Safety Alert

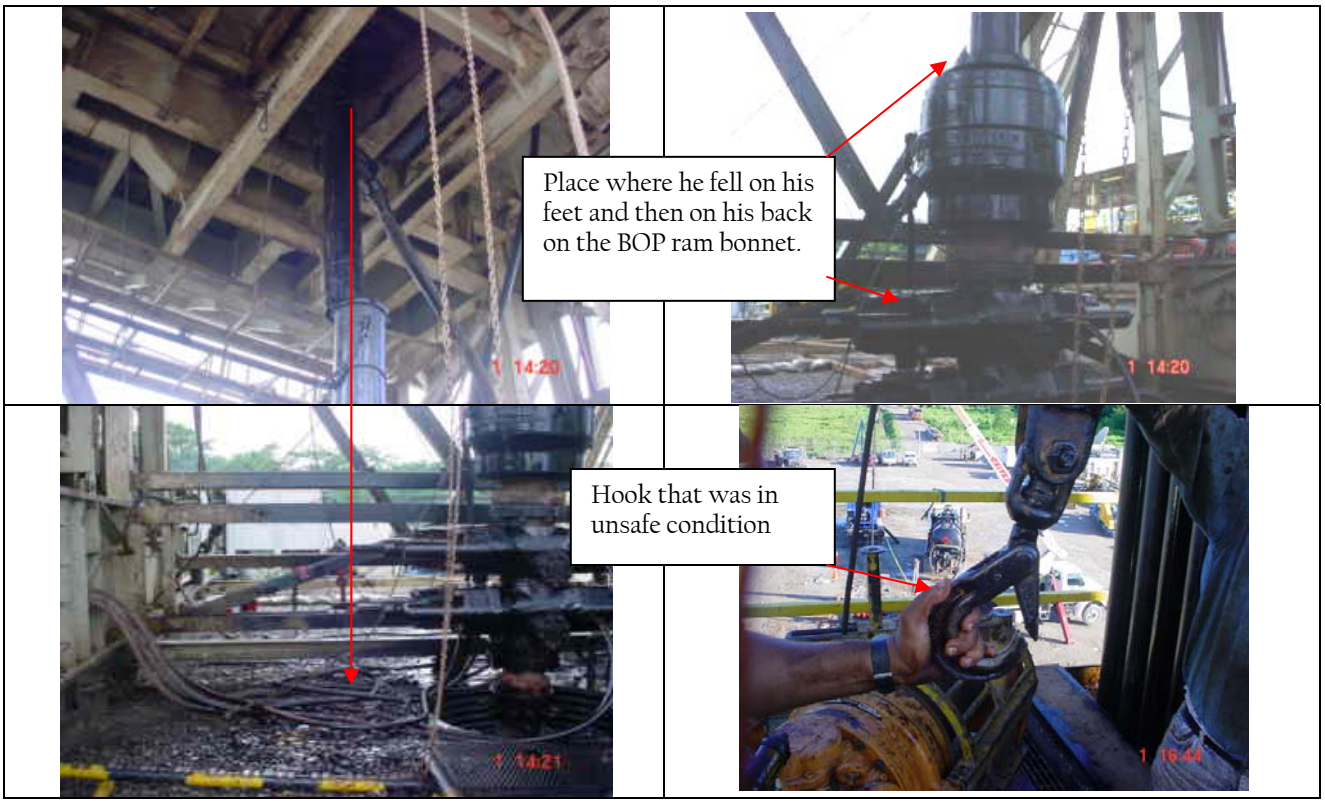
From the International Association of Drilling Contractors

ALERT 08 – 12

FALL FROM HEIGHT RESULTS IN LTI

WHAT HAPPENED:

Two roughnecks were working in BOP area to reposition the telescopic bell nipple. After working on the bell nipple, the Supervisor sent the winch line down through the rotary table opening. While the injured person (IP) was standing on the rotary beams he attached himself to the winch line hook and then unhooked his lanyard from the rotary table beams. As he disconnected his lanyard, the chest ring on his fall protection harness slipped out of the winch line hook causing the IP to be without fall protection which resulted in him falling 10-15 feet to the annular then another 15 feet to where he landed on his back over the BOP rams and eventually coming to rest on the ground near BOP hoses. The Rig's Emergency Response Team stabilized the IP and he was transported to a local hospital for evaluation and treatment then transported to a hospital trauma facility. The medical assessment showed multiple fractures of the pelvis and back.



WHAT CAUSED IT:

- The crew used a hook which was in unsafe condition.
- Rig did not have in place the self retracting lifelines (SRL) for working at height in substructure/BOP area.
- The winch used was not adequate for the activity. A Man-Rider Winch should have been used as required by standard operating procedure.
- The rig had scaffolding available for working on the BOP, but it was not installed due to nature of work being performed.

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.

Issued March 2008

- The unsafe hook had been identified earlier, but had not been replaced as per established procedure.
- No JSA or Permit to Work was issued to perform the activity and all potential hazards had not been identified for this task.

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

Immediate action: Instructed the Rig Manager to change out the unsafe hook as soon as the mast is rigged down.

- Per the company's equipment standard, a request was made to place a dedicated man-rider winch for the rig.
- Rig personnel are to use fall protection as per company standard for personnel hoisting activities.
- Rig personnel installed SRLs below rotary table that are adequate for the job.
- Rig personnel were instructed that scaffolding will be erected when working in BOP area.
- A third party investigation has been completed.
- An inspection has been conducted of all lifting and fall protection equipment on the rig. A follow-up on its condition has warranted several lifting equipment items to be taken out of service.
- Rig supervisory personnel were instructed to reinforce company policies on following the correct safety procedures such as, JSAs, Work Permits and use of Fall Protection Systems.
- Hand-over notes and responsibilities should be identified by supervision and communicated to all 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.

Issued March 2008