ALERT 05 – 14

MATERIAL HANDLING (DRILL PIPE) RESULTS IN AN LTI

WHAT HAPPENED:
A incident occurred during the routine task of offloading tubulars from a work boat that resulted in a Roustabout sustaining a fractured arm. As the preliminary incident investigation has confirmed this incident was no accident but once again a series of events which were not effectively managed and collectively produced an unacceptable result. The operation was offloading bundles of 3-1/2” drill pipe from a supply vessel. **Events involved in this incident include:** 1. The Assistant Crane Operator was attempting to spot the first bundle in the starboard pipe rack with one Roustabout flagging (Banksman) and the other Roustabout standing adjacent to the pipe rack on a walkway. 2. The Assistant Crane Operator’s view of the landing area was restricted by a tool basket. 3. During the lowering of the load the Injured Roustabout left his position of safety and entered the area of pipe rack bay. 4. The load appeared to have struck a Sampson Post and recoiled towards the injured party who had taken a position between the load and the tool basket, a blind spot. 5. As the load swung towards the Roustabout he raised his arms across his chest to protect himself and the load struck his right arm causing the fracture.

WHAT CAUSED IT:
- Failure to conduct proper Job Risk Assessment (JRA) and identify and manage known hazards.
- Failure to implement effective Management of Change.
- Crane Operator had gone to the galley leaving the Assistant in charge.
- The injured party had never worked offshore previously and his appointed Safety Partner was also in the galley at the time of the incident.
- The Banksman (Signalman) was relatively inexperienced this being only his second hitch.

CORRECTIVE ACTIONS: To address this incident, this company instructed its rig personnel to do the following:

Discuss as a team what went wrong and consider the following:
- Leadership / Supervision
- Short Service Employee (SSE) Safety Partner Responsibilities
- Team Work
- Varying levels of inexperience
- Blind spots and body positions
- Time 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.

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