



# Safety Alert

From the International Association of Drilling Contractors

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ALERT 13 – 27

## PIPE DROPPED FROM SIDE DOOR ELEVATOR

### WHAT HAPPENED:

While pulling and laying down 4 1/2" (11cm) tubulars, a crew member closed and secured the elevators with the verification pin and the Driller hoisted the tubing up to the next connection to be broken. Once the connection was landed in the slips, the tongs were engaged and the connection was backed out. A crew member grabbed the tubing and began to guide it to the lay-down machine. He was in the process of asking the Driller to hoist the tubing up when it fell down to the stabbing mat and came to rest against the rig floor. The rig crew members observed that the elevator was open with the verification pin still in the hole in which it had been placed.



### WHAT CAUSED IT:

- Workers were able to install the verification pin even though the elevator was not fully latched.
- The latch on the elevator was either not fully engaged prior to hoisting the tubing or it came open under load during the hoisting operation.
- A non-OEM modification had been previously made to the elevator.

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

- Company management reminded all employees that operating manuals for equipment are available. Supplier provided training is also available and should be utilized to increase crew member awareness when operating manual elevators that they are properly latched and secure prior to hoisting.
- The company agreed to prepare safety alerts to communicate this incident with all parties involved on a global basis.
- The company required all rig managers to review all side door and single joint elevators in their inventory for proper installation and functioning of the safety latch verification pin.

**Note:** Reference IADC Safety Alerts 09-15, 08-41, 06-06, and 04-28 for additional information.

Credit to: Enform – Safety Alert: # 04-2013

**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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Issued November 2013