UPSTREAM MALAYSIA LESSON LEARNT

Ref: MPM/ LL/ 20/ XX/ 0XX

Lost Workday Case: Foot Injury

Date : 22nd May 2022

Location: Onboard Rig Borr Gunnlod, SE-PA (Sarawak)

Incident Description :

Upon landing of a bundle of drill collar pipe at starboard cantilever deck, a roustabout (Injured Person, IP) was attempting to remove the tag line. The bundle inadvertently became loose causing a joint of drill collar rolled towards IP and landed on IP's safety boot of his left foot resulting in a deep wound laceration on the pinky toe. IP received first aid treatment by rig medic and later MEDEVAC to shore (Bintulu). The X-ray result showed comminuted fracture of IP left foot's pinky toe.

Immediate Action Taken:

- Banksman stopped the job. Time off for safety (TOFS) was called with everyone involved in the task.
- IP went to sick bay accompanied by the deck supervisor (Banksman).
- Standdown meeting held on 2345hrs for both shifts.
- IP received first aid treatment by rig medic and later MEDEVAC to shore (Bintulu). He arrives in Columbia Hospital around 0430hrs 23rd May 2022.

Active Failures/ Direct Causes :

- IP positioning his foot in the line of fire
- The tubular had moved within the bundle.

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Root Cause:

1. Procedures and Safe Working Practices

Load tension was not confirmed as it was not identified in the job steps/measures in Work Instruction

2. Human Factor

Crew had limited floater experience

Lack of situational awareness

- IP position his foot in line of fire as he was not recognizing the potential risk of the tubular could roll over
- No intervention due to Banksman failed to position himself to see all personnel involved in the task

Lesson Learnt :

1. Enhancing hazard identification in Job Safety Analysis (JSA) / Work Instruction (WI).
   - The JSA/ WI to be reviewed to assess the adequacy of hazards identified.
   - Always ask 'What Could Go Wrong' during the preparation and review of the JSA/WI. This to minimize the potential of 'complacency' and exploring all possible hazards and control measures for the job.

2. Continuous awareness for the improvement of situational awareness.
   - Reminder on the line of fire, complacency hunting and time off for safety

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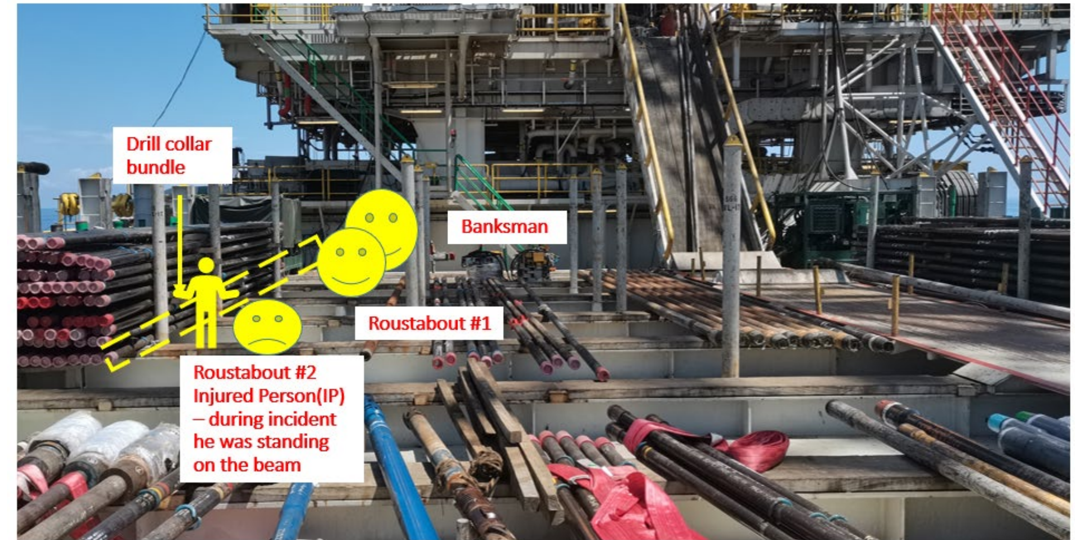
Pictures:



Enactment of IP position and the team during the incident

Triggering Questions :

1. LEARNING FROM THIS INCIDENT
   a) What do we learn from this incident?
   b) Have we had similar incidents at our activities?
   c) What can we do immediately after this incident?
   d) Have we plan any emergency response effectively?

2. OTHER QUESTIONS WE MAY TRIGGER IN THE DISCUSSION/ CONVERSATION DURING SHARING OF THE LESSON LEARNT
   a) Have we really learnt from our mistakes?
   b) Did we address the right root cause and mitigations?
   c) What have we done wrong/ missed that allowed the failures to occur?
   d) What would we do better? What could we do differently?

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