Safety Alert

From the International Association of Drilling Contractors

ALERT 05 – 20

MASTER BUSHINGS SET ON IP'S TOE - LTI

WHAT HAPPENED:

While flow checking the well, the Injured Person (IP) a Tourpusher, noticed that the drill pipe wiper rubber had dropped below the top of the fixed diverter. In order to retrieve the wiper rubber, the rotary master bushings had to be pulled. The bushings were pulled with the aid of an air tugger and the wiper rubber retrieved. In order to reset the bushings back into the rotary table the IP proceeded to pull them toward himself with the assistance of a floorman who was pushing in the same direction. The bushings obstructed the tugger operator's (Assistant Driller) view of the IP's feet and after the IP instructed the tugger operator to slack off, the IP's foot slipped out from beneath him and over the rotary opening. The tugger operator was unaware of the IP's foot position and the bushings were set down on top of the IP's left foot causing a fracture of his big toe. At the time of this incident the driller, pumpman and two floormen were eating breakfast in the galley.

WHAT CAUSED IT:

Causal Factors:

- Lack of awareness regarding the excess mud and slip potential
- Incorrect foot placement and not using the non-skid rotary mat
- Failure to consider and remove excess drilling fluid around the table
- No JRA was ever written for master bushing handling
- Possible self imposed time pressure to complete this task quickly
- Insufficient personnel available to safely accomplish the task
- Possible end of tour fatigue / complacency
- Inadequate number of personnel for the job
- IP's feet not in tugger operator's line of sight
- Pulling bushings rather that pushing (body position)

Root Cause:

- Failure to conduct formal risk assessment (JRA)
- Lack of proper supervision
- Failure to call Time Out
- The unplanned event of having to pull the bushings combined with three absent regular crewmembers involved change. This change was not considered, discussed nor managed.

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

OIM/PIC (Toolpusher) to review at the next Crew Weekly Safety/Environmental meeting. Rig Safety / Environmental Committee to communicate to all crew members. Post a copy of this bulletin on the Rig Information Center Board.

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.

Issued May 2005

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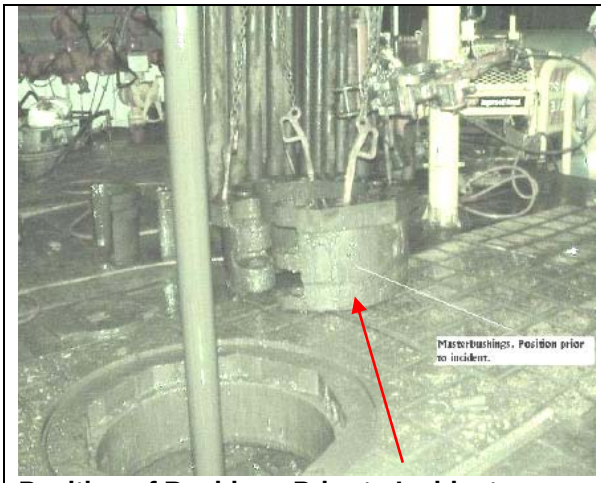
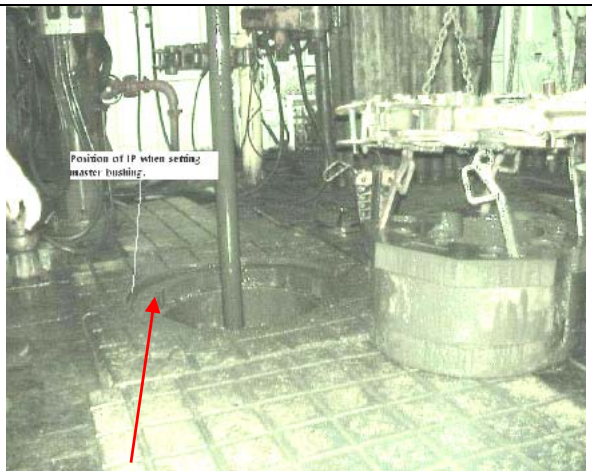


Position of Bushings Prior to Incident



Position of Injured Person's Foot

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