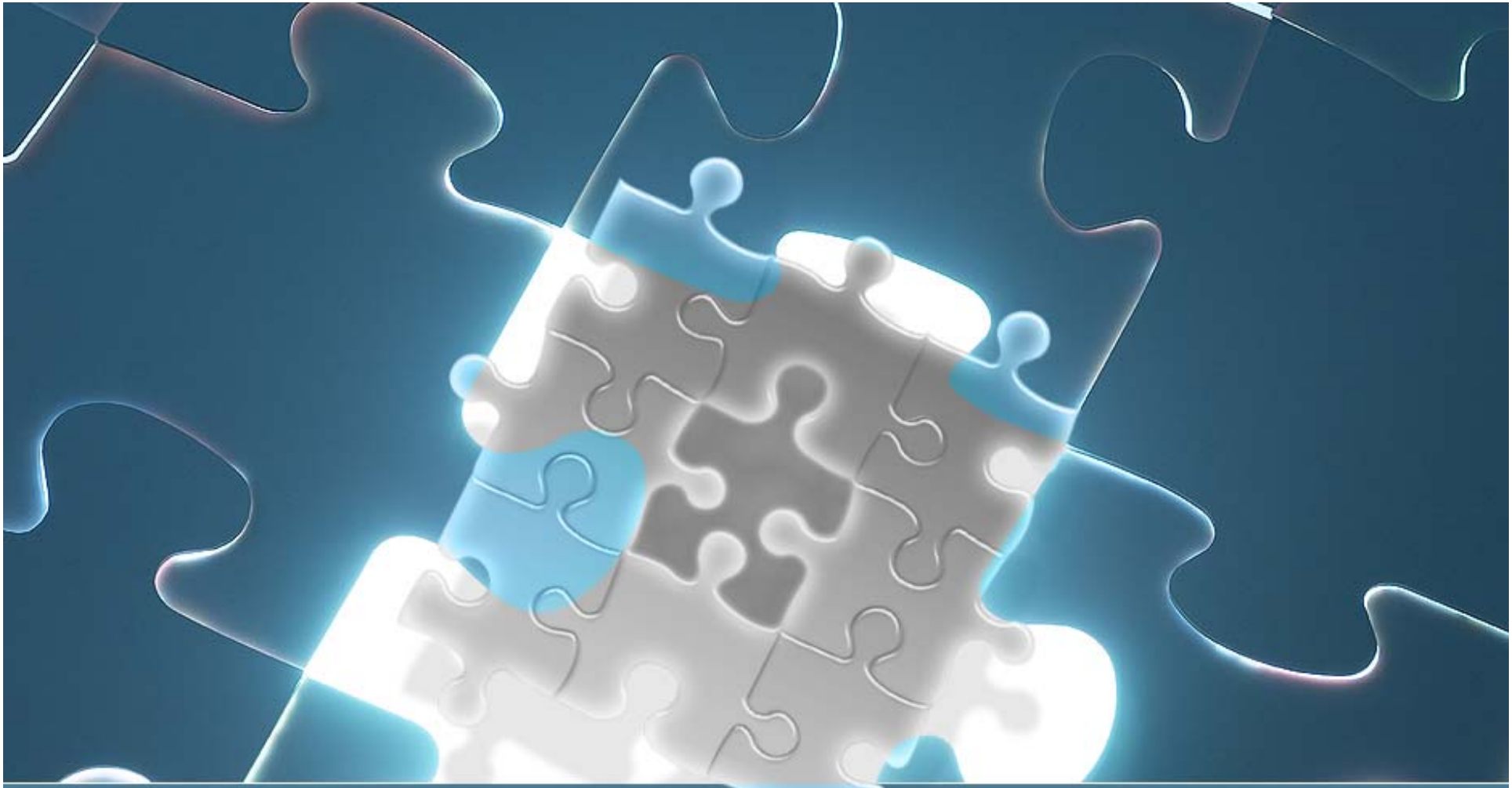

Dropped Load

Explanation of circumstances leading to improvement notice

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Events leading up to the Incident

- A 3 ½” tubing cement stinger was to be run in the hole
- The tubing chain tongs on the rig floor were found to be too small
- The 3 ½” tubing tongs were under the stbd side of the catwalk
- The Banksman and Roustabout were asked to send them to the rig floor

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Rigging the Load

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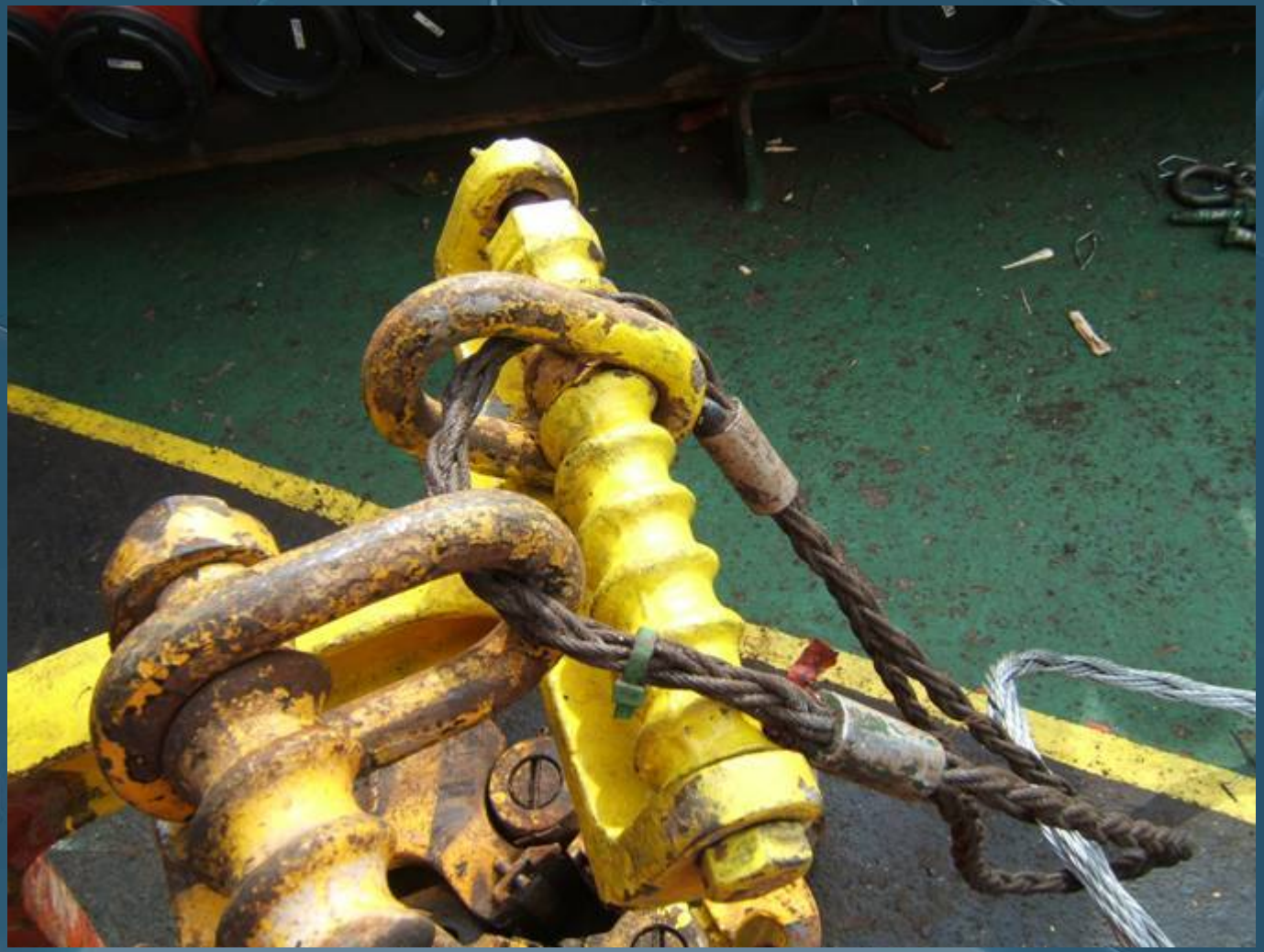
Rigging Method



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Pick up position

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Overview of Pick up Area

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Events Leading up to the Incident

- Day Toolpusher assisted with moving the tongs to the port side of the catwalk and slinging the tongs
- The Banksman then signalled the Crane Operator to commence the lift
- Banksman ascended the stairway to the catwalk to check there were no personnel on the catwalk where the lift was expected to pass

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Events Immediately Before the Incident

- The Crane Operator had a clear view of the catwalk and saw the Assistant Driller was at the forward end of the catwalk
- The normal practice is to take the load over the catwalk to avoid the natural hazard presented by the derrick
- The Crane Operator decided to continue to hoist instead of taking the lift over the catwalk to avoid personnel present on the catwalk

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Load Path

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Load Path

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Description of Incident

- During the lift, the lift started to swing and the crane operator attempted to arrest this by slewing forward towards the derrick
- When the lift reached 6m above the main deck, a section of one tong caught under the handrail on the stairway to the rig floor

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Hang up Point

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Tong Latch Jaw Which Hung up on Railing

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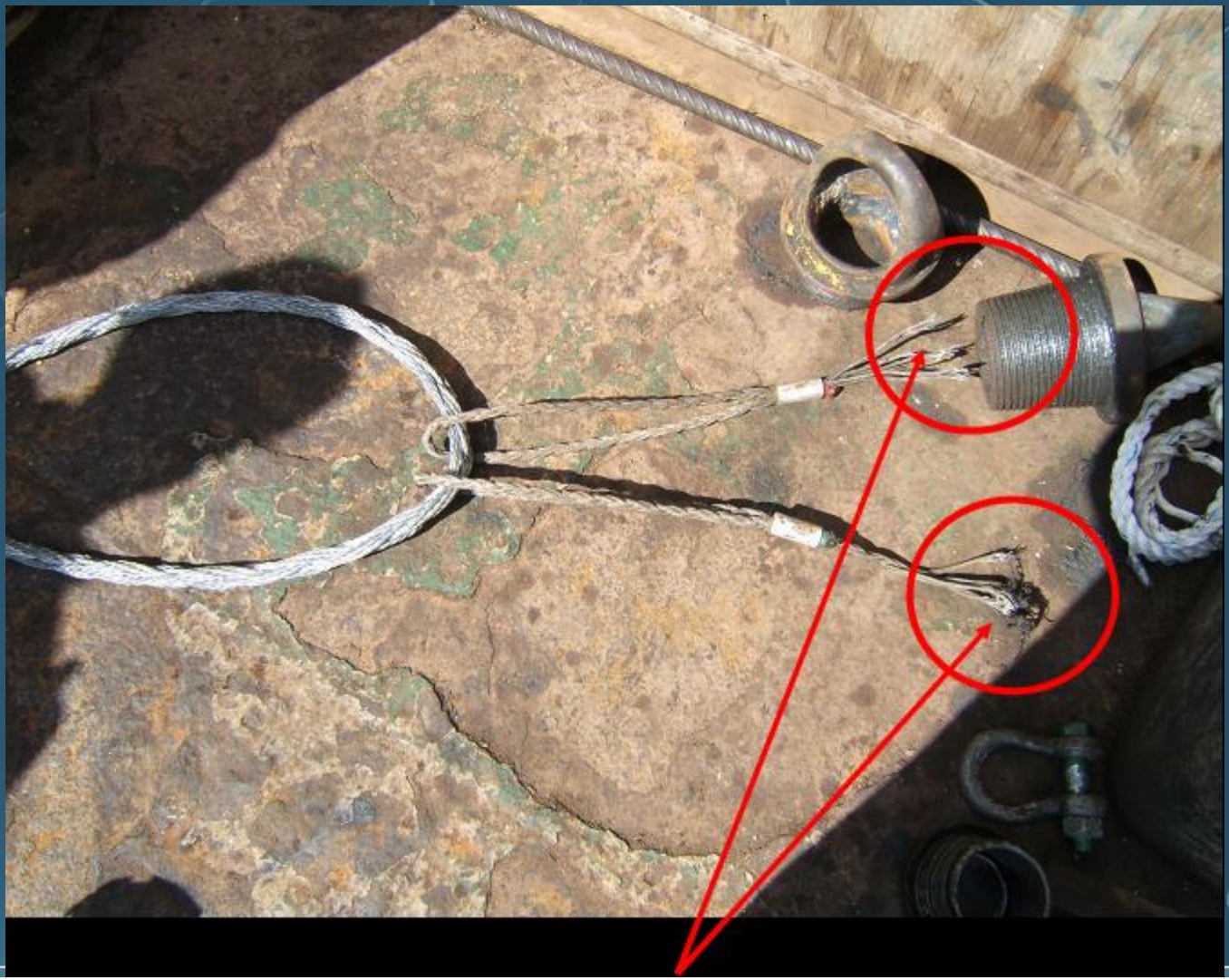
Sling After Failure



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Description of Incident

- The 0.5 t sling broke, one tong fell to the main deck forward of the stairs to the catwalk and one tong landed on the stairway 4th step below the catwalk and slid down
- The IP was ascending the stairway to the catwalk on the 3rd or 4th step and was hit on the right shoulder and left leg by the tong as it slid down the stairway

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Initial Point of Contact

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Overview of Situation

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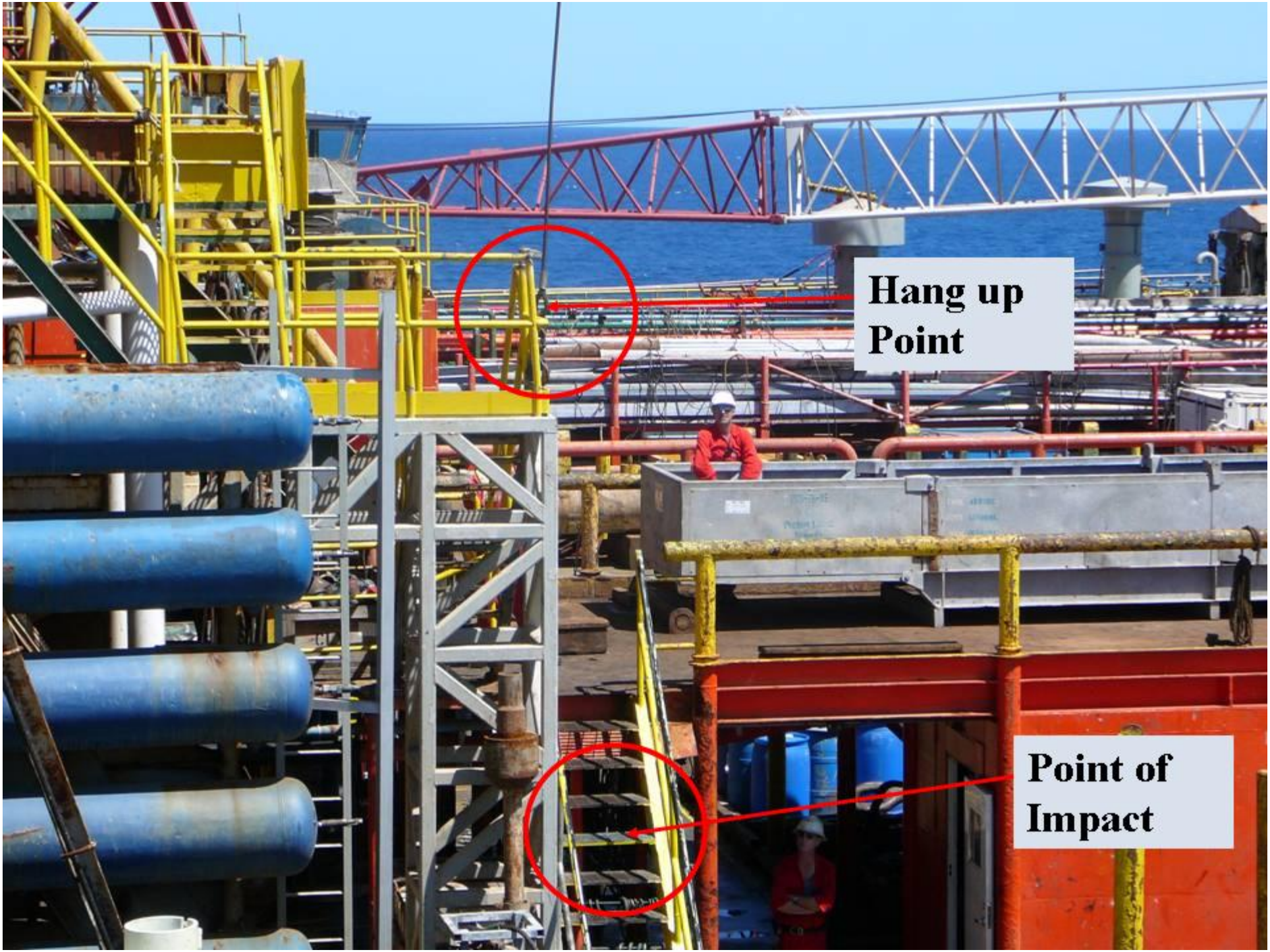
Hang up
Point
Point of
Impact

This is How Close it Was

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Person Escaped with Bruised Shoulder

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Final Resting Point of Tongs

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Background Information to the Incident

- The Stena Drilling SMS is the only prerequisite in Australia for offshore crane operators under the control of Stena
- Limited availability of crane assessors world wide
- Limited availability of experienced offshore crane operators
- All crane operators currently working on the Stena Clyde were originally Dogman on the rig
- The most experienced crane operator at the time of the incident had 2 years experience as a full time crane operator

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Root Cause

- Numerous contributing factors
- One root cause
- Crane operator's lack of experience / training.

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Learning Outcomes

- What may be considered a routine lift can go terribly wrong if those involved are distracted and / or the lift is not adequately planned.

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Corrective Actions

- Continue the assessment of crane operators by an independent 3rd Party
- Structured training of trainee crane operators
- An in-house crane assessor has attended the rig to conduct training with the crane operators and deck crew
- We have reviewed current operating procedures and recommended further improvements to ensure continuous improvement

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Corrective Actions

- Conducted further onboard training with deck crews and crane operators to ensure correct procedures are followed for rigging, handling and lifting of loads

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Corrective Actions

- Provide further onboard training to all current crane operators until they achieve competency in the following areas (in addition to routine lifting competencies):
  - Special lifting operations;
  - Assembly lifting
  - Personnel lifts
  - Tandem lifts
  - Blind lifts

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Corrective Actions

- Progress the Stena Competence Assurance program for all positions
- Monitor progress monthly for participation and completion within the allocated 2 years

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Thank You for Your Time

Any Questions?

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