



Safety Alert

From the International Association of Drilling Contractors

ALERT 06-14

CAUGHT BETWEEN – SPOOLING CABLE RESULTS IN AN INJURY

WHAT HAPPENED:

A crew was working dock side involved in a non-routine task of spooling off a multiplex control cable (MUX) from a rental reel directly onto a steel storage reel. The task was being conducted by manually turning the storage reel. As the task progressed, the reel became too heavy to manually turn. The job was stopped and an alternative mechanical method was devised by wrapping soft-line around the reel and pulling upwards with the rig crane, thus turning the reel. The crew commenced the rigging up of the soft-line and then normal operations were suspended to allow for a client safety seminar. The next day another crew continued with the task, however they did not use the soft-line and rig crane method as it had become too windy to use the crane. The decision was made to resume the spooling task by turning the reel by hand. The crew members were stationed on either side of the spool and between pulling down on the front and pushing up at the back they proceeded to rotate the reel to spool the cable. The injured employee was stationed at the right front of the spool and was pulling down by gripping the ribbed sections on the edge of the reel. As the reel turned, the IP's right elbow lodged against the frame of the reel and his arm became trapped between the ribbed section of the reel and the angle of the frame. This incident resulted in a compound fracture to the right forearm.



Position of crewmen when incident occurred.



Use of rig crane and soft-line arrangement with Personnel kept at a safe distance.

WHAT CAUSED IT:

A generic Job Risk Assessment (JRA) did not exist prior to the commencement of this job and as a result the initial crew prepared a hand written JRA. The investigation concluded that the generic JRA failed to identify all known hazards associated with the task and that if the Likelihood / Severity analysis had been properly conducted, the resultant Risk Rating would have fallen into the unacceptable range for carrying out the task. The following crew assigned to the job the next day did not have any JRA and proceeded with only a basic tool box meeting that did not adequately address the appropriate level of risk. The initial start, suspension and continuation of this job combined with the changing weather conditions, did not result in a proper or effective management of change (MOC).

UNDERLYING CAUSES:

- High Risk Tolerance
- Inadequate Risk Assessment
- Lack of Communication

ROOT CAUSE:

- Poor Supervision

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.

This material is presented for information purposes only. Managers & Supervisors should evaluate this information to determine if it can be applied to their own situations and practices

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CORRECTIVE ACTIONS: To address the incident, this company did the following:

- Instructed personnel to develop a Job Risk Assessment for this type of operation.
- Reviewed Risk Rating process with personnel involved.
- Reviewed Management of Change procedures.

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