



Safety Alert

From the International Association of Drilling Contractors

ALERT 98-26

More on Casing Safety

WHAT HAPPENED:

After running all 9-5/8" casing, the 10-3/4" 500-ton elevator was rigged up with the operating lever facing the opposite direction from the stabbing board. A 9-5/8"/10-3/4" crossover joint was made up, and the 500-ton elevator was lowered below the coupling. Because the length of the crossover joint was only 5.2 meters (17 feet), it was impossible for the stabber to reach the lever. The stabber was told to climb on the elevator, but it was necessary to raise the blocks for him to do this. It was decided then to close the elevator on the coupling with the intention of lowering the blocks afterwards so the slip would engage on the pipe body. But the blocks were raised too far, so that only the bottom three inches of the inserts were covering the top three inches of the coupling. In this position, the stabber closed the elevator. While the stabber was climbing back to the stabbing board the blocks were lowered to reach the pipe body. During this action, two cylinders of the elevator broke off. Rig floor personnel were under the impression that the inserts were set onto the pipe body due to the noise made. The string then was raised and the Flush Mounted Spider (FMS) was opened. The elevators were lifted a few additional meters to allow changing the FMS easier. At that point, the elevator lost its grip, dropping the complete string into the hole.

WHAT CAUSED IT:

1. Running procedures were being ignored.
2. There was a communications failure between the drill floor and the stabbing board; the stabber should have observed the safe operation of the elevators.
3. A riding belt should have been used to access the operating level on the elevator, which should also have been facing the stabber.
4. A stabber should not be ordered to climb from the stabbing board without proper protective equipment and good communications with the driller and rig floor personnel.

CORRECTIVE ACTIONS:

1. Written procedures should be followed at all times.
2. A safety/communications meeting should be held with all personnel affected whenever changing operating procedures.
3. Riding belts should be used to prevent unsafe and unusual stabbing operations
4. Crossover joints can be made up so that normal lengths are being used (this should be discussed with the drilling engineer).
5. Rig owners and operators should be consulted where stabbing boards may need to be modified, such as in cases where they cannot be raised or lowered enough for safe operations.

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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