ALERT 04 – 13

CLEANING OPERATING EQUIPMENT RESULTS IN HAND INJURY

WHAT HAPPENED:
Employee was directed to clean the pump engines as part of his work assignment for the night. He wiped down the #2 pump engine without incident. #2 pump was not on the hole and the engine was shut off at the time. Employee then began cleaning the #1 pump engine while it was running. He was wiping the skid near the rear motor mount when he got too close to the rotating clutch assembly and cut the top of his hand and fingers. Employee stated that just before the accident, the rotating clutch had snagged his wiping rag and shredded it instantly when he got too close to it. He was going to write a ‘near miss’ about it as soon as he went to the doghouse, but continued working and a few minutes later got his hand too near the clutch again and injured his hand. Broken bone in middle finger and lacerations requiring stitches. Employee was released to light duty.

WHAT CAUSED IT:
- Lack of communication
- Employee failure to recognize hazardous condition and/or hazardous act
- Inadequate equipment safety guard

CORRECTIVE ACTIONS: To address this incident, this company did the following:
- Reinforce policy: “Pre-job meeting must be held before any critical task is started.” Driller and employee agree to switch pumps after notification so that the engine to be cleaned is shut down.
- Continue to train employees on Basic Risk Assessment through training, rig visits, and safety meetings. We must continue to ask these four questions:
  - What could go wrong?
  - How could it affect me/us?
  - What can I/we do about it?
  - Will my/our actions create other problems?
- Conduct rig audit to assess the condition and adequacy of all equipment guards.
- Continue to promote the Process Behavior Based Training and Observation program. Emphasize with all supervisors and employees the importance of intervention, and if necessary, suspension of work when tasks associated with the job place employees at risk.

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.