HAND INJURY RESULTS FROM MISCOMMUNICATION

WHAT HAPPENED:

After setting cement plug the crew was to lay out the cement line. The chicksan was removed from the “Pump- In” sub. The connection between the pump-in sub and drill pipe was to be broken with the use of the Iron Roughneck™ so the sub could be removed with a chain tong. The Iron Roughneck™ Operator was asked to repeat this action to ensure the sub was loose enough to use a chain tong. He was then instructed to remove the Iron Roughneck™ but by mistake began to back out the sub. Just as he did this the IP placed his hand on the Iron Roughneck™ to assist in its removal from the sub. The pump-in sub with Lo-Torque valve spun and caught the IP’s fingers. He suffered severe injuries to the ring finger resulting in three quarters of it being amputated. The middle and index fingers sustained fractures and cuts.

WHAT CAUSED IT:

There are a few ways in which this situation went wrong:

- Incorrect use of equipment by Iron Roughneck™ Operator.
- Incorrect hand placement on the Iron Roughneck™ by IP.
- Poor observation from the IP, as he was not concentrating on what the IR Operator was doing.
- Poor communication between the Iron Roughneck™ Operator and the Rig manager as the operator did not understand the Rig Manager’s instruction.
- Failure to remove the Lo-Torque valve prior to removing the sub.

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

The following learning/corrective actions have been identified and implemented:

- **Equipment:** Instructed personnel that when using any equipment, think about and discuss the potential hazards associated with it.
- **Pinch Points:** Instructed personnel on the identification of all pinch points with all kinds of equipment. Instructed Rig managers to color code the pinch points.
- **Hand Placement:** Instructed personnel to continually ask: “What could happen if I place my hand here?”
- **Communication:** Instructed personnel to always remind each other to watch out for hazards to avoid complacency. If you are not totally sure of instructions, ask for clarification.

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.