Topic working with tubulars – Incident report

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While carrying out backloading operations at a rig, a crewman suffered a lost time injury.

What happened?

The operation being carried out at the time was the movement of tubulars to make room for an extra 50ft basket.

The company involved has reported the following lessons learned:

There were a number of learning points, which came out of the inquiry into this incident, which if instigated should prevent a recurrence of this type of incident.

1. No backload list had been supplied to the vessel to allow a loading plan to be produced before backloading commenced. The basket was also an additional item, which was only prepared for backloading after the original backloading was complete.This was an incident that occurred in the UK sector. The company notes that the preparation of a deck plan prior to loading is a requirement under the UK Code of Safe Working Practices for Merchant Seamen. It is also recommended that vessels are included in any work planning discussions that involve the use of the vessel.
2. This was the second time the tubulars had been moved during this voyage. The tubulars were in different size bundles and of differing lengths. There were not enough tubulars to make use of the pipe stanchions viable.

The United Kingdom Offshore Operators Association (UKOOA) Guidelines on Safe Handling and Packaging recommends that small tubulars be transported in racks.

- Inadequate risk assessments were carried out onboard the vessel when the task changed from a standard lifting process. The strops of one of the tubulars being moved were trapped and therefore the crane hooks were put through a bight on the strops to try and free them. Also when one of the strops failed to come free and it was decided just to straighten up the stow of that tubular, there was no reassessment. There were job discussions as to what to do (i.e. toolbox talks), but these did not include a discussion on the associated risks.Tasks should be re-risk assessed any time the job changes.

- At no time did anyone call a ‘time out for safety’ when the operation changed. Also nobody stopped the crewman going into danger when they saw him. (Crewman was seen to walk on the unsecured tubulars to grab hold of the for’d crane hook, instead of waiting for the hook to come to him).All crew were aware of their ‘stop work’ authority, but did not exercise it when it was important to do so.
- The crew of the vessel knew that the statutory procedures for backloading were not being followed, but saw the process as ‘common practice’ when working rigs. The company stated that during the investigation a comment that was made quite a few times regarding working on a rig was that ‘you never know what you are going to backload until it is on the hook,’ thus there still seems to be acceptance of ‘common practice,’ which is not always ‘best practice’.
- There was a general acceptance both on the vessel and the installation that non-compliance with the UKOOA PSV and Packing guidelines was accepted.The company notes that all companies have accepted the need for common guidelines and practices and that Masters should be encouraged to challenge installations which are not complying and vice versa.