



Safety Alert

From the International Association of Drilling Contractors

ALERT 13 – 29

COMPLACENCY WITH A COMMON JOB TASK RESULTS IN INJURY TO THE DERRICKMAN

WHAT HAPPENED:

The morning tour crew had just arrived to work on the last day of their hitch and would begin their shift by continuing trip out operations that were commenced by the daylight crew.

The Driller was watching the Derrickman via a CCTV monitor. After verifying that the rope around the stand was secure and that the elevators were unlatched, he floated the top drive link tilt cylinders back towards well center and began slacking off the top drive to get another stand of pipe. The Driller then looked up towards the fingerboard to verify that the stand had cleared the top drive and, after noticing it had not cleared, he quickly released the brake control joystick to apply full air pressure to the draw works brake to stop the load. The box (top) end of the stand had hung up somewhere on the top drive between the pipe handler stabbing guide and the link tilt actuator. The downward travel of the load had stacked weight on top of the stand and had put a “bow” in the pipe.

It was discovered that the Derrickman’s rope had become lodged between the spring-loaded latch handle and the body of the elevators, which was the reason why the stand had not cleared the top drive. Rather than letting go of the rope and moving to a safe position, the Derrickman attempted to free the rope by “jerking” on it. Instantaneously, the stand came free from its lodged position underneath the top drive and the stored energy in the “bow” of the pipe immediately shot the stand out towards the fingerboard and directly into the off-driller’s side (ODS) alleyway, where it forcefully struck the Derrickman in the mid-section and drove him into the back handrails of the fingerboard. Due to the extent of his injury, the injured employee was transported to a medical facility.



WHAT CAUSED IT:

- The Driller failed to completely stop the traveling equipment after disengaging the clutch, which is common practice during tripping operations. He also failed to visually verify that the stand was clear from the elevators and top drive and secured by the Derrickman before slacking off to come down and latch the next stand.
- The Derrickman had positioned his pullback rope too high (too close to the elevators), which allowed the rope to get caught in the elevator latch mechanism which prevented the Derrickman from being able to clear the stand from the elevators.
- The Derrickman attempted to free the pullback rope hung up in the elevators rather than letting it go. Additionally, he was positioned in the direct path of the stand of drill pipe as it freed itself from the logged position and was thus struck by it.

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

- The Driller was reminded that he should come to a complete stop once the pulled stand is properly positioned at the fingerboard level. He should also visually verify and ensure that the stand is secured and the path of travel is clear of any other obstructions prior to lowering the traveling equipment.
- The company implemented a company-wide policy requiring Drillers to follow these steps. The policy will be communicated electronically via distribution of this report as well as a formal email to all Toolpushers. Follow-up, on-site verbal communication of the newly-established policy will be provided by our Drilling Superintendents.
- “Stop” stickers will be made, distributed and posted at the Driller location on all company rigs to provide a visual reminder.
- The company suggested a recommended practice for Derrickmen is to keep their pullback rope below the waist. This practice will be emphasized via distribution and review of this report and follow-up, on-site instruction will be provided by rig leadership and Drilling Superintendents.
- If a stand cannot be secured and cleared by the Derrickman for any reason, he should immediately release the pullback rope and move out of harm’s way by positioning both feet on the monkeyboard. This recommended practice will be emphasized via distribution and review of this report and follow-up, on-site instruction will be provided by our rig leadership and Drilling Superintendents.

“Reminder” stickers will be made, distributed and posted at the Fingerboard on all company rigs to provide a visual reminder.

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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