



Safety Alert

From the International Association of Drilling Contractors

ALERT 12 – 31

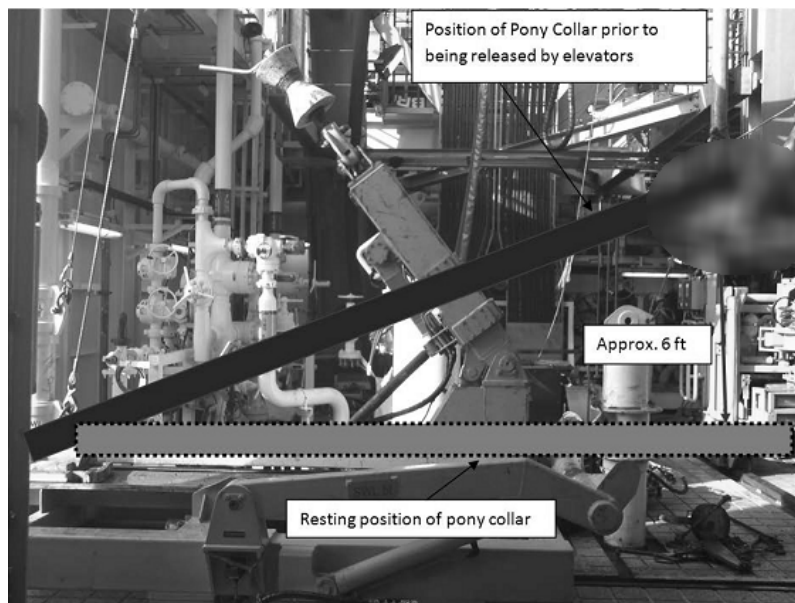
HIGH POTENTIAL - DROPPED PONY COLLAR

WHAT HAPPENED:

While laying down an approximately 16 foot x 10 inch (4.8m x 25cm) pony collar, weighing approximately 3400 pounds (1.5mt), the 500 ton (454mt) center-latch elevators opened inadvertently. The pony collar fell 6 feet (2m) and came to rest on the pipe skate. In the process of falling, the lift cap struck the stump, but there was no visible damage to the remaining BHA. No personnel were in the area.

WHAT CAUSED IT:

- Defective and inadequate equipment: While being operated in accordance with the 2009 manual, the center-latch elevator failed and resulted in the dropped pony collar.
- Inadequate information/data: The 2009 version of the Manufacturer's Operator Manual was used as the reference manual. As far as the company and the drilling crew knew, the 2009 version WAS the latest version, but after the incident occurred the company found out from the Manufacturer/Equipment Provider there was a 2012 version. In the 2012 Operator Manual, which had not been sent by the Equipment Provider to the company, the use of the center-latch elevators is not allowed for this type of lift or lay down; instead, rotating elevators are required.
- Inadequate engineering/manufacturing: Design of the center-latch elevator is not compatible with laying down a pony collar.
- Inadequate maintenance of standards/procedures/work instructions: Unavailability onsite of the inserts for the rotating elevators led the crew to use the center-latch elevators as a substitute, which was noted as an acceptable substitution in the 2009 Operator Manual. It is not an acceptable substitution in the 2012 version.
- Inadequate communication: The process for communication of updated manufacturers' technical documents and manuals was not well defined.



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

- The company has decided to maintain sufficient spares of inserts onboard all rigs in the fleet to allow the use of rotating elevators at both rotary centers.
- The company has decided to review and update the process, as necessary, for ensuring that current revisions of Operator/Technical Manuals are received onboard.
- The company will utilize cascade/share the learning points from this incident with other company vessels.
- The company will ensure that a clause is inserted in the Terms and Conditions of agreements with Equipment Providers that requires them to provide documentation updates, product bulletins, etc. as they are released.

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