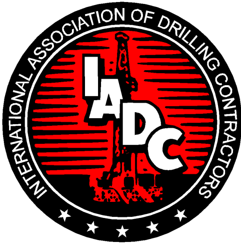

Safety Alert

From the International Association of Drilling Contractors

ALERT 03 – 15

SPINNING OUT PIPE WITH TOP DRIVE RESULTS IN INJURIES

WHAT HAPPENED:

Recently two rig floor workers were injured while working on the rig floor. The job at hand was pulling out of the hole, while pumping on the drill pipe. The slips had been set and the pump was turned off. The stand of pipe had been broken out at the floor with the iron roughneck. The mud bucket was placed around the drill pipe and the stand was picked up out of the box to allow the mud to drain. After draining, the mud bucket was removed and the stand was stabbed back into the box end of the drill string in the rotary. The Driller then proceeded to break out the upper connection from the top drive, using its hydraulic pipe handler. Manual make-up tongs were placed on the pin end of the drill pipe stand to hold back-up, against the top drive's spin out. As the Driller started the spin out, the stand jumped out of the box and swung around on the rig floor, striking employees. The two employees were evacuated to a local hospital, where they were treated and released for minor injuries.

WHAT CAUSED IT:

The stand was not properly secured in the box and the top drive pipe handler did not fully break the connection at the saver sub (top of the stand). The procedure had been in place as 'standard oilfield practice' to minimize mud spillage at the box end of the stand.

CORRECTIVE ACTIONS: To address this incident, this company issued the following instructions to rig personnel:

A procedure change is necessary to prevent recurrence of this incident.

1. After the pipe has been drained, spin the connection back up with the top drive.
2. Proceed to back out the top drive, with bottom connection spun up (not torqued up).
3. Repeat the pipe handler breakout, to ensure that the break is ready for spin out.

This will stabilize the stand and prevent the pipe from jumping out of the box.

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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