



Safety Alert

From the International Association of Drilling Contractors

ALERT 09 – 26

LIFTING OPERATION RESULTS IN ARM INJURY (LTI)

WHAT HAPPENED:

After nipping up the BOP stack the crew was installing the flow line from the shale shaker. The assistant driller (IP) was standing above annular preventer trying to connect the flow line's dresser sleeve with the bell nipple. He was holding the dresser sleeve with his left arm. The flow line was being lifted by the carrier hydraulic hoist, which created a blind lift. When he requested that the flow line be lowered a little, the night pusher ordered a new floor man to operate the carrier's hydraulic hoist instead of asking the driller to operate it. The new floor man operated the hydraulic hoist excessively upwards, which squeezed the assistant driller's left arm between the dresser sleeve and the beam located above the sleeve, causing a compound fracture to his arm.

WHAT CAUSED IT:

1. Using carrier hydraulic hoist to lift the flow line instead of using the crane.
2. The injured person was in an improper working position and there was a failure to identify job hazards (JSA).
3. The company's "Hoist 3" men operation system was not implemented and/or discussed (Quality of Pre-Job Safety Meeting).
4. Inadequate leadership as new and/or untrained person was assigned to operate the hoist.
5. JSA for the job was not adequate.

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

1. Instructed the rig crew to use a crane when lifting the flow line instead of using the carrier's hydraulic hoist.
2. Implement the company's "Hoist 3" men operation system when using air hoist and/or man riding.
3. Supervisors were instructed to assign duties based on competency.
4. Rig crews and rig supervisors were instructed to initiate (develop) a correct SJA (JSA) to cover nipple up, nipple down BOP and install flow line. This new SJA (JSA) is to be communicated with all drilling crews.



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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