



Safety Alert

From the International Association of Drilling Contractors

ALERT 14 – 02

DROP OBJECT RESULTS IN LOST TIME INCIDENT

WHAT HAPPENED:

A drilling jar mandrel clamp weighing 26 Kg (57 lbs) dropped from a height of approximately 30 feet (9.14 meters) above the rotary table. On the way down, and at about 15 feet (4.5 meters) above the rig floor, it struck and bounced off of a derrick beam. As it continued falling, the mandrel struck a floorhand on his hardhat and left shoulder thus causing a laceration.

WHAT CAUSED IT:

- Inadequate verification and inspection of equipment before use – the jar clamp was left unfastened.
- Absence of an interlock or secondary safety protection on the jar clamp.
- Ineffective supervisory control over a critical job – no supervision to identify inadequate fastening of clamp.
- Inadequate Risk Management – the task risk assessment did not include this risk.
- Inadequate Training & Competency Assurance for people handling critical operations/ equipment.
- Lack of Communication – this is an industry known hazard.
- Inadequate Equipment Specification. (lighter, safer jar clamps are available).
- Poor operation & maintenance check – the bolts on the clamp had not been serviced.

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

- The company mandated that all rigs ensure all existing clamps be replaced with a safer design and specified in the contract with that the mandrel clamp shall include a safety interlock mechanism.
- The company reminded all rigs personnel to secure loose objects while operating on the derrick.
- The company revised their Task Risk Assessment (TRA) and Standard Operating Procedure (SOP) to include specific details on the handling of mandrel clamp assemblies.
- Rig Managers were tasked with ensuring that all the crew members are appropriately trained and competent to identify hazards and risk mitigation.
- The HSE Department was tasked with verifying competency assessments and assurance of all employees.
- The company initiated an HSE Audit with terms of reference on risk management practices.
- The company distributed a safety alert within the business units to promote learning from the incident and design improvements.

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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