Safety Alert

From the International Association of Drilling Contractors

ALERT 03 – 28

TONG INCIDENT RESULTS IN A FATALITY

WHAT HAPPENED:

The rig floor crew was making up drill pipe prior to running into the hole to land the PBR on the tubing string. The rotary brake was used to hold the pipe in the rotary from turning. The Lead Floorman (Injured Person - IP) was operating a backup manual pipe tong while torquing a stand of drill pipe with the top drive system. As the Driller began to see the spinner torque-up the drill pipe, he released the rotary brake, to transfer the torque to the backup manual pipe tong. As the torque was transferred to the backup pipe tong it moved in a clockwise position and the IP became caught between the snub line and backup pipe tong lever. The IP was evacuated from the rig and later died from the injuries.

WHAT CAUSED IT:

- The snub line was reportedly longer than normally installed due to a non-routine operation prior to the incident.
- The breakout tong appeared to be tensioned by the snub line, when in fact it was the cathead breakout line.
- The cathead breakout line and snub line were both attached to the tong.
- The cathead breakout line was jammed at the cathead giving the appearance that the snub line was tensioned.

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

- The Rig Manager should review and confirm the current operating practices for torquing tubulars at the rotary table.
- Review tong management on the drill floor. Confirm correct operation of pipe tongs during routine and non-routine operations.
- Include a review of safe positioning of people, supervision by Driller and Asst Driller, and the hazards associated with pipe tong operations.
- Length of snub lines and angle to anchor point to be physically verified to ensure no pinch point hazards exist for a Floorman while operating manual pipe tongs.

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 July 2003