NEAR MISS—DROPPED JOINT OF CASING

WHAT HAPPENED:

While running casing in the hole, the rig floor crew stabbed a joint of 9 5/8” casing. The stabber then removed the single joint pick-up elevators. The power tongs were placed around the pipe, but it was found that they were too low for the make-up process. In order to get the power tongs in the proper position, the air winch operator utilized the rig floor winch to hoist them, but the tongs came up at an angle causing them to bind on the casing. The binding of the tongs on the casing resulted in the upward motion of the tongs to be transferred to the casing joint allowing the air winch to lift the joint of casing. This caused it to fall across the rig floor and lean against the derrick.

WHAT CAUSED IT:

The winch operator failed to notice that the tongs had jammed on the casing. He also failed to notice that the winch was lifting the joint of casing. There was nothing in the JSA for running casing addressing the process of adjusting the height of the casing tongs should they be too low on the pipe to allow make-up. There was no procedure to identify the winch operator’s competency for various tasks. It is easy to see in retrospect how this kind of incident can happen. The air hoist is rated to lift over 6000 pounds so it could easily lift the weight of the tongs and the joint of casing. It didn’t take much to lift the casing pin from the box of the casing in the rotary table.

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

A safety meeting was immediately held to discuss what went wrong. The incident was reported to the corporate office the same day it occurred.

• Rig crews were instructed that all JSAs addressing running casing should be reviewed to include the step “raising and lowering tongs”, along with the hazards identified in this incident.

Rig crews were also instructed to identify those crew members who will operate the air hoist, based upon each employee’s demonstrated level of competency. Certain air hoist operations require a higher level of competency, such as hoisting personnel and making unusual or heavy lifts.

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.