
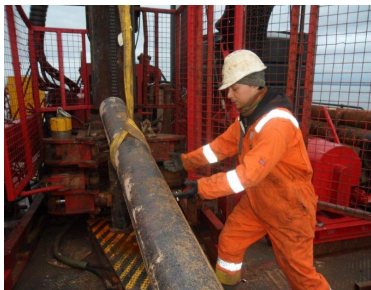





SAFETY ALERT



Fugro Company:	FGSL – Fugro GeoServices Ltd												
Location/Site:	Site Investigation, Morecambe Bay, UK.												
Date and Time:	13 April 2016 – 22.15hrs												
Consequences:	Personal Injury - Severed left thumb above first knuckle												
Incident Potential:	High <input checked="" type="checkbox"/> Medium <input type="checkbox"/> Low <input type="checkbox"/>												
Golden Rule(s) Breached:	<table border="1" style="width: 100%; text-align: center; font-size: small;"> <tr> <td>Confined Spaces</td> <td>Driving</td> <td>Equipment Isolation</td> <td>Fitness for Work</td> <td>Ground Disturbance</td> <td>Hazardous Substances</td> </tr> <tr> <td style="background-color: red; color: white;">Lifting Operations</td> <td>Load / Unload Vehicles</td> <td>Personnel Transfer</td> <td>Simultaneous Operations</td> <td>Working at Height</td> <td style="background-color: red; color: white;">Working with Equipment</td> </tr> </table>	Confined Spaces	Driving	Equipment Isolation	Fitness for Work	Ground Disturbance	Hazardous Substances	Lifting Operations	Load / Unload Vehicles	Personnel Transfer	Simultaneous Operations	Working at Height	Working with Equipment
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Lifting Operations	Load / Unload Vehicles	Personnel Transfer	Simultaneous Operations	Working at Height	Working with Equipment								
Incident Description:	<p>During nearshore geotechnical drilling operation onboard a jack-up barge, a length of 7” casing had to be lifted from a stack of casing on the deck into the moonpool / borehole</p> <p>Due to operational constraints, a three tonne endless lifting sling was placed around the casing in a “choked” configuration. The sling was positioned approximately 0.8 - 0.9 metres up from the female (internal thread) end of the casing and attached to the derrick heavy lift winch.</p> <p>A combination of the casing being contaminated with wet clay, the angle of the lift / casing and the sling failing to properly tighten on the casing resulted in the sling slipping off thus allowing the casing to fall down onto the stacked casing below.</p> <p>The Injured Persons (IP) immediate instinctive reaction was to attempt to grab the casing as it dropped, resulting in a serious personal injury.</p>												
Injuries / Medical Treatment Required:	<p>The casing acted as a guillotine as it fell onto the stacked casing severing the top section of the IP’s left thumb.</p> <p>The IP was taken from the jack-up barge by the Coast Guard before being transported by road to the hospital. The IP underwent corrective surgery before being discharged.</p>												
Photographs:	<div style="display: flex; justify-content: space-around;"> <div style="text-align: center;">  <p>Endless sling –“Choked & Pinch Point</p> </div> <div style="text-align: center;">  <p>Simulated actions of IP</p> </div> <div style="text-align: center;">  <p>Clay material on underside of 7” casing</p> </div> </div>												

<p>Findings:</p>	<ul style="list-style-type: none"> ➤ The casing had not been sufficiently cleaned and borehole material (clay) removed after being tripped out from the borehole. ➤ The sling had been placed around the casing whilst it was laid on top of other lengths of casing which were pyramid stacked on deck. This resulted in the sling becoming pinched and not "choking" around the casing fully as the weight was taken by the heavy lift winch. ➤ The combination of the increasing lift angle, contaminated slippery casing and the sling not being properly choked caused the casing to fall from the strop. ➤ The instinctive action of the IP to attempt to grab hold of the falling length of casing is a significant factor that resulted in a personal injury being sustained. ➤ The task risk assessment and method statement failed to identify the potential risks and controls for tubular lifting operations, especially in the use of endless slings to "choke" lengths of casing.
<p>Lessons Learnt:</p>	<p>The activity was undertaken without fully assessing the risks associated with the task, the communication of those risks and the implementation of a safe system of work (i.e. clean casing and the strop properly choked).</p> <p>Irrespective of the inadequate assessment of risk or lack of documentation, essentially this was a routine lifting operation with several missed opportunities to prevent the incident.</p>
<p>Recommendations and Corrective Actions:</p>	<ul style="list-style-type: none"> ➤ Review and update the drilling operations risk assessment and procedures to capture tubular lifting operations, including non routine activities. ➤ Following changes or encountering abnormal conditions within an operational activity, a "Time Out" should be taken and the situation assessed to identify and communicate any new risks (Principles of S.L.A.M – Stop, Look, Assess & Manage) ➤ All drill pipe and casing are to be stowed at all times within stillages and racks whilst on the drill deck. Prior to applying an endless sling the casing must be clean and free from contamination (e.g. drilling mud, clay, grease, oil etc) ➤ When the use of an endless sling is required to lift a length of drill casing, it <u>must</u> to be applied in a "Double Choke" configuration. ➤ The development of a Technical Briefing Note to clearly outline the methodology of lifting casing / tubular with a lifting sling. ➤ Safety stand-down to deliver site based operational training and technical guidance on the methodology to be used when lifting casing with an endless sling (soft strop).
<p>Alert Issued by: FGSL HSSEQ Department</p>	<p>Safety Alert Reference No: FGSL-02-16</p>