Injury during personnel transfer capsule operation

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A Member has reported an incident in which a person was injured during a personnel transfer capsule operation.

What happened?

Three persons involved in pipeline commissioning activities on a recently installed jacket were preparing for a personnel transfer back to the vessel from which they had initially been transferred. The method of transfer was to be by the transfer capsule.

Prior to the actual lift, a swing developed on the crane's headache ball. The swing gathered momentum, despite the efforts of the crane operator to stop it, until it eventually hit one of the platform's legs and ricocheted into the capsule frame. A section of the crane rigging and headache ball hit the frame of the transfer capsule before sliding into the interior of the frame and impacting one of the three occupants.

The injured person was medevaced to hospital for attention. After a thorough medical examination and precautionary tests, the worker was released that same evening and deemed fit to return to work for light duties.

jacket showing personnel transfer capsule and crane wire

What were the causes?

Following investigation, the following findings were made:

- Alternative arrangements for accessing the platform had been identified but not

considered.

- For this work, the personnel transfer capsule should have been identified as the primary means in the event of an emergency only.
- The crane operator had received no training for transfer capsule operations even though this omission had been identified during risk assessment.
- The transfer capsule operation had taken place safely on two previous occasions and thorough risk management controls had been followed and implemented.
- On this occasion the risk assessment for the operation had not taken into account a number of important factors and necessary risk control measures were not implemented.
- Procedures specific for vessel to platform (jacket) transfer were not followed.
- The personnel transfer capsule was not lowered on to the jacket in the area originally specified during risk assessment.
- The size of the area to which the capsule was lowered was not in compliance with the manufacturer's recommendations.
- On this occasion the crane operator did not lay the headache ball down on the jacket during the boarding of the capsule because of worsening swell conditions and restrictions on landing area (see picture).
- The personnel being transferred took longer than normally required to secure themselves within the capsule.
- The sea state in this region is known to produce a 'larger swell' at irregular intervals. This was the case in this event as a 'rogue swell' was also involved in causing the initial swing on the headache ball.
- A shift change had taken place between the initial lift on to the jacket and the recovery from the jacket back to the vessel. The crane operator was the same throughout but the deck foreman and his crew were all new to the operation and not been involved in the task risk assessment (TRA) or toolbox talks.

Actions

The following actions were recommended:

- Risk management processes should be followed thoroughly for all high potential operations and repeated every time an operation is carried out; this is even more important when operations are carried out by different personnel.
- Actions identified during risk assessments should be fully closed out before operations begin. In this instance crane operator training had not been carried out.

- Management of change processes should always be followed whenever circumstances change during an operation; if necessary the operation should be stopped whilst this is carried out.
- All personnel involved in an operation should be fully briefed beforehand during the toolbox talk.
- Manufacturers' instructions and recommendations on the use of equipment should be followed.
- All personnel have a responsibility to intervene and stop an operation which is clearly unsafe.