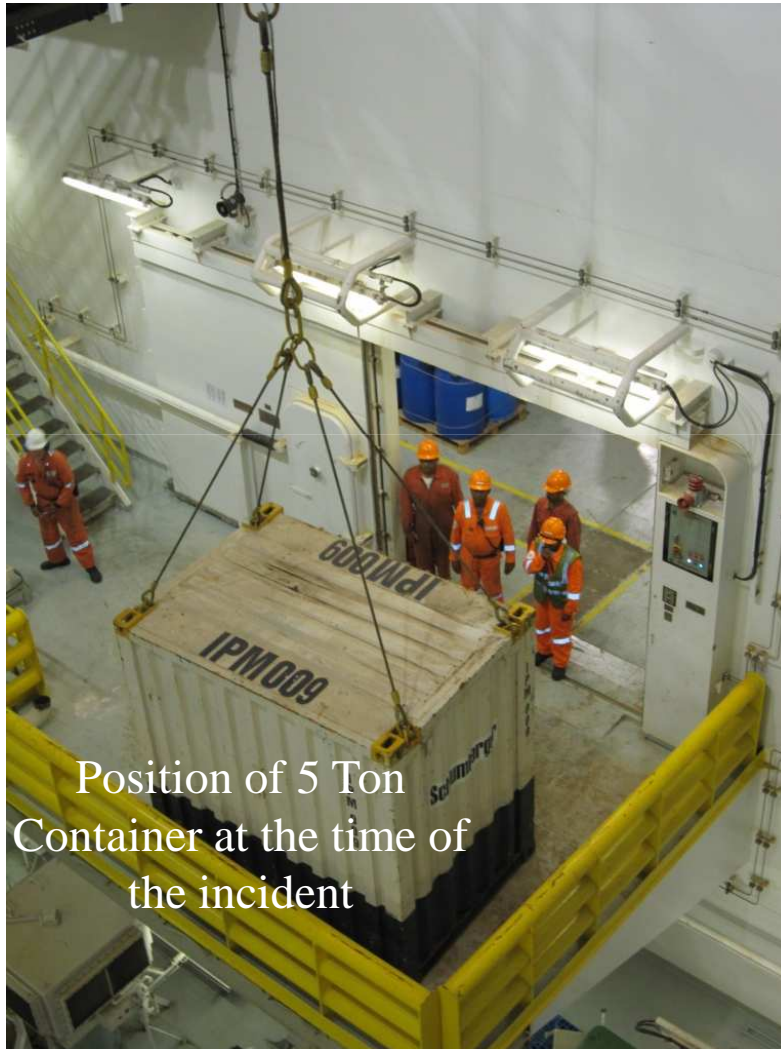
R1 remained in position between the container and the landing platform handrail. As the container was raised quickly the bottom edge of the container gave a glancing blow to R1's lower abdomen on its way pass causing a fatal injury

At no point in this cargo operation did any of the crew exercise a stop work authority when the operation changed, from the original plan or when a hazardous situation occurred

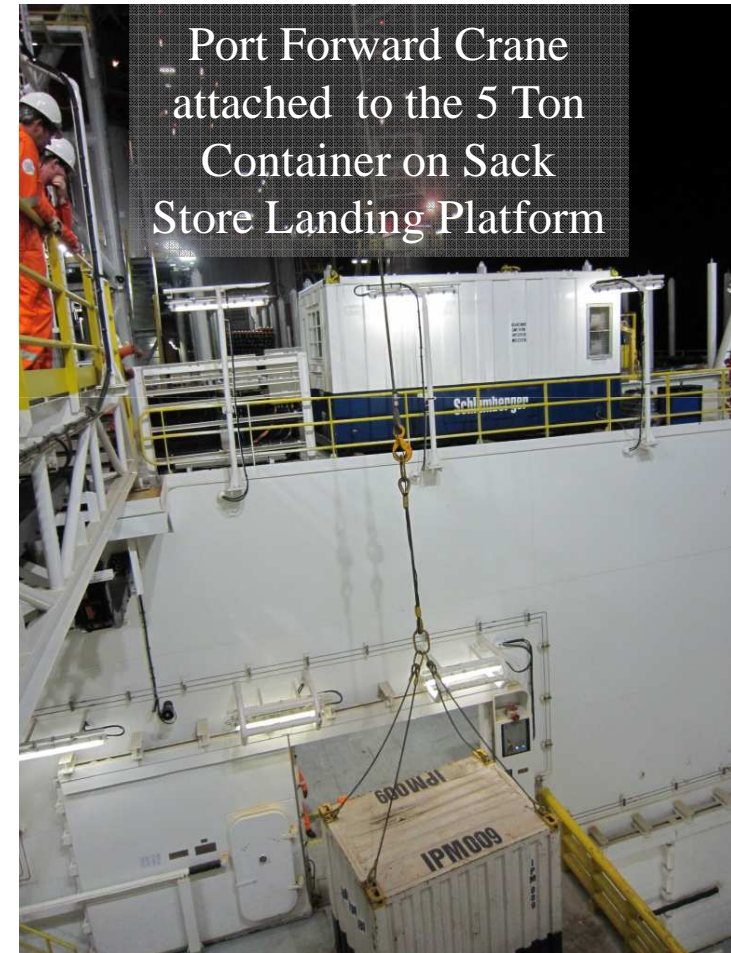
Diagram of Incident Area at the Time of the Incident



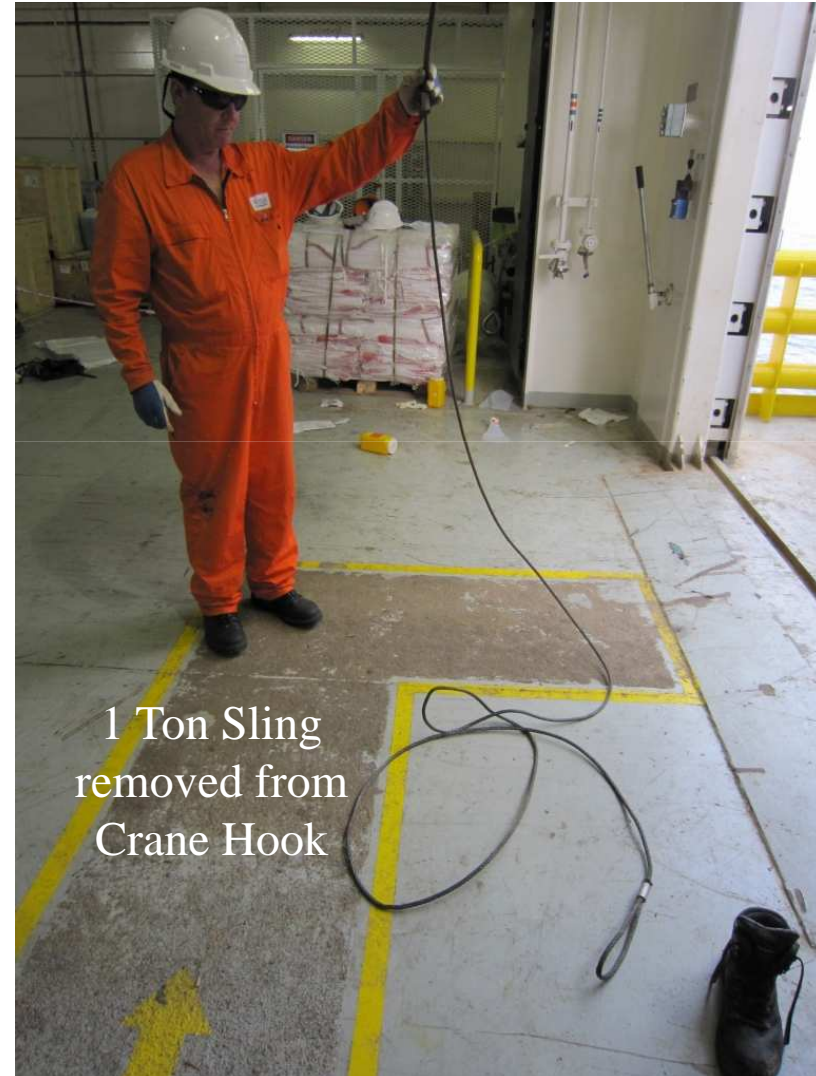
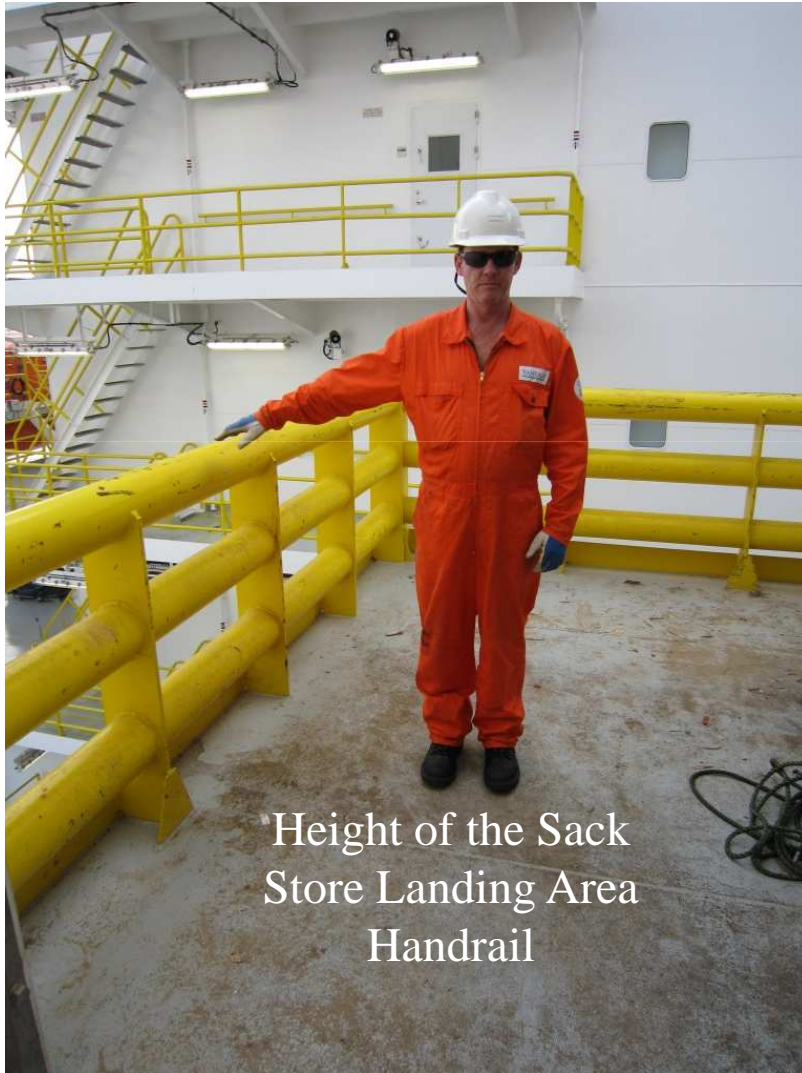
Photographs of the Scene Post Incident



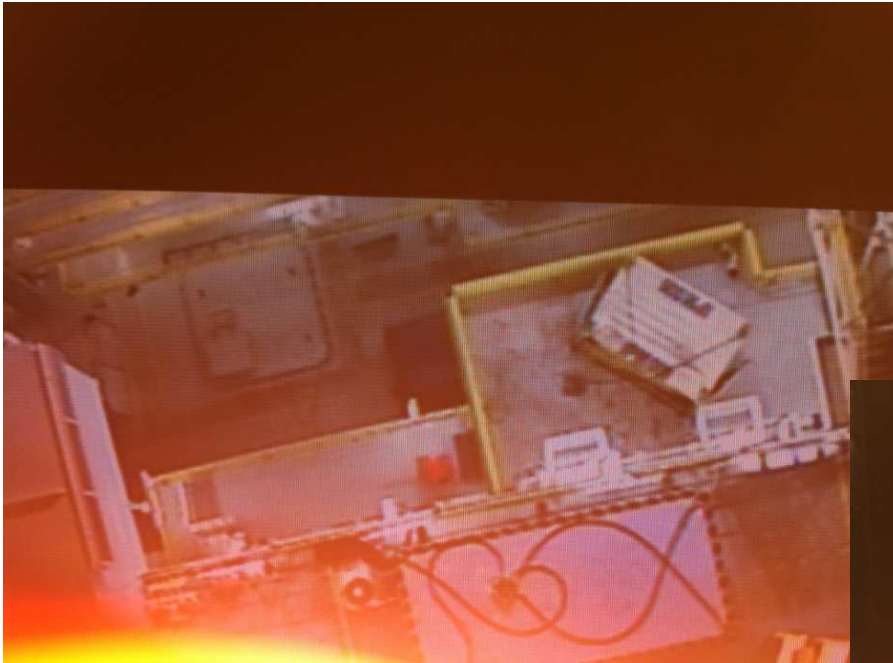
Photographs of the Scene Post Incident



Photographs of the Scene Post Incident



Photographs of the Scene Post Incident



Boom Tip Camera View
at the time of the Incident

Crane Main control Display



Critical Factors

Human

The chemical container was lifted off centre quickly by Crane Operator

Human Factor – Knowledge Based Decision Required

Human

The Roustabout (R1) was in the wrong position (line of fire) when the container was lifted

Personal Performance – Inadequate problem detection/situation awareness

Human

Wrong instructions given to the crane driver over the Radio – not from the Banksman

Communications – Communication between work parties issue

Human

An additional 1 ton sling was put on the Crane hook by the supply vessel crew

Management System – Change control not identified & reviewed

Action Plan

A number of safety stand downs were held with all personnel onboard, deck operations were suspended and limited for several days after the accident.

The incident was explained in detail identifying how the IP was hurt and lessons learnt.

All were reminded of the need to follow correct procedures and conduct the required Risk Assessment and Planning Process.

All were reminded if they see anything they consider not to be right they must exercise “STOP Work Authority” and halt the operation.

Action Plan

Identified Plans from the previous day are now discussed by the ARM & OIM at the morning meeting with Department Heads for improvement opportunities

A formal Control Plan for Portable Radio's has been implemented, including their restricted use for deck operations

A Safety Critical Rig Specific Procedure and Task Risk Assessment for loading and unloading containers on the sack store landing platform has been implemented

14 What Actions Were Taken

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Action Plan

A “No Go” area in front of the heavy duty handrail on the Sack Store loading platform has been identify using high visibility paint



All personnel have been given the basic outline of the incident and the lessons learnt (Newly arriving personnel are also given this information)

Action Plan

A review of all currently used Safety Critical Rig Specific Procedure has been conducted prioritising the Task Risk Assessments needed to be implemented immediately.

All department heads are now required to outline at the morning meeting their departments participation in the Observation process, to include any “Management of Changes” identified.

FURTHER ACTIONS TO FOLLOW