ALERT 09 – 03

PIPE FALLS OFF CATWALK RESULTING IN AN LTI

WHAT HAPPENED:

Rig personnel were in the process of laying down 5" DP and the injured person (IP) was working in catwalk area attempting to remove lifting caps. The employee operating the rig floor winch lowered the 5" drill pipe down the V-door slide to the catwalk and two nipples were placed under the pipe. Then the IP started to remove the lifting cap from the 5" drill pipe by standing on cat-walk with the drill pipe between his feet. He attempted to turn the lifting cap with his hands, but he failed to realize that he was moving the opposite end of the pipe on the rack. The pin end of the drill pipe fell off the side of the cat-walk causing the box end of the pipe to strike the IP legs. The pipe knocked the IP to the ground and then the pipe fell to the ground hitting and breaking his left leg.

WHAT CAUSED IT:

• The lessons learned from previous industry and company incidents involving lifting cap removal were not communicated to the new employee.
• The proper procedure was not followed or understood by the injured person (IP).
• The IP was new and he was working alone and was not aware of hazards involved.
• Lack of training to the new employee by rig supervisors and other crew personnel resulted in the new employee (IP) not receiving instruction on the proper way to remove lifting caps.
• The supervisor failed to assign the newly hired person with experienced crew member.
• The supervisor also failed to inform the IP that he should not work alone.

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

• Instructed rig supervisors to use pre-job safety meeting to communicate job plan with hazards to all crew members.
• Rig supervisors are to implement the company Safety Management System of mentoring.
• Newly hired personnel are to be assigned to work with an experienced crew member.
• All rig personnel are authorized to apply safety standards and intervene to stop the task if the work is unsafe.

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.