



# Safety Alert

From the International Association of Drilling Contractors

ALERT 09 – 11

## RESTRICTED WORK CASE RESULTS FROM CAUGHT BETWEEN INCIDENT

### WHAT HAPPENED:

The Work Group Supervisor instructed three workers to manually transfer the mud pump air duct (about 80 Kg) from cement bulk room to mud pump room through the cement unit room. When they reached the mud pump room door an additional employee (IP) decided to help with this manual lifting operation. When they attempted to land the air duct on mud pump room floor the IP's left hand middle finger was caught between the air duct and a pipe flange caused swelling in his middle finger tip end.



The IP's hand position between the air duct and pipe flange

### WHAT CAUSED IT:

- The company's safety management system was not followed; as the job was considered routine job where there is no specific preparation Safety Job Analysis or Permit To Work.
- The job was poorly planned and executed. The Work Group Supervisor failed to assess the hazard of the job and failed to assign adequate personnel to manually lift the air duct, to the extent that the IP decided to join in when he saw that the three persons assigned to the job had difficulty continuing.
- The work group was having difficulty with the load, but they did not stop and assess / ask for a new plan.
- They allowed the IP to intervene without being part of the original job, plan.
- Instead of intervening to stop the project, the injured added to the hazard by physically putting him self in harms way.
- Group communication; lessons learned from previous incidents involving manual handling was not communicated.

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

- Conducted refresher "Manual Handling" training at the rig for all crews –
  - Used learning's from previous incident (s) in the refresher training.
  - The training also included instructions to the personnel that the company's Safety Management System, Safe Job Assessment / Work Permit / Lifting Plan are to be adhered to.
- Work Group Supervisor was instructed to carry out his responsibilities towards his work group safety.
- Personnel were instructed to practice beyond Safety – Stop when in doubt.

**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.**

This material is presented for information purposes only. Managers & Supervisors should evaluate this information to determine if it can be applied to their own situations and practices

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