



Safety Alert

From the International Association of Drilling Contractors

ALERT 07 – 30

FATAL INCIDENT OCCURS WHILE DEMONSTRATING A FAULT IN CONTROL SYSTEM

WHAT HAPPENED:

The Assistant Driller (AD) onboard a jack up rig was fatally injured while performing a function test of the Casing Stabbing Board (CSB) from within the unit. The demonstration was intended to illustrate to the Toolpusher, who was present, a hand controller (ascent/decent) fault related to an apparent 'sticking valve'. When the ascent/decent control lever was activated the CSB ascended; the Assistant Driller moved the lever through its range of positions but was unable to reverse or stop the movement of the unit.

The AD attempted to exit the unit onto the fixed derrick walkway by grasping the entry bar and swinging himself feet first beneath the bar towards the walkway.

The AD failed to exit the unit fully when he collided with the Toolpusher who was standing on the walkway. As the CSB continued to ascend the AD's upper body became trapped between a cross beam of the CSB running rails and the floor of the CSB. This trapped position and subsequent force applied to the upper chest region resulted in death at the scene.

WHAT CAUSED IT:

- Inadequate Management of Procurement. This allowed the purchasing of critical equipment from non approved vendors.
- Failure to implement and manage the CSB installation project, while in the shipyard, through the use of a structured and systematic Project Management System. This resulted in inadequate training, support material and commissioning.
- Inadequate Maintenance System and overall management of maintenance. This resulted in a failure to capture the equipment on the PMS system.

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

- Maintenance system structure and management process reviewed. This review included an encompassing analysis of appropriateness of current system. An asset register and compliance with Management of Change (MOC) procedures (including training needs and documentation) were implemented.
- Undertook immediate analysis of current PMS system and cross-referenced with all inventoried onboard equipment to ensure full inclusion.
- Undertook review and roll out of operating procedures to ensure all are complete and detailed instructional documents.
- Established preventative maintenance schedules that test limit switches and control mechanisms.
- Removed and replaced the existing CSB control assembly with an approved type.
- Passed on learning to other users of identical equipment.

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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