Fall/Fatality during P&A/Platform Abandonment:
Supervision, Operational, Equipment, and Organization Errors

An offshore roustabout was fatally injured while assisting P&A’ing wells and decommissioning a production platform. The P&A operation was being conducted on the main deck of the platform, using a power swivel skid, casing jack, and crane, in conjunction with other equipment.

The accident occurred at night while the power swivel was being moved from atop the well with the roustabout acting as a rigger helping control the load. When the power swivel was lifted, the roustabout stepped, or was dragged by the load into the well-access opening in the deck that was exposed by the movement of the power swivel, and fell to his death. Night medevac callout was delayed due to confusion in emergency planning.
An investigation by BSEE personnel concluded the following factors contributed to the accident:

- The supervisor and company man on site did not have an emergency plan with medevac procedure and contact information readily available.

- The pre-shift JSA meeting did not address the hole in the main deck beneath the power swivel. The JSA meeting was not attended by all parties including the roustabout, and no signed, unique JSA form was created.

- The pre-lift “tool-box” meeting did not discuss the existence of the hole beneath the power swivel, and no fall protection was provided as required by company policies, BSEE, and USGC.

- The power swivel skid was equipped with two “tag lines” that were only three-feet long thus requiring the riggers to be in close proximity to the load. The tag lines were attached to the power swivel in such a way that they would drag across the open hole as the skid was moved;

- Other P&A equipment on the platform was positioned poorly and interfered with the crane operation.
  - A rudimentary, inherently dangerous, “pipe rack area” allowed the box ends of 15 joints of work string to protrude over the skid, requiring riggers to manually maneuver the load to keep from hitting the pipe.
  - The temporarily stored casing jack interfered in the crane operator’s vision of the lift.
  - The lighting may have been inadequate for a night operation.

- Management and on-site supervision failed to address safety hazards and equipment deficiencies in planning, and made operational errors that contributed to the cause of the accident.

- There was no clearly designated, direct supervision of the lift because of multiple responsibilities assigned to the only supervisor on duty.

BSEE recommends the following to operators conducting plug and abandonment and platform decommissioning operations.

- Medical evacuation procedures and contact should be prominently displayed and all crew members acquainted with that information and the procedures.

- P&A/platform decommissioning operations should have a comprehensive safety evaluation for the organization of multiple simultaneous tasks.

- A fully attended and comprehensive JSA that covers all the risks should be a requirement.

- Fall protection should be available and used in the presence of open holes, or if holes may be exposed in the course of an operation.
A lift should be evaluated for all risks, and the appropriate tag lines, and use of tag lines, should be reviewed.

Management and supervisors should insure the work space organization, availability of necessary equipment, proper positioning of equipment, and the conduct of operations, be fully and constantly reviewed for safety hazards before and during operations.

Management should assign enough supervisors to P&A/platform decommissioning operations to allow direct, oversight of operations.

A full report of the accident can be reviewed on the BSEE site. To access the site, click on link as follows:


A Safety Alert is a tool used by BSEE to inform the offshore oil and gas industry of the circumstances surrounding an accident or a near miss. It also contains recommendations that should help prevent the recurrence of such an incident on the Outer Continental Shelf.

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