ALERT 06 – 33

DROPPED OBJECT - DERRICKBOARD SLIDE BAR INCIDENT

WHAT HAPPENED:

After laying down drill collars, the Derrickman positioned the Slide Bar across the derrickboard “alleyway” and came down to the rig floor. The rig crew and casing crew were rigging up to run casing. While using the rig floor hoist to pull the casing slips up the V-door, the Slide Bar fell from the derrickboard and hit the lay down stanchion (pole) in the mouse-hole. The Slide Bar ricocheted off the stanchion and struck a member of the casing crew in the back of the head, then struck the Assistant Driller in the left calf.

WHAT CAUSED IT:

Several days earlier, the Slide Bar could not be retracted into its storage position and upon inspection, it was found to be bent. Due to safety concerns of attempting full repairs while the derrick was up, a decision was made to repair it temporarily and follow up with a permanent fix at the next rig move. Temporary repairs consisted of cutting approximately 8” off the length of the Bar to allow it to retract fully and then affixing a bolt with double nuts to prevent the shortened bar from working all the way out when extended.

Afterward, the Rig Manager attempted to inform the Superintendent about the change but due to different vocabularies, the message was misunderstood (the Rig Manager stated the “toe board” needed to be fixed when it was really the Slide Bar that had been modified). Subsequently, crew change occurred and neither the oncoming Rig Manager nor Derrickman was made aware of the change.

After working the derrick that day, the Derrickman slid the Bar out of its retracted position but didn’t recognize the new double-nutted bolt and didn’t understand why it was there so he removed the bolt and slid the Bar on across the alleyway prior to coming down from the derrick.

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

1) Conduct Engineering design review and rebuild the Slide Bar assembly at next rig move.
2) Revise the JSA for working derricks to specify the proper configuration and positioning of the Slide Bar.
3) Improve Rig Manager Communication through the use of handover notes.
4) Distribute Safety Alert.

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.