COS SAFETY SHARE

WHAT WILL WE DO TO PREVENT THIS FROM HAPPENING HERE?

LINE-OF-FIRE INCIDENT RESULTS IN FATALITY

What happened?

While removing the Christmas tree using air tuggers, the securing bracket for the air tugger failed, this [caused] the air tugger winch to rotate and fatally crush the IP [Injured Person] against a steel I-beam.

Rig and all non-essential activities fieldwide were suspended. Emergency medevac activated and area secured.

What went wrong?

Location of tugger controls required the floorman to stand between tugger and I-beam.

Why did it happen?

Potential for tugger moment and line of fire hazard was not identified.

Tugger swivel pedestal base was modified from the original design without documented engineering review or management of change.

Previous tugger incidents involving swivel base malfunction and failure were undocumented and were not shared.

What areas were identified for improvement?

Install OEM-available remote operation capability for tuggers and establish criteria for remote operation to manage line of fire hazard.

Implement physical walk through upon installation to identify and mitigate crush points.

Ensure lifting equipment permanently installed on adjustable foundations is engineered, fabricated and installed per approved design, and modifications are in accordance with contractor's MOC process.

Prohibit work on critical equipment outside of the maintenance system.

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CENTER FOR OFFSHORE SAFETY