

Safety Alert

From the International Association of Drilling Contractors

ALERT 04 – 42

CASING RUNNING INCIDENT RESULTS IN LTI

WHAT HAPPENED:

While running 13 3/8" casing, the company man requested the fill line length to be extended. The casing company did not have the proper joints available, so it was decided to add a Kelly valve to the Kelly. The top drive was put in the extended position to clear the well hole, which contained the casing. Spider elevator was placed beside the well hole. The extension was placed on the rig floor and not in the mouse hole due to it being covered and not available. The crew was attempting to hold onto the fill line arrangement with the air hoist line and chain sling on one side and supported on the other side by the left side (back up tong) rig tong. The IP was placed in between the left rig tong and the spider elevator to support the tong while make up torque was applied. Due to make up torque from the top drive, the fill line arrangement and the left rig tong moved toward IP who was trapped by the spider elevator and struck him in his right arm causing a fracture.



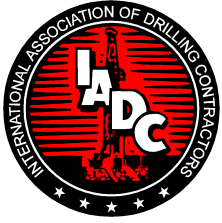
Black circle is point to spider elevator place beside well hole

WHAT CAUSED IT:

Placing the extension on the rig floor and not in the mouse hole did not provide good stability for final make up torque. The placement of the spider elevator on the rig floor made a tight work place and the IP worked between fill line arrangement and spider elevator. Since they could not rotate the rotary table, the top drive in the extended position was used to torque the extension. By not having the proper extension was not available, third Party Company failed to comply with equipment requirement. Company safety procedures not followed, supervisors conducting this operation on rig floor directly instead of the mouse hole. Inadequate task preparation, Supervisors didn't conduct this operation in the mouse hole and left spider elevator beside the well hole waiting for next job. Lack of safety awareness, Supervisors supporting fill line arrangement by air hoist wires with break failure and tight it with chain sling. Poor supervision, Supervisors didn't maintain a good practice / good supervision because they start making torque while IP still in trapped position between left rig tong and spider elevator. Job risk assessment was not adequate for the task. IP didn't recognize the hazards of the task or his position.

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

- Prior to beginning operations, third party equipment is to be checked to ensure proper equipment is on hand.
- A JSA including a risk assessment is to be conducted prior to changes in procedures.
- Supervisors are to follow company policy requiring the mouse hole to be used to steady connections.
- Personnel are to be instructed to stay out of possible trap areas.

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