ALERT 01-24

FALL FROM TOP DRIVE CAUSES TWO LTIs

WHAT HAPPENED:

A drilling crew had just completed a drilling line slip and cut operation. The deadline anchor was more than three meters above the rig floor. A Motorman and a Driller had just finished double-checking the tightness of the deadline anchor bolts.

The Driller climbed down and instructed the Motorman to climb upwards and out onto the top drive to take off the winch line that was stabilizing the blocks. The winch line was unhooked and the Motorman started to pull down on it. His glove caught on a bent thimble eye that caused him to lose his balance and fall. He landed on the Leasehand, who had just walked out from the tool house (24 foot fall by a 230lb man).

The Leasehand was knocked unconscious for a short time. First aid was administered and both employees were transferred to the hospital. The Motorman sustained broken ribs and a cracked hand. The Leasehand had a concussion and a broken ankle. Both injuries resulted in lost time incidents.

WHAT CAUSED IT:

The Driller and Motorman did not use any means of Fall Protection while working over three meters above the rig floor at the deadline anchor or when the Motorman climbed onto the top drive to remove the winch line. The Motorman had not received any formal training in Fall Protection. There were no warnings given to other personnel regarding the overhead operations that were being carried out.

CORRECTIVE ACTIONS:

• A JSA should be developed for Drilling Line Slip and Cut Operations.
  o The JSA should address falls from the elevations over six feet (i.e. three meters at the deadline anchor and from the top drive).

• Before beginning slip and cut operations, a Pre Job Safety Meeting should be held for the crewmembers involved in the slip and cut operation. The Slip and Cut JSA should be reviewed during the Pre Job Safety Meeting.

• Procedures should be developed to restrict access to the rig floor when overhead operations are being conducted.

• All employees should receive Fall Protection Training and appropriate fall protection equipment should be available.

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.