

**SAFETY ALERT**

E&P (Onland)

No. 14/08

Title: *Fatality during Surface Casing Lowering Operation*

Location: *Derrick Floor / Monkey Board Area*

Activity Type  
(Result/outcome): *Fatality*

***What Happened?***

20" surface casing lowering operation was being carried out. One Casing pipe single was picked up and stabbed into the box of the lowered casing string. The shift driller then noticed that one of the casing line of the hoisting system (Crown to Travelling Block) was entangled in the first finger of the Monkey Board. An unsuccessful attempt was made to release the same with the help of air winch. On getting instructions, the deceased climbed to the monkey board. During making effort to release the entangled casing line, he slipped & fell down from monkey board at the derrick floor. He was brought down and transported to the nearby hospital where he was declared brought dead.

***What Caused It?***

1. Casing line Entanglement

The Shift driller lifted the travelling block after latching the casing side door elevator to the casing pipe single, partially lying on inclined walk without monitoring the movement and position of the casing lines and tried to stab it in the box of lowered casing string. During lifting casing from inclined walk, the travelling block and casing lines have a normal tendency to tilt towards the monkey board side.

The "lock for isolating space between first finger main beam & diving board" and lock of first finger also were not in place. Due to this, one of the casing lines entered the first finger and entangled during picking up the casing pipe single.

2. Improper use of PPEs

After reaching the monkey board, the deceased may have tried to release the entangled casing line by pulling it with both the hands. During the process, since the entangled casing line was in tension due to weight of hanging casing single and travelling block, the deceased may have slipped due to sudden jerk during pulling the casing line with both the hands and fell down.

3. Improper Training

The person deployed to carry out the job at a height of 30m was neither trained nor properly briefed to carry out the job. Apparently, the risks associated with such jobs and precautions to be taken were not discussed properly.

***Corrective Actions:***

1. Only competent persons should be allowed for such specific jobs. Competency is to be enhanced by training, retracing and periodic assessments.
2. A pre-job check list is to be developed for each operation being carried out at the rig.
3. Job-safety analysis must be done for all jobs particularly when working at a height of 30m from ground.
4. The integrity of the fingers must be ensured; in this case finger locks were found missing.
5. Inexperienced persons should not be allowed to carry out such critical jobs at height.
6. Use of PPEs shall be confirmed prior to each operation being carried out at the drilling as well as work-over rigs.
7. All jobs must be carried out under strict supervision and monitoring.

*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.*