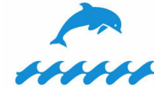
Dolphin

LESSONS LEARNED REPORT

CRANE FAILURE



TYPE OF INCIDENT: NII

INCIDENT NO: 06-2009

COUNTRY: UK

DATE OF INCIDENT: 18/03/09

BRIEF ACCOUNT OF INCIDENT:

OPERATION WAS MOVING THE NEW SLIP JOINT FROM THE RIG FLOOR TO THE DECK USING THE STARBOARD CRANE WHIP LINE. THIS WAS SUCESSFULLY COMPLETED BUT RE-POSITIONING WAS REQUIRED, AND ON THE 2ND RE-POSITIONING LIFT THE CRANE WHIP LINE DRIVE FAILED AND THE SLIP JOINT DROPPED APPROXIMATELY 18" TO THE DECK FOLLOWED BY THE HEADACHE BALL AND ABOUT 40' OF WIRE.

WHAT WENT WELL?

ALL PERSONNEL WERE SENSIBLY POSITIONED AND THERE WERE NO INJURIES. TBT HAD BEEN HELD PRIOR TO THE TASK COMMENCING. EVERYONE INVOLVED FULLY ASSISTED IN THE INVESTIGATION.

WHAT WENT WRONG?

THE TRA AND STOP FOLLOWED DURING THE OPERATION WERE FOUND TO BE OUT OF DATE, UNSUITABLE AND HAD MISLEADING AND INSUFFICIENT INFORMATION. THE TBT HAD NOT BEEN A COMBINED ONE WITH BOTH DRILL & DECK CREWS ATTENDING. DESPITE COMMENTS ABOUT THE METHOD USED BEING INCORRECT, NO-ONE INTERVENED TO STOP THE OPERATION. PLANNING AND PREPARATION WAS POOR.

THE LOAD INDICATOR ON THE CRANE WAS UNRELIABLE, AND ALTHOUGH SPARES HAD ARRIVED, THE TIME HAD NOT BEEN TAKEN TO AFFECT THE REPAIR. A WIRELESS LOAD CELL HAD BEEN HIRED AS A STOP GAP UNTIL THE LOAD INDICATOR WAS REPAIRED BUT IT WAS NOT USED FOR THIS LIFT.

INFORMATION ABOUT THE WEIGHT OF THE NEW SLIP JOINT WAS MISLEADING AND MOSTLY INCORRECT AND IT WAS NOT MARKED SHOWING THE WEIGHT.

LESSONS LEARNED:

WHENEVER A NEW ITEM OF EQUIPMENT IS USED ALL RELEVENT DOCUMENTATION SUCH AS STOPS, TRA'S AND LIFTING PLANS ETC SHOULD BE REVIEWED BEFORE INITIAL USE AND REFERRED TO EACH TIME SUBSEQUENTLY. ACCURATE WEIGHTS OF NEW EQUIPMENT MUST BE SENT TO THE RIG <u>BEFORE</u> THE EQUIPMENT ARRIVES.

TRA'S MUST BE SUFFICIENT AND SUITABLE AND CONDUCTED BEFORE EACH TASK, AND ANY DISCREPENCIES IN TRA'S TO BE HIGHLIGHTED AND CHANGED FOR FUTURE USE. LIFTING PLANS MUST BE UPDATED MORE FREQUENTLY, AND WHENEVER A REPLACEMENT ITEM IS A DIFFERENT WEIGHT OR SIZE FROM THE ORIGINAL. LIFTING PLANS MUST BE CONSULTED AT ANY TBT REGARDING LIFTING OPERATIONS.

NO INJURIES WERE SUSTAINED DURING THIS INCIDENT ALTHOUGH THE POTENTIAL WAS VERY HIGH. THE IMPORTANCE OF CORRECT POSITIONING OF PERSONNEL DURING LIFTING OPERATIONS CANNOT BE OVER-STATED. NEVER ALLOW ANYONE UNDER A SUSPENDED LOAD, NOT EVEN TO GRASP A TAG LINE - USE A BOAT HOOK OR SIMILAR FOR THIS AND KEEP EVERYONE

ALERT UNTIL THE LIFT HAS BEEN FINALLY LANDED AND CORRECTLY LOCATED.

ALL THOSE IN A SUPERVISORY CAPACITY SHOULD BE FAMILIAR WITH THE RELEVENT STOP FOR THE OPERATION AT HAND AND ALSO THE MOST RECENT DDL PROCEDURE ASSOCIATED WITH THE TASK.

MESSAGES:

WHENEVER ANYTHING IS LIFTED WHICH IS ANYWHERE NEAR THE UPPER LIMIT OF THE WHIPLINE SWL AND THERE IS ANY DOUBT AT ALL OF THE EXACT WEIGHT, THEN IT MUST ALWAYS BE TREATED AS A MAIN BLOCK LIFT.

PROPER PREPARATION IS CRUCIAL FOR A SAFE OPERATION. BEFORE ANY JOB THERE SHOULD BE A PROPERLY CONDUCTED TBT WITH ALL THOSE INVOLVED PRESENT. TRA'S LIFTING PLANS AND ANY RELEVANT STOP SHOULD BE REFERENCED AND DISCUSSED DURING THE TBT AND EVERYONE PRESENT SHOULD LEAVE KNOWING EXACTLY WHAT THE JOB ENTAILS AND THEIR OWN PART IN THAT JOB.

TRA'S, STOPS, LIFTING PLANS AND EVEN DDL PROCEDURES ARE 'LIVING DOCUMENTS' AND CAN BE CHANGED (THEY FREQUENTLY ARE). NEW TRA'S AND/OR LIFTING PLANS SHOULD BE MADE IF JOB REQUIREMENTS CHANGE DURING THE OPERATION, AND THESE NEW DOCUMENTS ENTERED INTO THE SYSTEM. IF THERE ARE ANY IMPROVEMENTS TO EXISTING STOPS THEN THEY SHOULD BE PRESENTED TO THE RIG MANAGEMENT FOR CONSIDERATION AND POSSIBLE INCLUSION IN THE SYSTEM.

ANYONE IS ENTITLED, AND EXPECTED, TO STOP ANY OPERATION IF THEY BELIEVE IT IS NOT BEING CONDUCTED CORRECTLY. THIS IS A RIGHT AND A DUTY; WE CANNOT COUNT HOW MANY INJURIES ARE PREVENTED BY CALLING A TOFS BUT WE CAN CERTAINLY COUNT THOSE WHICH DO OCCUR AND COULD HAVE BEEN PREVENTED. IT IS STRESSED THAT THERE WILL BE NO CRITICISM OF ANYONE CALLING A TOFS, FOR GENUINE CONCERNS, WHICH EVENTUALLY PROVES TO BE UNNECESSARY.

ALTHOUGH PROCEDURAL FAILINGS WERE IDENTIFIED, THE INCIDENT WAS CAUSED BY A MECHANICAL FAILURE OF THE CRANE WHICH COULD HAVE HAPPENED AT ANY TIME AND WITH ANY LIFT. UNDETECTED DEFECTS SUCH AS THIS ONE ARE VERY DANGEROUS AND NORMAL PM ROUTINES WILL NOT DETECT THEM. ANY EXPERT THIRD PARTY RECOMMENDATIONS FOR INTRUSIVE INSPECTIONS SHOULD BE COMPLIED WITH IN A TIMELY FASHION.