FALL FROM RIG FLOOR

WHAT HAPPENED:

A drill crew was preparing to nipple down the 20” diverter and cut off the 16” casing. The air hoist was attached to the casing and the Welder went down to the cellar area. In order for the Driller to see the signals given from inside the cellar, a 28” x 101” floor plate was opened directly in front of the controls. The Welder signaled how high he wanted the diverter raised. Once the diverter was raised high enough, the Welder signaled the Driller to stop and the casing was cut. Once the Welder had finished cutting the casing he went up to the rig floor. The 20’ by 10” length of casing was raised up to the rig floor with the the air hoist. The Motorman and Welder attempted to push the casing towards the V-door but could not reach the edge of the V-door. At approximately one foot from the edge of the V-door, momentum was lost and the joint began to move back towards the drawworks. The casing pushed the two workers back towards the open floor plate and the Motorman fell through the opening, falling 12 feet 9 inches to the scaffolding and additional 9 feet to the matting below. The worker sustained a fracture at the base of his skull, a fracture to his right thigh and multiple bruising.

WHAT CAUSED IT:

The rig crew did not realize that leaving an opening in the rig floor created a potential fall hazard and they did not utilize lay-down equipment to handle heavy pipe.

CORRECTIVE ACTIONS:

Prior to conducting a new task, example: laying down casing cut off, a Job Safety Analysis of the task and work area must be conducted by the Supervisor and crew. This Job Safety Analysis should identify the risks and proper equipment needed to conduct the job safely.

- To remove the risk of personnel falling through openings, floor plates that have been removed for signaling, should be replaced immediately.
- Utilize rig lay-down equipment to pull the casing to the V-Door slide.
- Ensure all unnecessary equipment is removed away from traffic area.
- Ensure adequate personnel for the task.
- Ensure all personnel understand 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.

This material is presented for information purposes only. Managers & Supervisors should evaluate this information to determine if it can be applied to their own situations and practices.

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