



# Safety Alert

From the International Association of Drilling Contractors

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ALERT 01-19

## FATALITY – FALL FROM DERRICK LADDER

### WHAT HAPPENED:

A fatality occurred when an employee fell from a derrick ladder while descending from the 86-foot level to the 74-foot level after changing a fluorescent light bulb. The employee had reached the last two rungs of the vertical ladder at the 74-foot platform level when he fell backwards. He passed through the space between the bottom of the safety cage and the top of the handrail, and fell to the pipe deck.

### WHAT CAUSED IT:

The employee lost his grip on the vertical ladder and fell backwards. At the time he fell, he was holding the burned out 4-foot fluorescent bulb in his left hand. There was an existing gap (42 inches) between the bottom of the safety cage and the top of the handrail. Additionally, the shallow depth of the platform results in the handrail being nearly directly underneath the back of the safety cage. At the time of the accident, there was no work pressure to get the lights changed out and it appears the employee took it upon himself to get this work done during his tour. The Driller was not notified that the work was being conducted in the derrick.

### CORRECTIVE ACTIONS:

- When climbing or descending a ladder, the person will face the ladder and have free use of both hands. He will not carry tools or other objects in his hands. A hand line must be used to raise or lower heavy or bulky objects.
- A JSA should be conducted for work in the derrick covering “equipment removal or installation; maintenance; inspection”.
- An inspection of all vertical ladders should be conducted. On landings where the handrail opposite the ladder is four feet (1¼ meter) or less from the rungs of the ladder, and the gap between the bottom of the safety cage and the top of the handrail exists, this gap should be closed unless the ladder is equipped with a ladder fall arrest system.
- All work projects in the derrick should be cleared with the driller.

**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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