



Safety Alert

From the International Association of Drilling Contractors

ALERT 06 – 28

SLING PARTED AND DROPPED DRILL PIPE

WHAT HAPPENED:

An employee was struck in the head by 5" drill pipe when the lifting sling parted. This resulted in sutures to the forehead and a severe sprain to the ankle. The crew was picking up and racking back 5" drill pipe. The roustabout crew positioned six joints of 5" drill pipe on 4" x 4" boards onto the catwalk. The roustabout crew attached the lifting caps into the six joint of pipe and the Deck Coordinator signaled the drill floor flagger to hoist the six joints of drill pipe. As the drill pipe was being hoisted up the V-door, the pin end of a single joint of drill pipe rolled off the catwalk and became wedged between the pipe rack stanchion and catwalk. The Deck Coordinator signaled the rig floor to STOP; which they did. The remaining (5) joints of pipe slid forward towards the V-door, which placed excessive tension on the sling that was secured to the wedged joint of pipe. This added tension parted the sling. The injured roustabout was positioning himself at the bottom of the V-Door to insert the pipe stop. The joint of drill pipe fell down the side of the V-Door and struck the employee in the head. This incident resulted in a Restricted Day Case, but the potential for greater injury was high.

WHAT CAUSED IT:

1. On occasion the drill pipe would roll off the catwalk and become lodged between the stanchion and the catwalk. The rig crewmen had identified the hazard, but failed to correct it, or identify/control the hazard in the JSA.
2. The air hoist operator was unable to see the drill pipe (load) as it was being raised up the V-door. This was due to the location of the air hoist chosen on the rig floor for this operation.
3. The injured employee had his back to the load as it was being raised, conducting normal duties. He felt the area next to the V-door was a safe zone.

CORRECTIVE ACTIONS: To address this incident, this company instructed rig personnel:

- Review picking up tubular procedures and JSAs on your rig. Hazards should be identified and first engineered out. If the hazard can not be removed, then the JSAs must be updated to include the hazard and list mitigating actions.
- Revise JSA to define safe zone, and include as a safety warning not to turn your back to the load until the load is secured or completely out of harms way.
- At the next safety meeting, educate the crews on eliminating hazards instead of working around them or accepting a hazard as "part of the job".
- Review air hoist operator position for picking up tubulars to ensure a direct line of sight from operator to load. This may require:
 1. Enlarging windows in wind wall
 2. Relocating the air hoist
 3. Adding a remote control station
 4. or a combination of the above

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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