Dropped wooden block in conductor support frame

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During a decommissioning project, a wooden wedge, weighing approximately 13 kg, dropped 6 m, striking a rigger's hard hat and shoulder on its way down.

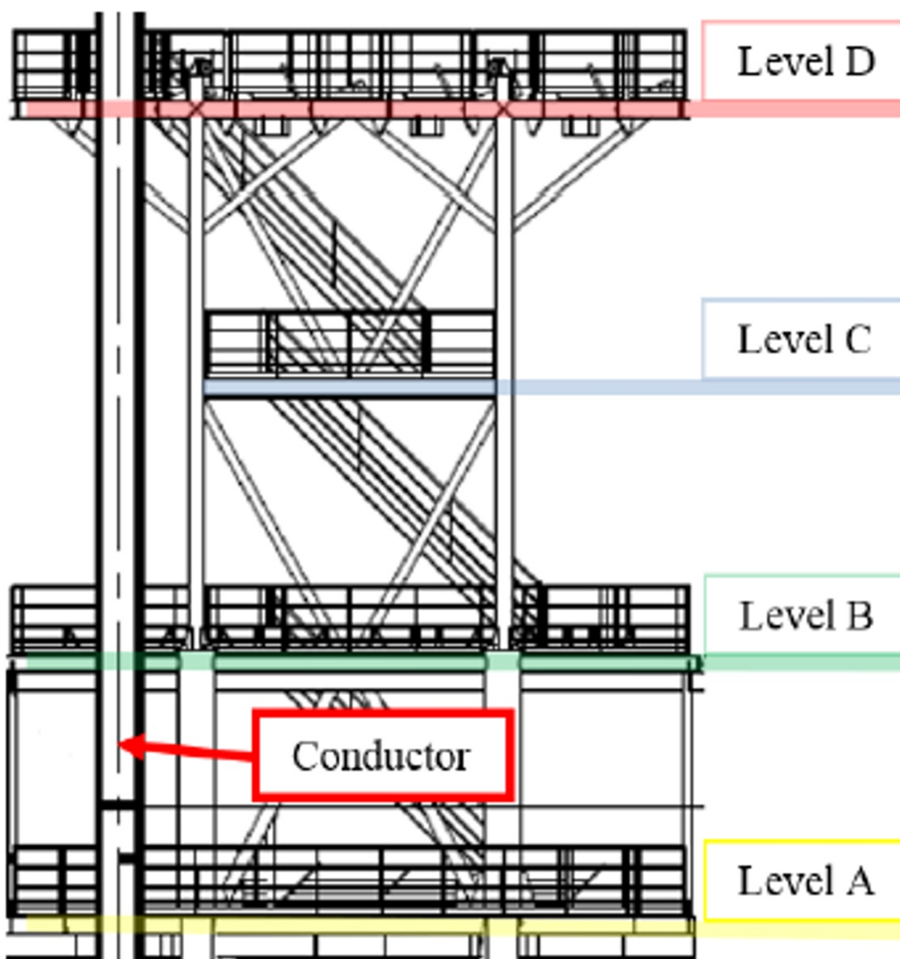
IOGP Life Saving Rules:

Work authorisation

What happened?

The rigger suffered minor cuts; it was fortunate that his injuries were not more serious. The incident occurred during decommissioning operations using a conductor support frame (CSF) to help with the removal of conductors.

Conductors were pulled into position in the CSF by crane. To reduce horizontal movements, wooden wedges were installed, whilst the conductors were being cut in smaller sections. During removal of the wedges, one of the wedges fell and struck the rigger.



What went wrong?

As per company procedure, the wedges were to be placed into position at level B, to remove any horizontal movements of the conductor. To reduce movements from the top of the conductor, additional wedges were installed at level D (top level) of the CSF; *this addition was not part of any procedure.*

After completion of the sectioning cut at level A, the rigging team started to remove the wedges installed at level B, as per original procedure. Whilst removing the wedges at level B, one of the wedges installed at level D dropped to level B striking one of the riggers.

The investigation revealed that:

- Procedures had not been updated to include the additional wedges at level D.
- Management of change (MoC) was not implemented/followed.
- There was a failure of the wedge securing eyes due to vertical movement of the conductors caused by vessel/platform movement.
- It was not identified that removal of the (upper) level D wedges prior to removal of the (lower) level B wedges would have eliminated the dropped object risk.

What actions were taken? What lessons were learned?

- Any change to a procedure should be subject to MoC.
- Procedures should be updated immediately and re-issued to include any changes.
- Any changes to procedures should be communicated to all personnel potentially affected by the change.
- All persons involved should take part in risk assessments/job safety analysis (JSA) in order to ensure all hazards are identified and eliminated/controlled.

Members may wish to refer to:

- IMCA HSS001 Guidelines for management of change
- IMCA DROPS videos:
  - Technip DROPS (IMCA HSS039)
  - Saipem DROPS – choice not chance (IMCA HSS042)
  - DROPS (IMCA HSS043) *[shared by Subsea 7]*

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