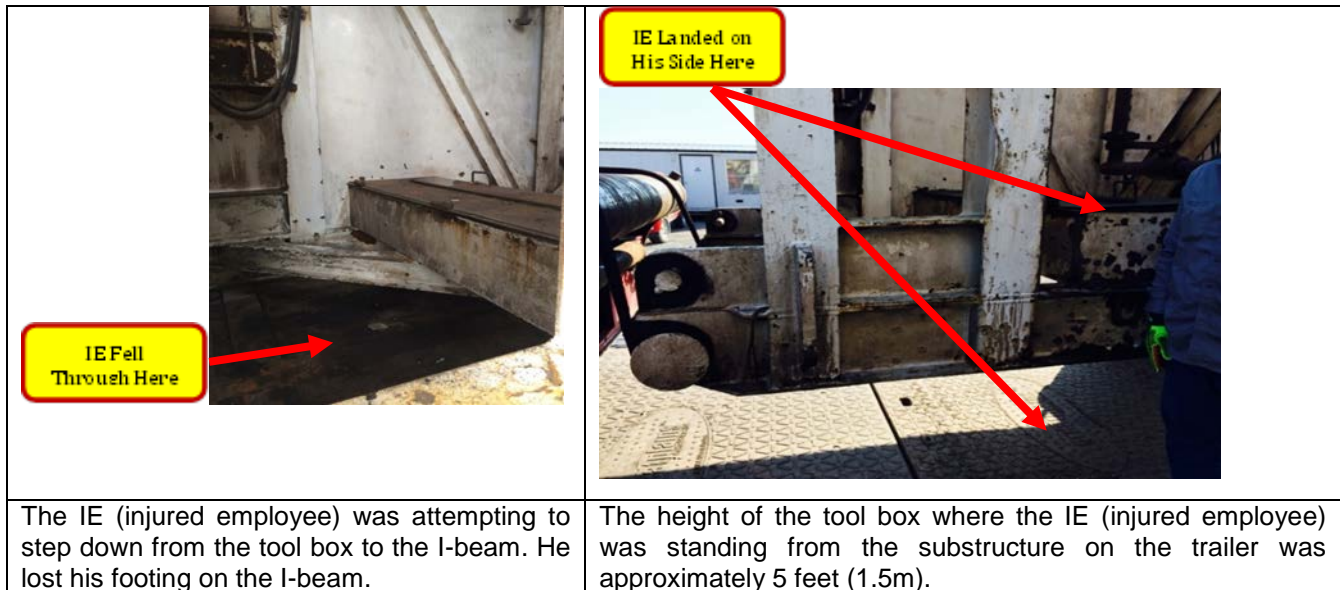


ALERT 14 – 28

FALL FROM EQUIPMENT ONTO A TRAILER RESULTS IN A LACERATION

WHAT HAPPENED:

Once loaded onto a trailer for transport to a new location, the “toe” extension on the Driller side substructure base was removed due to it extending too far off the trailer because the driver was concerned about maneuvering the load to the new location. With the extension secured, two employees climbed up inside of the substructure to remove the pins. After the extension was removed, the employees then climbed down. While descending, one employee slipped off of a tool box, which was fabricated into the substructure. He fell approximately 5 feet (1.5m) to the ground and landed on his right side. Shortly thereafter, he noticed a laceration in his arm pit that required sutures to close. It appears that the employee may have struck a keeper pin as he fell from the substructure.



WHAT CAUSED IT:

- The employee did not remain tied off as he descended the substructure and trailer.
- The “toe” extension had not been removed prior to it being loaded onto the trailer, and it was removed only after the driver expressed concern.
- JSA was not performed once a decision was made to remove the “toe” extension.
- A work basket was available, but it was not used to remove the pins.
- The Rig Manager (who was at the trailer and provided instruction) did not take a leadership role (he did not make sure that the above safety actions were implemented).

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

- Employees were reminded of the tie-off requirements when working at heights, which includes the determination of means for maintaining the tie offs when ascending and descending equipment.
- The Rig Manager was reminded to coordinate with the Truck Pusher and Truck Driver to determine if an extension should be removed prior to a load out (i.e., utilize a measuring tape to determine overall length).
- All crew members were reminded that a documented JSA must be performed for any critical, abnormal, or major change in an operation.
- Utilize the right tool for the job; the work basket should have been utilized to remove the pins.
- The Rig Manager was reminded that he must ensure that company expectations (JSA, SWA, tool / equipment selection, working at height) are discussed and implemented, especially for any critical, abnormal, or major change in an operation.

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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