

ALERT 04 – 19

INADEQUATE MANAGEMENT OF CHANGE RESULTS IN A FATALITY

WHAT HAPPENED?

An incident occurred when a 45-foot joint of 5-inch XL liner was being hoisted into the V-Door. The rig personnel were using a set of single joint elevators and the rig floor air hoist. The joint of liner came free from the latched elevators allowing it to slide down the V-Door towards the catwalk. The joint of casing then bounced and given the high center of gravity the box end “rocked” towards the rig floor where it struck the derrickman on the side of the head, resulting in a fatal blow.

WHAT CAUSED IT?

The Well Program kept changing, which resulted in an ineffective Management of Change (MOC) process and there was failure by both the client and the contractor to effectively plan for these changes. Because of the ineffective MOC there was failure to check technical specifications for equipment required for this job. The operator was responsible for supplying all running tools up to 7” but when the tools and the third party casing crew arrived at the rig site it was noted that there was no 5” single joint pick up elevators supplied. Although this was the first occasion that this type of casing had been run by the rig the decision was taken jointly by the Drilling Foreman and the Company Man to utilize the Rig’s own elevators. This decision was not communicated from the rig site to the Office based operations management. The rig’s elevators were dressed with inserts for 5” drill pipe and no consideration was given to the comparative taper difference between drill pipe and the casing to be run other than the elevators being tested on the casing by latching and unlatching them.

There was no discussion of, nor reference to, determining actual engineering specifications of compatibility between the casing and the elevators to be used. The investigation identified other areas of non compliance such as a failure to comply with the Company’s Task Risk Mitigation process, inadequate Job Risk Assessment and less than full participation in the Company’s Vocational Training Modules.

RECOMMENDATIONS

- Closer monitoring of Company Training compliance at the rig site
- A more thorough Job Risk Assessment of the planned task.
- Compliance with the established Management of Change process

The Corrective Actions stated in this alert are one company’s attempts to address the incident.

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.