



Monkeyboard Incident and Work at Height Initiatives.

Drillsafe HSE Forum – 16 June 2005



presented by

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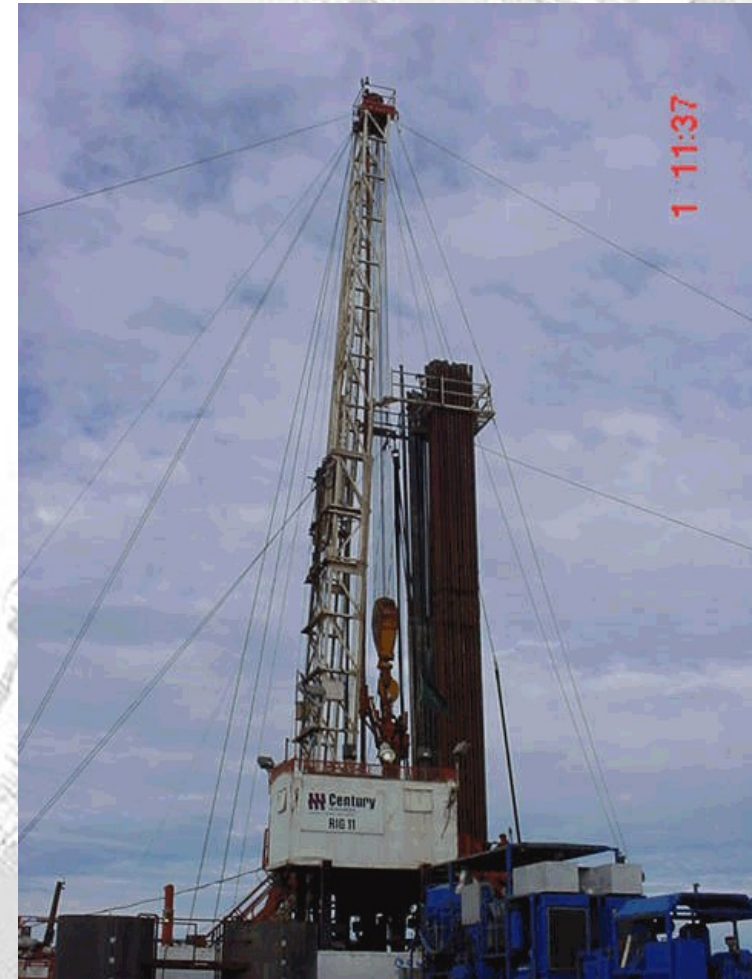
HS&E Advisors

“Safer, Smarter : Together”



Incident Background.

- Rig 11 was RIH for 3.5 hours between midnight and 3.30am on 25 April 2005.
- The FM was performing the DM duties for this 3.5 hour period.
- The incident occurred following the FM's ½ hour break as he was returning to relieve the DM.



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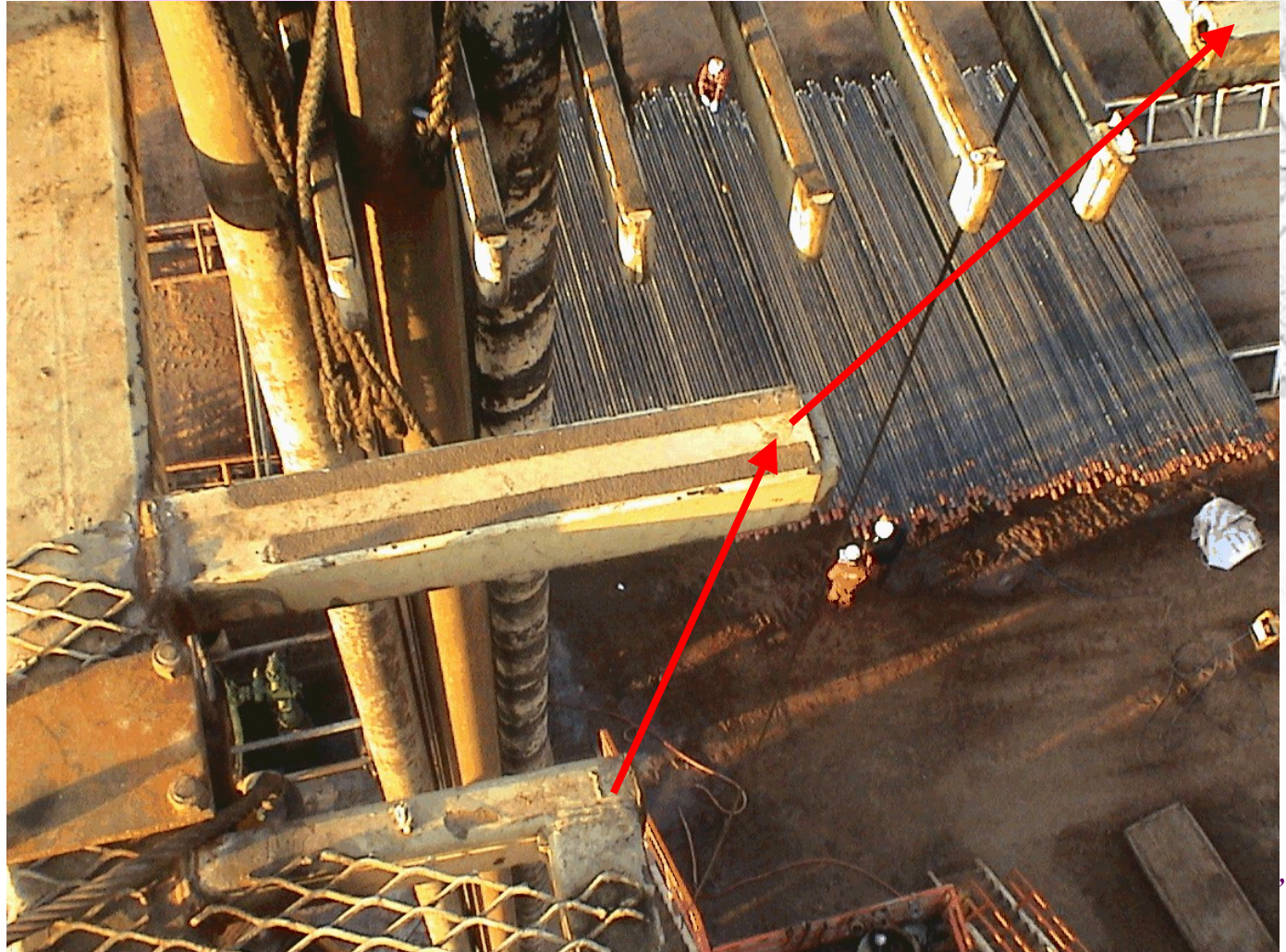
Incident Breakdown.

1. FM arrives at monkeyboard.
2. Driller lowers top drive to make up new stand.
3. FM crosses in front of fingers to the diving board.
4. Line is hooked on top drive.
5. FM is pulled to the fingers as the top drive descends.
6. DM yells to Driller to stop and top drive is raised 2 metres.
7. Driller dons harness and ascends to monkeyboard.
8. FM is removed from the mast using the manrider and taken to local hospital for x-ray and cat-scan.
9. Besides the concussion, only bruising was found. No severe head or chest injuries were found.



Photograph 1 – Step across fingers.

(NB. Fingers were full of pipe)





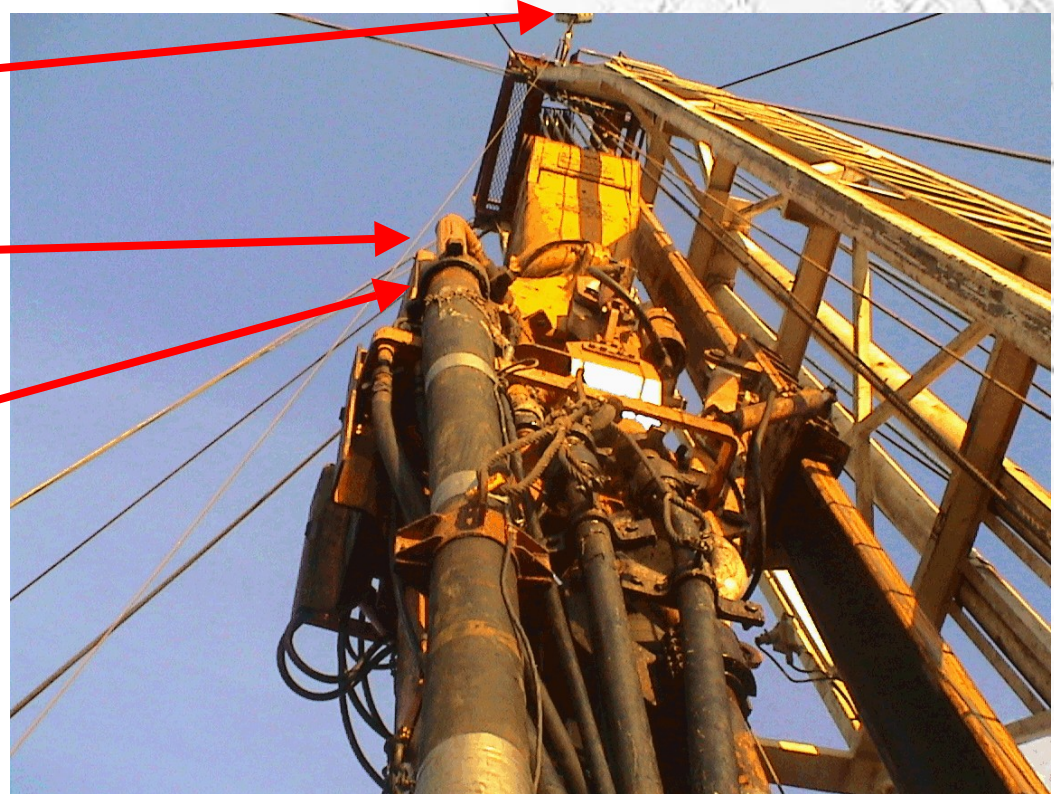
Photograph 2 & 3 – Diving board and direction FM was pulled.





Photograph 4 – Top-drive and Inertia reel set-up.

- Inertia reel from crown
- Reel Line
- Gooseneck hammer union





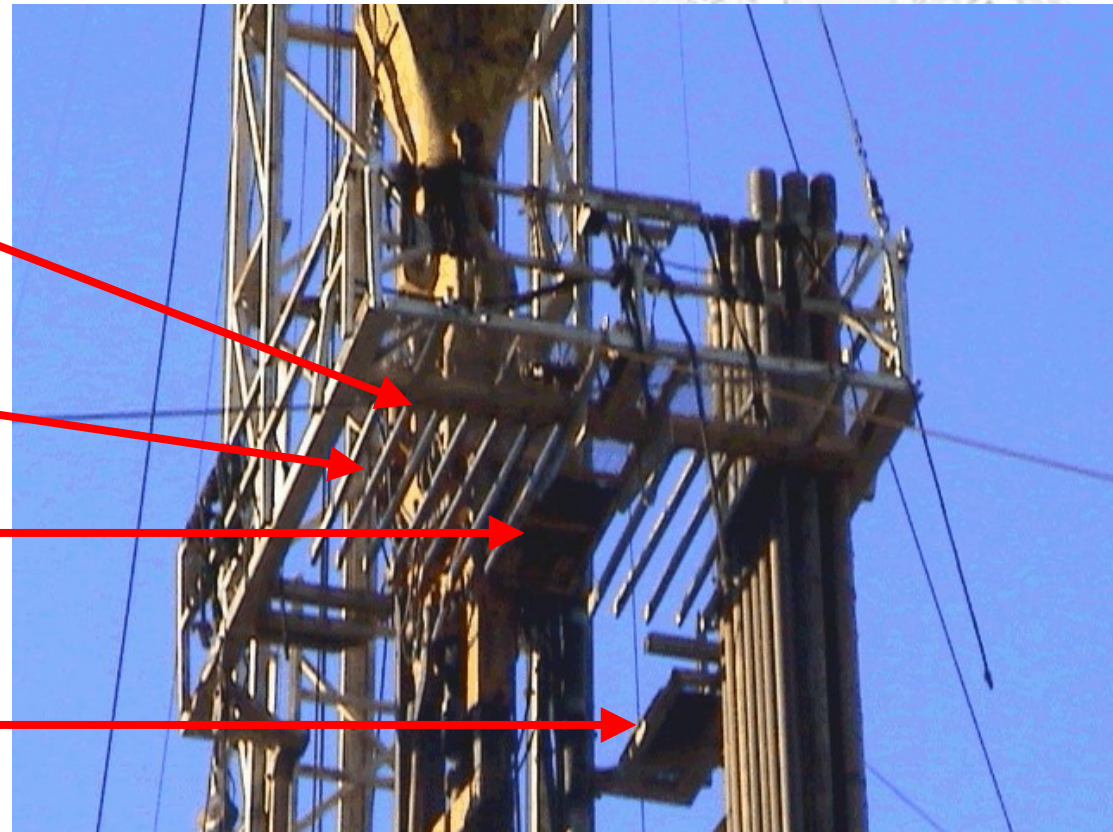
Photograph 5 – Monkeyboard set-up.

- **Top drive
(behind m-board)**

- **Pipe fingers**

- **Diving board**

- **Platform
beside ladder**






Photograph 6 – Ladder access point.

- Ladder
- Geranimo Line
- Monkeyboard Platform





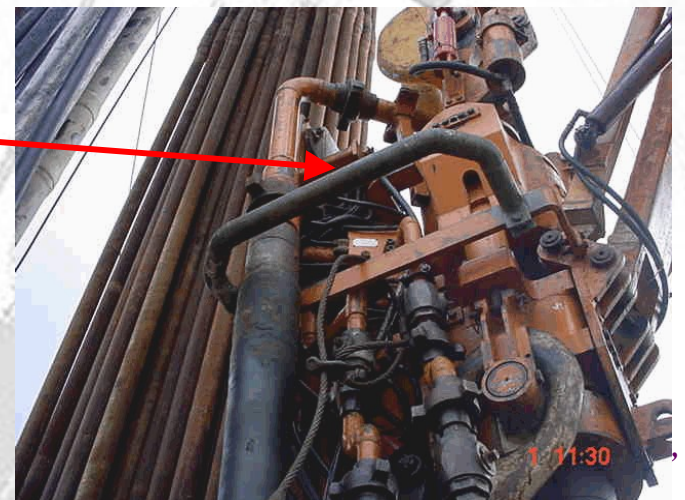
Causative factors.

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1. The inertia reel static line became snagged on the top drive.
 2. The blocks / top drive were in motion.
 3. The gooseneck hammer union protrudes from the top drive.
 4. The SOP was not specific enough.
 5. No JSA was completed.

Corrective Actions.

Engineering:

- Modify the monkey board.
- The top drive was modified to incorporate a u-shaped bracket.



Corrective Actions. (Cont)

Administrative:

1. A JSA was completed.
2. The SOP was reviewed and updated
3. The incident was discussed and disseminated across all operations.
4. A safety alert was provided to all parties.

Corrective Actions. (Cont)

Personal and Protective Equipment:

1. The inertia reel was replaced with a new unit.
2. A personal de-brief/counselling session was provided to the FM and DM.



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Moving Forward – Work at Height Initiatives - Background.

- In late 2004, working at heights management is identified as insufficient given legislative changes and the well being of our employees.
- RoofSafe were contracted to conducted audits of our Australian rigs.
- We felt that RoofSafe gave us valuable recommendations but did not sufficiently address our issues in regard to the hierarchy of controls.
- The completed audits were then reviewed by John Luck from Safety Rescue and Training.

Audit Findings and Recommendations.

The items identified as critical, in order of priority, were:

1. Climbing the Mast Ladder.
2. Accessing the Monkey Board.
3. Working on the Stabbing Board.
4. Accessing and working on the crown.
5. Working on the BOP's.
6. Escape line from the Monkey Board.
7. Horizontal static lines when the Mast/Derrick is laid over.

1. Climbing the Mast Ladder.

- Personal Protective Equipment

2. Accessing the Monkey Board.

- **Engineering**

3. Working on the Stabbing Board.

- **Engineering**



4. Accessing and Working on the Crown.

- **Engineering**



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5. Working on the BOP's.

- Design

6. Escape line from the Monkey Board.

- **Engineering**

7. Horizontal static lines when the Mast/Derrick is laid over.

- Design



Further Recommendations, Future Implementation and Improvement.

- **Elimination**





THANK YOU QUESTIONS?



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