



Safety Alert

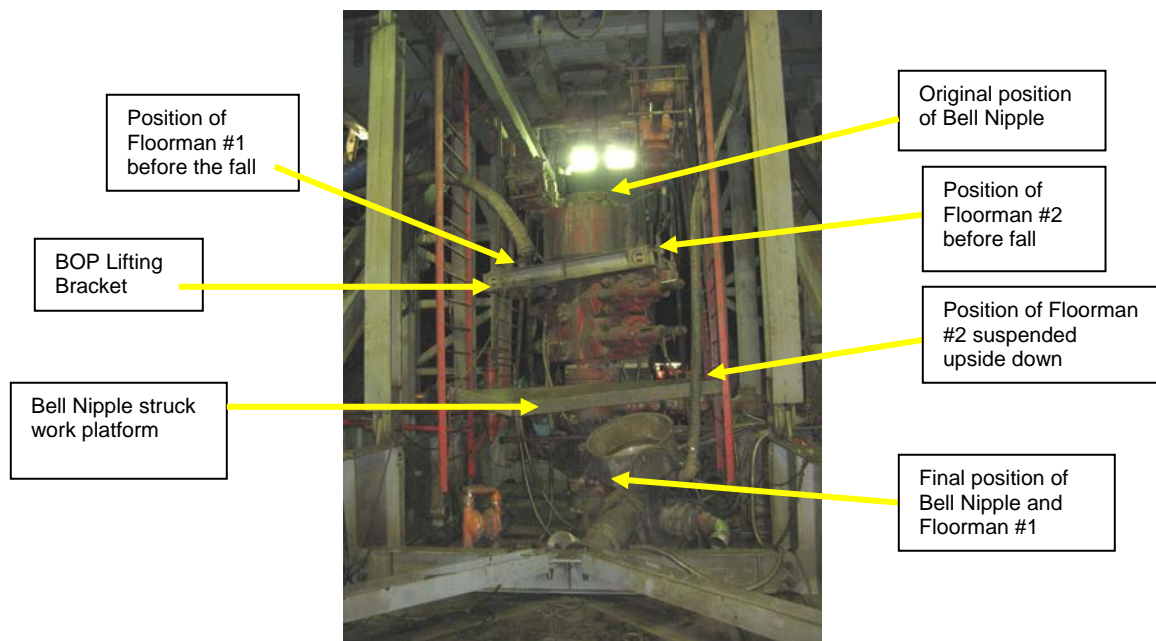
From the International Association of Drilling Contractors

ALERT 08 – 26

FALL FROM HEIGHT RESULTS IN DOUBLE MTO

WHAT HAPPENED:

Two Floormen were working in the substructure approximately 4 metres (13.4 feet) above the ground and removing the bell nipple from the top of the blowout preventer (BOP). The flow line had been disconnected from the bell nipple but was still attached to the winch on the drill floor when it was raised unexpectedly. The flow line flange knocked the bell nipple from the BOP seating and it fell to the ground. The Floormen had moved from one side of the Bell Nipple (v-door side) to the other side (draw works side) where they had just connected a soft sling to secure the Bell Nipple. One Floorman (#1 in picture below) had attached his shock absorbing lanyard to the Bell Nipple (approx 300 kg) and he was pulled down and fell to the ground. The other Floorman (#2 in picture below) was knocked off balance and fell backwards to the extent of his shock absorber lanyard before coming to rest suspended upside down with the unused work platform stopping his fall any further. His lanyard did not extend far enough to activate the shock absorber. Both workers were standing on the BOP lifting bracket. Both workers received soft tissue injuries and returned to work the next day.



WHAT CAUSED IT:

- The winch line connected to the flow line was supposed to have been disconnected.
- The original plan was to use two winch lines to remove the bell nipple, one through the mouse-hole and one through the rotary table. One line was ready and passed through the mouse hole, but not connected. The Driller changed the plan to use only one winch.
- Neither worker was connected to the Safety Retracting Life (SRL) line fall arrestors which were attached to the underside of the rig floor on each side of the sub base.
- Lanyards used were not secured above head height and in one case the lanyard was connected to an unsecured anchor point (bell nipple).

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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- All four studs that attach the bell nipple to the BOP annular had been removed before it had been secured with a hoist line.
- No procedure was available for this job.
- No JSA/JHA was used for this task.
- Brief pre-job discussion was inadequate for the task being undertaken and potential risk
- Lack of adequate and / or specific instructions during the task, particularly just before the incident.

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

- Procedure to be developed with sequential steps particularly the restraining of all equipment before unbolting or removing it.
- Ensure all provided safety devices are used (in this case fall arrestors)
- Processes to be put in place to ensure adequate and thorough Pre Job meetings are planned as part of the job, including the communication of hazards and why controls are necessary to prevent an accident.
- Ensure all instructions given during a job are specific, understood and recorded.
- Outline Supervisor expectations to ensure that jobs are undertaken safely
- Reinforce to the work force that they are empowered to **STOP THE JOB** when safety controls or precautions are bypassed.
- Ensure fall protection lanyard is secured to a suitable (stable) anchor point.
- To reduce fall distance, lanyards are to be secured to anchor points that are above head height.

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