Safety Alert

From the International Association of Drilling Contractors

ALERT 08 – 24

DERRICK OPERATION RESULTS IN A FATAL INCIDENT

WHAT HAPPENED:

The operation was pulling out of the hole and racking back drill pipe. After the slips had been set, and before spinning out the pipe, the iron-roughneck operator looked up at the monkey-board, and did not see either the IP or the tugger chain attached to the stand of pipe. He commenced to break the connection and back-out the stand. While the exact sequence of events is not clear, during this process the IP's left hand became trapped between the pull-back chain and the pipe. The pipe rotation was stopped with the IP's left hand facing the monkey-board, palm out.

The IP was rescued from the monkey-board and given on-board medical attention. The IP was then sent to the hospital ashore via medivac, and subsequently passed away at the hospital.

Demonstrating placing the chain on the stand of pipe.

Demonstrating the position of the injured hand

WHAT CAUSED IT:

1. The IP had not completed the "Derrickman On-The-Job Training".
2. No direct communication had taken place between the Driller and the IP immediately prior to the incident.
3. The tugger chain used was 5.5-ft (168-cm) in length.
4. It was a common practice to place the chain on the tubular prior to it being backed out.
5. Neither the crew nor the rig had a "Rescue from Heights" plan as part of their Job Risk Assessment.

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

Instructed the Rig Manager and OIM to ensure to verify:

1. All personnel working as a Derrickman (or relieving a Derrickman), should have successfully completed the Derrickman On-The-Job Training program.
2. All personnel manually racking tubulars (Derrickmen), have been instructed to **NEVER** place their pull back ropes or air tugger chains on a tubular while it is spinning, or prior to it rotating.

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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3. The Driller is responsible for communicating to the Derrickman (via the hands-free communication system), that it is clear for the Derrickman to place the rope or chain on the tubular – when it has been confirmed that rotation has been stopped, the iron roughneck or spinning wrench has been removed from the pipe, and the pin is lifted clear of the box.
4. Length of a chain used for manually racking tubulars should be formally risk assessed, to ensure that it does not create a potential hazard (either too long or too short).
5. All Job Risk Assessments involving manually racking tubulars are reviewed to include the previous points.
6. Ensure that the hands-free communication systems are in good working order, as per the company's Health and Safety Manual.
7. A plan for the rescue of personnel at elevated levels is included in the relevant Job Risk Assessment and all necessary equipment is available [References: Company Health and Safety Manual section on Fall Protection].

Rig Specific Corrective Action Plans are to be developed, tracked, and closed in the company's incident closure tracking system.

Regional and Rig QHSE Managers are to follow up and report to the Director of Corporate QHSE upon completion and close out.

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