

ALERT 14 – 26

LINE-OF-FIRE INCIDENT RESULTS IN MEDICAL TREATMENT CASE

WHAT HAPPENED:

The crew of a hybrid well service rig had pulled the lubricator to the surface to bleed off the pressure in it. An operator was using an aerial lift to unthread the "Otis" connection on the 10 k stack. The operator unthreaded the nut, and then the rig manager attempted to separate the connection by lifting up on the injector/lubricator assembly. The lubricator was binding on top of the BOP, and the operator in the aerial lift remained in position behind the assembly to direct the rig manager as to which way to move the injector carriage to free the lubricator. The rig manager was following the operator's directions, and as there was weight pulled into the lube assembly, when the rig manager hit the correct spot, the lubricator assembly sprung free of the BOP stack and sprung backwards, thus striking the operator in the aerial lift in the face and knocking him down. The operator was able to regain his stance and bring the aerial lift down to the ground under his own power. He was evaluated by the on-site medic and sent for further medical treatment. The operator underwent an MRI, was diagnosed and underwent surgery to repair a fractured cheekbone and misaligned orbital socket. His recovery time is estimated to be 4 weeks, after which a light duty program should be able to be instituted.



Image 1 is the position of the employee before being struck.



Image 2 is the approximate kick of the lubricator stack.



Image 3 is the employee being struck by the lubricator.

WHAT CAUSED IT:

- The lubricator assembly sprung free off the top of the BOP stack and sprung backwards, striking the operator in the Aerial lift in the face and knocking him down.
- The crew had not identified a potential stuck connection nor the stored energy that could be released during the disconnection process.

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

Investigation identified the following:

- The company will endeavor to find an engineering solution to prevent the lube from kicking out of the BOP.
- The JSA procedure has been changed, to identify the hazard and ensure that all personnel are clear before the lubricator assembly is lifted off the top of the BOP stack.
- The company will also reinforce the importance of pausing and identifying any new hazards when the scope of a job changes.
- There will be an internal hazard alert sent out

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