



Safety Alert

From the International Association of Drilling Contractors

ALERT 05 – 02

DROPPED OBJECT - EMPLOYEE STRUCK BY SLING

WHAT HAPPENED:

A serious incident occurred on a Jackup Drilling rig when an employee was struck in the head by the eye of a ¾" stainless steel sling, resulting in a skull fracture and multiple sutures to the face and hand. The crew was in the process of picking-up and laying-down the #3 Deep Well Pump. A nylon sling was secured to the 6" deep well hose, and the hose was lifted 50 ft through the opening on the main deck. The power supply cable and the safety cable for the deep well pump were tied to the deep well hose with a ½" manila rope. As the hose was lifted the rope parted. As the cables fell through the hole on the main deck the eye on the end of the safety cable struck the employee on the forehead rendering him unconscious.

WHAT CAUSED IT:

Several company safety management systems such as JSA, PTW, and Safe Work Practices were not properly followed. These systems were being used as a "check the box," instead of an important tool so that hazards are discussed, identified and managed. The crew had reviewed a JSA, but the JSA was for the #1& #2 deep wells, which are located over the side of the rig. The #3 deep well poses different hazards because of its location, and those hazards were not recognized or managed. The JSA used did identify several safety critical steps such as "inspect rigging and equipment," but these safety steps were ignored. Inadequate inspection of the rigging used to lift the pump and secure the auxiliary cables. The nylon sling used to lift the hose was not fit for purpose and showed severe wear and damage. A permit was also issued, but an Area Supervisor was not assigned to oversee the operation, or to ensure that company Safe Work practices were adhered to. Although a JSA and PTW were completed, the principal safety systems, which are in place to prevent this type of incident from occurring, were not enforced. Rig personnel were not following the PTW and JSA procedure in the company's procedures manual. When the deep well tower was removed 8 years earlier, rig personnel did not attach permanent brackets and fasteners to secure the power supply cable and safety cable to the 6" hose. Instead, rope was used to hold these cables to the deep well hose. Inadequate Risk Assessment - rope was used in place of brackets and fasteners, and unfortunately this was an acceptable practice with rig personnel. Reference the company manual on rigging (Rigging Module, Fiber Rope, and for proper application of fiber rope).

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

Action Items (Rig)

The **Safety Committee** for each rig will review all JSAs and identify specialty lifts (installation of boat ropes, take-on hoses, deepwell installation, etc.). After identification, each JSA must be reviewed by the Safety Committee to ensure that the rigging utilized in these operations is specified in the JSA and is fit for purpose for the intended job. **Due Date: 30-Jan-2005**

Action Items (Management)

There have been several incidents recently where rope failed while supporting weight. The **Operations** and **HSE Departments** are currently revising the procedures manual section on Rigging Module, Fiber Rope so the allowable applications for fiber rope are clearly defined. **Due Date: 15-Jan-2005**

Operations and **HSE Departments** will develop a company approved rigging and support system for running submersible pumps over the side. **Due Date: 15-Jan-2005**

This incident is still under investigation, further information may follow.

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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Issued January 2005



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