



# Safety Alert

From the International Association of Drilling Contractors

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ALERT 08 – 18

## FALL FROM CASING RESULTS IN LTA

### WHAT HAPPENED:

The deck crew was in the process of back-loading a 30 foot mud motor to a crew boat off the port side of the rig. The deck coordinator had slung the mud motor with a sling at each end using the double wrap method of slinging. After attaching the tag lines to the load, the deck coordinator moved to what he perceived to be a safe area (approximately 6 feet (2 meters) away) on the light end of the load. The deck coordinator then signaled the crane operator to raise the load. As was discussed in the pre-job talk the crane operator raised the load to height that the deck coordinator could determine that the load was stable (approximately 2 feet [.6t meter]). At this time the deck coordinator approached the load on the light end and signaled the crane operator to raise the load for back-loading. When the crane operator started his lift, the load shifted, causing it to rise on the light end and to move towards the deck coordinator. In an effort to get away from the unexpected movement of the load the deck coordinator put himself on the side of the load that had no room for escape. He was then forced to sit down on the other smaller tubulars also stored on top of the casing. The starboard aft movement of the load coupled with elevation of the light end of the mud motor caused the entrapment of the deck coordinator's left leg. Now the deck coordinator was over the edge of the racked casing and his leg was trapped between the suspended mud motor and the two mud motors on the racked casing. The crane operator stopped the crane, and the load then moved forward releasing the trapped deck coordinator, who then fell approximately 9½ feet (2.85 meters) from the top of 10¾" casing stacked on the port pipe rack to the catwalk. The injured person sustained fractures of his left leg and his right arm as a direct result of the fall and the entrapment of his leg.

### WHAT CAUSED IT:

The deck coordinator's position in relation to the load when it shifted caused the entrapment and subsequent fall. The crane block was centered prior to the lift and appropriate slinging techniques were employed for the lift. The heavy end of the load was not free during the initial lift to see if the load was stable. The most likely reason for the load transition is the shifting of the balanced load from the heavy end to the light end as it came to equilibrium.

When the casing was initially loaded aboard the rig it was determined that it would be there for an extended period. There was no mitigation of the risks associated with landing and lifting loads from that height. The pre-job planning used a JSA that did not make mention of the height to which the deck coordinator would be rigging the loads. The crane operator made mention of the edge and the height during the pre-job planning; however no controls were put in place.

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

- The person in charge of the load is responsible to check that both ends are free.
- When loading or unloading items from racked tubulars, all lifts will be checked for stability and correct rigging.
- Personnel shall move off the racked tubular prior to making the lift.

**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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Issued May 2008