Safety Alert

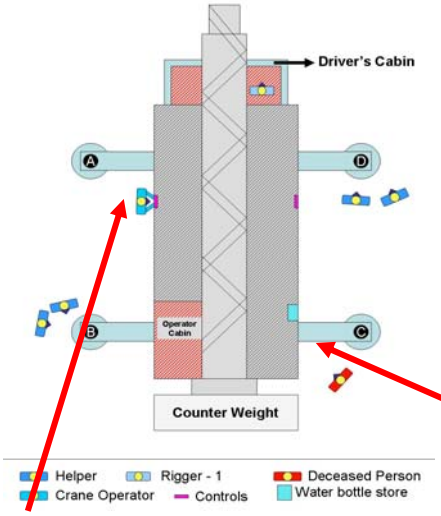
From the International Association of Drilling Contractors

ALERT 08 – 37

FATAL INCIDENT – WORKER CAUGHT BETWEEN OUTRIGGER AND CHASSIS OF CRANE

WHAT HAPPENED:

Six workers were preparing a truck-mounted crane for relocation in a lay-down area on the site. During outrigger retraction, one of the workers reached across an extended outrigger beam. It is thought that he was attempting to retrieve a water bottle stored in a recessed area of the crane chassis. As the outrigger was retracted into the sleeve, the worker was trapped between the chassis and the outrigger stabilizer cylinder. The worker was severely injured and transported by the other workers to the nearby hospital. Unfortunately on arrival the worker was pronounced dead.



Position of the operator

Position of Worker reaching across the outrigger beam.

WHAT CAUSED IT:

The incident investigation revealed the following key factors that contributed to the incident:

- **Human errors.**
  - The deceased placed himself between the crane chassis and the outrigger stabilizer cylinder.
  - The crane operator had no visual contact with the deceased as he operated the controls for the outrigger from the opposite side of the crane, instead of using the controls on the other side of the crane.
  - The deceased was not directly involved in the demobilization activity and the work area was not properly barricaded off to restrict access to the crane area.
- **Inadequate risk awareness.**
  - There was no evidence that a toolbox talk was conducted and that the specific risks associated with this activity were acknowledged and properly explained to the workers involved.
  - The work group was assembled ad-hoc for this activity comprising workers from different background and nationalities; hence language barriers may have hampered communication.

The Corrective Actions stated in this alert are one company's attempts to address the incident, and do not necessarily reflect the position of IADC or the IADC HSE Committee.

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- **Inadequate supervision.**
  - The supervisor left the work area before the task was completed as he considered this activity not being part of his work scope.
- **Inadequate procedures and work instructions.**
  - There was no adequate method statement and Job Safety Analysis (JSA) for this activity available as crane set up and breakdown activities were not properly addressed in the documentation provided for this job (e.g. lift plan, permit to work, JSA, etc.)

CORRECTIVE ACTIONS: To address this incident, this company did the following:

Several fatalities have occurred in the Group in the past involving crane operations. In general, risk management of those activities is focused on the actual hoisting and lifting operations at the site of work. This incident demonstrates that crane preparation or demobilization activities involve significant safety risks as well and hence require rigorous HSE management controls.

Supervisors and Workers are to:

- Assure yourself that similar activities are adequately managed in your area of operational control and that key controls are effectively implemented when performing these activities by asking and answering the following questions:
  - Do you use similar type of equipment in your area of operation?
  - Are preparation and demobilization activities treated as being part of your lifting and hoisting plan?
  - Determine if clear procedures are developed and work instructions for these activities are communicated?
  - Do you supervise these activities permanently?
  - How well are your workers trained in executing the emergency response plan?
  - Determine how you are going to deal with language problems?
- Conduct a toolbox talk prior to commencing the work.
- Ensure that the work area is barricaded off to prevent access to the crane area for those not involved in the crane operation.

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