



Safety Alert

From the International Association of Drilling Contractors

ALERT 03 – 08

DROPPED OBJECT – JOINT OF HEAVY WEIGHT DRILL PIPE

WHAT HAPPENED:

An incident occurred recently which resulted in a lift sub backing out in the elevators and a joint of Heavy Weight drill pipe being released. The drill crew was making up a sub to a single joint of 6-5/8" HW drill pipe. No elevators were available on the rig for the HW pipe size, so a decision was made to use a lift sub to pick-up the HW. The lift sub was made up with chain tongs and "bumped-up" with a hammer. The HW was then picked up in the elevators and moved over a sub and stabbed onto a rotating pin sub that was in the rotary bushing pinhole. The HW was spun-up with a pipe spinner. The torque from the spinner backed out the lift sub from the HW box and the joint of pipe fell across the drill floor. There were no injuries.

WHAT CAUSED IT:

The lift sub was not torqued to the HW Drill Pipe. The practice of "Hammer Tightening" a connection is not sufficient to withstand the torque and acceleration applied by a power spinner. The crew was not watching the break for the potential of the lift sub backing out.

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

Instructed Rig Supervisors to:

- Review this incident with all crews with specific focus on the ineffectiveness of hammer-tight connections to withstand the force of power tongs.
- Review with crews and modify all JSAs to reflect that all lift subs will be torqued to a minimum 20,000 ft-lb prior to being racked in the derrick or being spun with a power spinner.
- Review with crews and modify all JSAs to reflect that power-spinning equipment will not be used to make up any connection where a "Hammer-up" lift sub is overhead.
- Review with crews and modify all JSAs to require a specific individual be assigned to watch the break on all lift subs, lift caps, lift nubbins, etc. while being made up either manually or with power tools.

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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