Safety Alert

From the International Association of Drilling Contractors

ALERT 06 – 07

LOST CONTROL OF DRILL PIPE RESULTS IN A FATALITY

WHAT HAPPENED:

The operation was Pulling Out Of the Hole (POOH) with 5-1/2 inch drill pipe. The Derrickman was pulling back the stands of drill pipe with the assistance of an air hoist with a chain and hook attached. After setting down stand # 26 in the set back area, the Derrickman unlatched the elevators and the Driller retracted the link tilt. The Derrickman then used the derrick mounted tugger (air winch) to pull the stand of drill pipe back towards the finger board, clear of the traveling block. The Driller commenced lowering the traveling blocks and after approximately a ten foot descent, the Top Drive came into contact with the top of stand #26. As the Top Drive impacted the stand of pipe, energy was transferred causing the pipe to bow and snap back towards the Derrickman who was positioned on the monkey board. The stand struck the Derrickman knocking him backwards causing his head to strike a derrick beam. Although no one actually saw the incident take place, it appears that the Derrickman lost control of the pipe thereby allowing it to fall back in to the path of the descending top drive.

WHAT CAUSED IT:

Root Cause:

- Derrickman lost control of the stand of pipe.
- View from Derrick camera was obstructed at a critical point of the operation.
- The Derrickman did not attend the Job Risk Assessment.
- No Procedure was in place to ensure that stands are secured in the finger board before the Top Drive is lowered.

CONTRIBUTING FACTORS:

- Teamwork was insufficient to compensate for the obstructed view of the monkey board.
- Relied solely on the inadequately placed derrick camera to establish if it is clear to lower the Top Drive.
- The length of pull back chain and design of hook may have contributed.

CORRECTIVE ACTIONS:

Each company should review their top-drive tripping operation procedures to address the potential causes of this incident listed above.

- Review JSA
- Review SWA (stop Work Authority) and decide on a signal that is understood by all, and when given stops the work
- Discuss communication methods and maintain constant communication between the derrick and rig floor
- Maintain line of sight with the Derrickman while on the Monkeyboard

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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