INITIAL INCIDENT ANNOUNCEMENT

URGENT

Business Unit: Project/Operation Name: Team: **SURF** Incident Report No: **48** Incident classification**: DAFWC**	Contact:
Country**: ANGOLA**	Location of incident: **Sonamet yard 1, Spools fabrication area.**
Date of incident**: Monday 2nd July 2007**	Time of incident: **08.00**

Brief account of incident

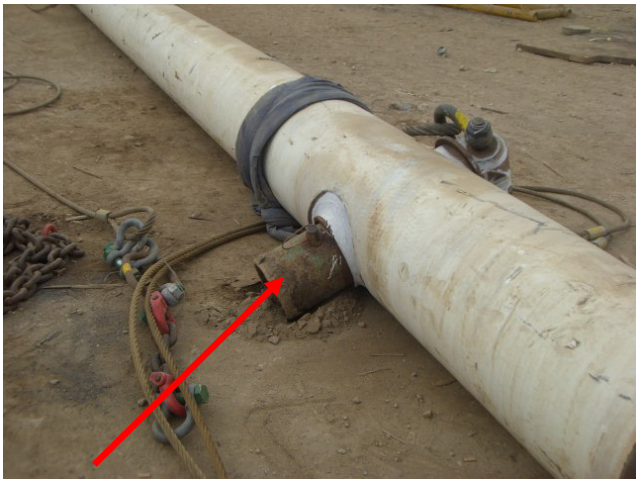
A Spreader bar had been brought into the area for temporary storage; the Spreader bar was 25 m long, 480mm diameter and weighed 6.5 tonnes. A five man rigging crew had the task of de-rigging Spreader bar from the crane hook.

The crane driver lowered the spreader bar to the ground, on this occasion the Spreader bar remained standing on the 240mm lift pins which acted as legs. Normally the Spreader bar would have been rested on its side. The Rigger approached the free standing Spreader bar and proceeded to unhook the rigging from the crane hook. Without warning the Spreader bar fell towards the Rigger trapping his left foot on impact to the ground.

The spreader beam had been used on Saturday to lift a large piping spool for the xxx project and was being de-rigged on the next regular work day being Monday.

The Rigger sustained serious injuries to his left foot. Later the same day he underwent surgery to amputate his foot at the ankle as his injuries were so severe it could not be saved.

Spreader beam after fall



240mm lift pins

Point where spreader beam crushed persons foot

Potential Outcome: **B3 – Permanent injury to single person on site**

Actual Outcome: **B3 – Permanent injury to single person on site**

Accountability **Boundary: Track and Influence**

Likely Cause:

Failure to lay down load (Spreader Bar) in a stable and safe manor.

Failure to identify unstable load as a hazard before placing body near load.

Failure to instruct and supervise Rigger of correct method of handling and adequate securing of load.

Spreader Beams

Position of Rigger
(re-enactment with beam after fall

Boot from injured person

Actions Taken:

Work was immediately suspended.

Injured Rigger was taken to the Sonamet Clinic for assessment and first aid, then taken for X rays and then transferred to clinic in Benguela for surgery. Additional support from xxx eg Medevac was offered to Sonamet but declined as they have their own medevac arrangements should this have been required.

The Spreader bar was placed in quarantine until investigation completed.

A safety stand down was conducted at 13.00 with all Sonamet Riggers in attendance. The incident details were shared with the Sonamet Riggers and the correct process of the incident activity was explained. Safety stand-down held at the 3 xxx work areas the next morning and information shared with other operators on site.

Sonamet commenced investigation immediately. Acergy mobilising investigation team which will be supported by independent xxxxx HSE advisor.

Sonamet / Acergy engineers reviewing design and lifting arrangements for spreader beam

Sonamet have contacted North Sea Lifting (NSL) to provide additional Rigging and Lifting support and training.
[NSL have been engaged by BP on 3 previous occasions to provide rigging and lifting training with the last visit culminating in a test and competency check.]

Incident shared with Petromar at Lobito who are fabricating well to manifold jumpers. Incident to be shared with Acergy for the offshore lifting operations. They will be using spreader beams for lifting these spools and jumpers.

Person in charge: Name: **Nicolas Poirier** Company: **Sonamet**