Safety Alert
From the International Association of Drilling Contractors

ALERT 11 - 03
LAYING DOWN JOINT OF CASING
RESULTS IN A FALL

WHAT HAPPENED:

After running casing, a floor plate was removed from the rig floor to access the cellar. A 20 foot piece of casing was cut off and hoisted with the rig floor air winch. Two rig floor workers were attempted to push the 20 foot piece of 16” out the V-door. The load was too heavy for the two workers to handle and it started swinging back towards the rotary table. As the load came back, one of the workers fell through the opening in the rig floor. The worker fell approximately 22 feet and suffered a fracture at the base of his skull, a fractured right thigh and multiple bruising.

WHAT CAUSED IT:

1. The supervisor (driller) did not realize that the casing would be too heavy for only two rig floor workers to handle.
2. No lay-down equipment was used.
3. The air hoist operator did not let the load down when it became apparent that the load was moving backwards.
4. The hazard of working around an open hole was not identified in the pre-job safety meeting.

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

Recommendations are as follows:

Prior to conducting a new task, (i.e. example laying down cut off casing), a pre-job assessment of the task must be done and the supervisor must conduct a review of the work area. The pre-job assessment should identify all the risks involved and the proper equipment needed to conduct the job safely.

Steps recommended to be taken next time casing is to be laid down:

- Close all floor plate openings
- Rig up lay-down equipment
- Ensure all unnecessary equipment is removed from work areas
- Ensure adequate personnel are present to complete the task
- Ensure all personnel understand the task to be completed.

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.

Issued January 2011