ALERT 08 – 36

TRAVELING BLOCK HITS CROWN
RESULTING IN A FATAL INCIDENT

WHAT HAPPENED:
The elevators were at the monkey board and the Derrickman had just latched the stand of pipe. The relief driller shifted into gear and picked up the stand. The traveling block hit the crown and the drilling line parted resulting in the traveling block with stand of pipe falling across the monkey board. The Derrickman was struck by the falling equipment and was killed.

WHAT CAUSED IT:
- Inspection records indicated proper functioning of the crown saver device but the safety margin for setting the crown saver device did not allow for enough distance to stop the blocks from striking the crown.
- The drawworks was put in highest gear, not allowing sufficient control of traveling block.
- The selection of the relief driller was not done according to company procedures.

CORRECTIVE ACTIONS: To address this incident, this company did the following:
- Rig personnel are to comply with all procedures. If it is not possible to comply, stop the job, contact the Operations Manager.
- In the event procedures cannot be complied with immediately, it becomes the responsibility of the Managers, Supervisors, and Safety Supervisors to stop the job, review and modify the standards and procedures as needed to complete the job while ensuring safety.
- To assure personnel competency, personnel qualifications for all positions both permanent and relief should be verified with the area Human Resources department.
- Supervisors are to ensure that company procedures are followed regarding relief employees.
- Drillers are to ensure that the crown saver device is set in the correct place so there is sufficient stopping distance to the crown.
- Drillers are to test the crown saver device system as per company procedures.

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.