Safety Alert

From the International Association of Drilling Contractors

ALERT 99-25

ELEVATOR FATALITY

WHAT HAPPENED:

A dry-dock shipyard incident resulted in a fatality when a shipyard elevator operator fell from the elevator just below its top stop station. The incident was not witnessed but an investigation showed that the limit switch on the elevator's cab door was not functioning and the elevator could have moved with this door open. When the top stop station's outer doors were closed; the elevator appeared to have moved with the inner door still open.

WHAT CAUSED IT:

A short was detected in the elevator's control cable that was the source of the limit switch malfunction. The short was found in a field splice in the cable. While the accidental movement of the elevator could have resulted from further shorts or from activation of one of the external call buttons, the investigation could not confirm whether this occurred.

Although the elevator operator's standard procedure was to set the emergency stop button at each station, the button was found in the active position after the incident – it apparently had not been set.

CORRECTIVE ACTIONS:

The shipyard contractor was required to put in place a number of new procedures and safeguards, including the following:

1. Elevators with automatic latching mechanisms that prohibit the elevators from opening unless the elevator is at one of the stop stations. Splicing of the control cable will be prohibited and the shipyard will maintain a spare on site.
2. A sign will be posted in the elevator cab near the emergency stop button explaining the procedure for setting the button at each stop. This procedure will be included in elevator operator training and in safety meetings.
3. Call buttons will be deactivated or signs will be posted at each station call button restricting their use to emergencies only.
4. A daily safety/maintenance checklist will be completed before operating the unit. The checklist will be verified and signed by the operator's supervisor and posted in the elevator cab.

The Corrective Actions stated in this alert are one company's attempts to address the incident, and do not necessarily reflect the position of IADC or the IADC HSE Committee.

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