Safety Alert

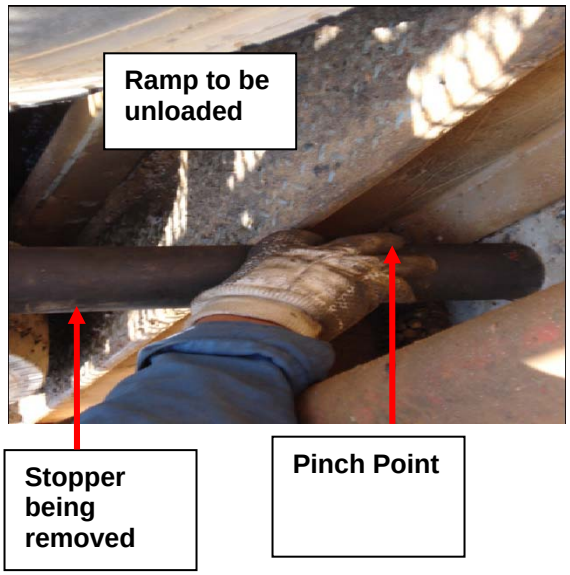
From the International Association of Drilling Contractors

ALERT 08 – 23

IMPROPER LIFTING PRACTICE RESULTS IN A (RESTRICTED WORK / TRANSFER CASE)

WHAT HAPPENED:

An improper lifting practice resulted in a restricted work/trasfter case during a rig move, and while removing the carrier's ramp off the trailer at a new location. The workgroup consisted of a driller (supervisor), a derrick man and a floor man (Injured Person). The forklift was positioned to take off the ramp from the right side of the trailer and the driller was beside it giving signals. To facilitate the lift, two stoppers were removed from the forklift side. The forklift operator tried to lift the load off the trailer but it couldn't lift the load higher than the stoppers installed on the opposite side of the trailer bed. The driller asked the forklift driver to rest the load on the truck and asked the IP to remove the stoppers from the other side, which were in between the ramp and the delivery line (narrow place). The IP went to the other side of the truck where the driller couldn't see him and tried to remove the stoppers. Without checking on the status of the IP, the driller asked the forklift operator to raise the ramp again and didn't notice that the IP had not finished removing the stopper. The IP's left index finger was crushed in between the stopper and the ramp causing a severe cut.



WHAT CAUSED IT:

- Poor supervision and communication as the driller did not make sure that the IP had finished the job assigned to him.
- Change of procedure during task.
  - Normal procedure is to lift off the ramp, from the trailer, high enough so that the trailer can pull out from under the load. Then off load the ramp in place.
  - The driller decided to have the IP remove the stoppers on the side opposite the forklift.
  - The injured ended up being in a position where he was not full view of the driller.
  - The driller decided to lift the load again without checking to determine if the injured person had removed the pins and his hands were out of harms way.

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

- Improve lifting competency of the crew and supervisors.
- Failure to follow Management of Change (MOC).

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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