ALERT 13 – 01

FALL FROM V-DOOR RESULTS IN NEAR MISS

WHAT HAPPENED:
The crew was in the process of preparing to lay down the directional tool. One crew member was running the hoist while the other was unchaining the snatch block from the handrail next to the V-door post. The crew member running the hoist was pulling slack from the lay-down line when it snagged on the substructure pulling the line tight and against the crew member standing next to the V-door post and the open V-door gate. The now tightened lay-down line pushed the crew member out of the open V-door and down the V-door slide where he hit the pipe stop and rolled onto the catwalk. The injured person sustained some minor swelling and discomfort to his back.

WHAT CAUSED IT:
• The V-door gate was opened prematurely which allowed the injured person to work from a height without the use of a guard rail in place.
• The injured person and the crew member running the hoist were not communicating properly during this procedure.
• The snatch block was hung from a handrail too close to the open V-door area.
• The crew became complacent and did not recognize the potential hazard in performing multiple tasks at the same time.

CORRECTIVE ACTIONS: To address this incident, this company did the following:
• Reviewed and/or updated all JSAs for this particular task and the information was shared amongst all rigs in the fleet.
• Reminded crew members that the V-door gate should never be open until you are ready to either lay something down or lift something to the rig floor. The crew members were also reminded to take one step at a time.
• Reminded all crew members to remain in constant communication during such a task.
• Informed all rigs that the snatch block should be hung below the V-door gate. This would allow the V-door gate to remain closed until they are ready to open it.
• The crew was reminded about the need to recognize the potential of all hazards while performing their job tasks.

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.