



Safety Alert

From the International Association of Drilling Contractors

ALERT 04 – 10

USE OF ROPE FOR ELEVATOR HOBBLE RESULTS IN LTI

WHAT HAPPENED:

Rig crew was pulling the drilling string out of the hole to prepare for final logging in the well. First stand of drill pipe had been pulled out and racked back. The elevators were lowered and latched onto second stand, crew had checked that elevators were closed correctly, but as the driller lifted the stand approximately 1.5 meters (5 feet) the elevators suddenly opened, and the drill string fell into the hole. The roughneck who had been pulling slips, was moving back from the rotary table when the force of the elevators opening caused them to hit the roughneck. The left horn of the elevator struck on the right side of his head behind the ear region. This force of the impact pushed him, causing him to land approximately 1.5 meters (5 feet) from the rotary table and the point he was standing when struck. Operations were halted, IP (Injured Person) assisted onto stretcher and transferred to nearby medical clinic. An assessment was made and he was medivaced to the nearest hospital. The IP was released from the hospital ten days later.



WHAT CAUSED IT:

A contributing factor could have been the piece of rope used as a hobble prevented the latch on the elevators from closing completely. The rope was tied around the right hand horn (section closest to elevator body) of the elevators. The elevators have been tested and proven to be fault free. Following investigation and checking of equipment, talking to crewmembers and verifying the checking of latch being closed, it was concluded that the rope could have inadvertently contributed towards this incident. Drilling practices and policy state, while POOH hobble is not normally used, even if used in this instance use of correct hobble would have eliminated the possibility of replacing rope jamming" latch.

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

- All crews notified about nature and potential consequences of the incident.
- Rope to be removed from elevators, hobble acquired for use in future operations, but only if policy states hobble is going to be used.
- Continue to conduct safety meetings prior to all such operations. Encourage crewmembers to conduct Step Back 5X5 work place Safety Meetings.
- Use of JSAs to state that crews to check prior to such operations. First if hobble is required during running of drill pipe.
- Secondly, if hobble is required, correct equipment is used and checked for condition prior use.
- Correct Policy and Procedures to be followed during all Operations.



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.

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