

Oil Industry Safety Directorate

Safety Alert

E&P (Offshore)

No. 13/01

Title: Derrick Operation results in a Fatal Incident

Location: Rig Derrick Floor

Activity Type
(Result/outcome): Fatality

What happened:

The operation was pulling out of the hole and racking back drill pipe. After the slips had been set, and before spinning out the pipe, the iron-roughneck operator looked up at the monkey-board, and did not see either the IP or the tugger chain attached to the stand of pipe. He commenced to break the connection and back-out the stand. During this process the IP's left hand became trapped between the pull-back chain and the pipe. The pipe rotation was stopped. The IP was rescued from the monkey-board and given on-board medical attention. He subsequently passed away at the hospital.

What caused it:

- IP's competency was not ensured. The IP had not completed the "Derrickman On-The-Job Training".
- No direct communication had taken place between the Driller and the IP immediately prior to the incident.
- It was a common practice to place the chain on the tubular prior to it being backed out.
- Neither the crew nor the rig had a "Rescue from Heights" plan as part of their Job Risk Assessment.

Corrective actions:

- All personnel working as a Derrickman (or relieving a Derrickman), should have successfully completed the Derrickman On-The-Job Training program.
- All personnel manually racking tubulars (Derrickmen), shall be instructed to NEVER place their pull back ropes or air tugger chains on a tubular while it is spinning, or prior to it rotating.
- The Driller is responsible for communicating to the Derrickman (via the hands-free communication system), that it is clear for the Derrickman to place the rope or chain on the tubular - when it has been confirmed that rotation has been stopped, the iron roughneck or spinning wrench has been removed from the pipe, and the pin is lifted clear of the box.
- Length of a chain used for manually racking tubulars should be formally risk assessed, to ensure that it does not create a potential hazard (either too long or too short).
- All Job Risk Assessments involving manually racking tubulars should be reviewed to include the previous points.
- A plan for the rescue of personnel at elevated levels should be included in the relevant Job Risk Assessment.

It is provided for information purpose. This information should be evaluated to determine if it is applicable in your operations, to avoid reoccurrence of such incidents.