Safety Alert

From the International Association of Drilling Contractors

ALERT 06 – 37

SLIPS KNOCKED OVER RESULTING IN LTI FOOT INJURY

WHAT HAPPENED:

Well testing had been completed and the operation at the time was pulling 4½ inch production tubing out of the hole in single joints. The rig had been pulling tubing for over 12 hours (6 hours on Injured Person's (IP) tour and 6 on the previous tour). A cable from the Spider / Single joint elevators snagged the slip handles causing them to fall over striking the injured person on the upper foot, behind the steel toe cap of his boot. A fracture was found on the upper part of his right foot, resulting in an LTI.

WHAT CAUSED IT:

The tubing had square-shouldered tool joints which occasionally snagged the automated slips and lifted them out of the table, so it was decided to use manual slips.

Figure 1

Figure 2

The IP's tasks were to set and remove slips, and ensure the elevator cable was clear of the pipe when pulling to the next tool joint. **Fig. 1** above shows how the elevator cable can easily snag the slip handles. This possibility should have been identified with risk mitigated by relocating the cable to ensure it did not interfere with the slip handles. **Fig 2** indicates the IP's position with his back to the rotary table and preoccupied with the elevator cable. The IP was not aware of impending hazard.

Six hours of repetitive work contributed to diminished crew safety awareness without supervisors calling a step-back to review procedures and associated risks.

Although a tool box talk had been conducted, there was no formal risk assessment as prescribed by JSA and PTW.

JSA risk considerations include:

- Snagging hazard from cables; not only on slips.
- Cables also presented trip hazard.
- Slips freestanding around a busy work space (rotary table) in this operation are vulnerable.
- Complacency due to repetitive tasks call for extra effort to be on alert to hazards and tendency to take risks.

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

Focus on Behavioral Modification by use of PTW, JSA, and Basic Safety Tools. JSA, reviewed at pre-job meetings should be modified as necessary in the event of change, and reviewed by relieving crews. All personnel should be fluent in the language and process of risk assessment.

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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Supervisors need to regularly offer input to their crews and draw them into the task process or job. This is often needed to draw attention to complacency and tendency to overlook hazards and take risks. Effective Supervision does not happen by merely maintaining a presence. Supervisors should constantly ensure that their personnel and areas are safe by monitoring closely, offering support, and intervening when necessary. It is not enough just to criticize when something looks or goes wrong but solutions must be offered and corrective measures taken.

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