



Safety Alert

From the International Association of Drilling Contractors



ALERT 07 – 35

PERSONNEL HOISTING INCIDENT RESULTS IN A FATALITY

WHAT HAPPENED:

The Senior Toolpusher (STP) instructed the Driller to prepare the wire line for the next survey. The Driller delegated the task to the Assistant Driller who in turn assigned a Floorman to don the man-riding belt and be hoisted to near the Monkey Board, then go outside the mast on the drawworks side, and be lowered back down to floor to pick up the wire line. The wire line was attached to the riding belt and he was being hoisted again, towards the monkey board where he was to install the wire in its sheaves (30 meter height) (99 feet). As the individual was being hoisted, the buckle/strap of the riding belt caught a mast beam and the riding belt was pulled against two opposing forces and was sheared. The Floorman fell from a height of 15 meters, (50 feet) struck against the drawworks and landed on the rig floor where he died instantly.

WHAT CAUSED IT:

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| Defective/Incorrect PPE: The riding belt used was defective. The D rings were hanging by the fabric, and not the metal socket inside. |  | Correct PPE: The riding belt did not meet the company's man-riding requirements, as only a full body man-riding safety harness is to be used. The requirement was issued three years earlier and communicated to the rigs, but it was not followed on this rig. |  |
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- Job was poorly planned; poor personnel assignment, noncompliance with Safety Management System (work permit, Safe Job Assessment and pre-man-riding check list).
- Job hazards were not identified and not communicated to the crew. Selection of crew member to perform the job was random. The Driller advised he did not work with that crew before and did not know whom to select for the job.
- The Driller acknowledged that operation should have been stopped to perform man-riding but he did not think he was authorized to do so, unless told by the STP.
- STP considered the job to be routine and in his own judgment, it was not required to stop the work to perform man-riding. Although he knew that procedure dictated that all operations to be stopped when performing man-riding.
- General safety culture on the rig suggested lack of safety awareness and no empowerment to stop the work.

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

- Rig Supervisors were instructed to remove all non standard man-riding belts from all rigs and replace with proper man-riding full body safety harnesses immediately.
- Man-riding awareness sessions are to be conducted at the company's Training Centre and include all company STP's.
- Warehouse Supervisors are to audit company warehouses to ensure that only approved full body safety harnesses are being used/distributed. All other non-standard/non-approved equipment to be removed (use/distribution).
- Personnel are to practice "Beyond Safety" techniques, where personal safety is a core value and should STOP the job if in doubt.
- Incident to be discussed in all safety meetings and all forthcoming "Beyond Safety" sessions (Safety Culture) with company personnel.

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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- Rigs will be required to dedicate a safety stand down to discuss this incident and confirm the discussion to company office.

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