CASE STUDY

OISD/CS/2021-22/E&P/01 Dt.: 16.09.2021

INTRODUCTION

Title: Fall of the Hatch on a Roustabout.

Location: Offshore Drilling Location

Loss/ Outcome: Fatal Injury.

BRIEF OF INCIDENT

According to plan, power tong was to be picked from heavy drilling tool store. Victim, the roustabout-1, connected the lifting sling of the Hatch cover of heavy tool store to the crane. Other crew member a Roustabout-2 was giving signal to crane operator from cantilever area. Hatch was opened and after getting the signal from the victim, lifting sling was released from the crane. Roustabout-2 heard a thud sound and observed that victim was lying unconsciously between hatch cover and kick back plate of the hatch. Immediately Hatch cover was lifted by using crane and victim was moved to Rig sickbay and was given initial medical treatment. Later on victim was evacuated to base for further treatment but declared dead on arrival at hospital.

OBSERVATIONS/ SHORTCOMINGS

- During investigation it was observed that surrounding area of pole where hatch cover is meant to be secured is not easily accessible because of storage of stabilizers and other items. The person who secured the hatch cover cannot physically see that whether the bolt had passed through both the holes (eye pad on hatch as well as pole). This is in Violation of Rule-162 (sub rule (2) of P&NG rules-2008.
- There was poor housekeeping around the hatch area.
- Heavy tool store is made in a confined space, which has a single exit. Permit to work system for entry into confined spaces was not followed, which violates Rule-131 of P&NG rules-2008.
- Rig management has not made any Standard Operating Procedures (SOP) for material transfer into heavy tool store, which is located into a confined space. Risk assessment with the material transfer process into heavy tool store is inadequately done in Violation of Rule-21 of P&NG rules-2008.
- There is no provision of negative angle in hatch securing provision so that force of gravity prohibits hatch cover from accidental closing on its own.
- Top most railing of stair case in heavy tool store needs to be removed for closing of hatch door and this railing needs to be put again prior to crew movement. However, there is no means to ensure this.

- Victim was not supervised by anyone, when the accident took place. The practise of buddy system was not followed.

REASONS OF FAILURE/ ROOT CAUSE

- Unsafe working condition is the root cause of this fatal accident.
- Absence of SOP for material transfer to/ from heavy tool store.
- Permit to work system was not being used while entering into confined space.
- Poor supervision

RECOMMENDATIONS

- Hatches are primarily meant for cargo transfer and for alternate exit route in emergency conditions. Hatches should not be used for regular entry and exit.
- Rig crew entry through hatches should be stopped and use of this heavy tool store should be discontinued till the time normal entry route is made available for crew using management of change.
- Hazard identification and risk assessment system should be reviewed holistically.
- Housekeeping near the hatch area should be improved by relocating stabilizers to some other place.
- Supervision needs to be improved to prevent recurrence of this kind of accident.
- Rig crew should follow safe work practices and buddy system should be followed.
- Internal audit by Shelf needs improvement so as to capture all hazards and shortcomings.
- comprehensive Internal audit by operator and contractor should be done covering all aspects of OISD ESA checklist for Offshore Drilling Rig.

Hatch

Provided for information purpose only. This information should be evaluated to determine if it is applicable in your operations, to avoid recurrence of such incidents.

Entry into Drilling Store via Hatch

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