ALERT 02 – 24

TUBING TRANSFER RESULTS IN NEAR MISS

WHAT HAPPENED:

A crane was being used to transfer 3 joints of 2 7/8" tubing form one side of the rig to the other side. The individual doing the rigging left his hand between the load and the lifting sling that was wrapped around the joints of tubing. When the crane lifted the load, and the injured person still had his hand between the load and the sling, his fingers were squeezed between slings and joints of tubing.

WHAT CAUSED IT:

1. No pre-job safety meeting was held.
2. From the report we presume that there was no assigned person to give signal to crane operator.
3. Lack of communication between crane operator and IP.
4. Lack of alertness by the workers.

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

1. Pre-job safety meeting to be conducted with all crew members involved in the task and shall be documented.
2. Communication to be agreed upon.
3. Tag line to be used for all lifts.
4. Crane operator to ensure all personnel are clear from load before beginning to lift.
5. Supervisor shall exercise total observation techniques during the job.

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.