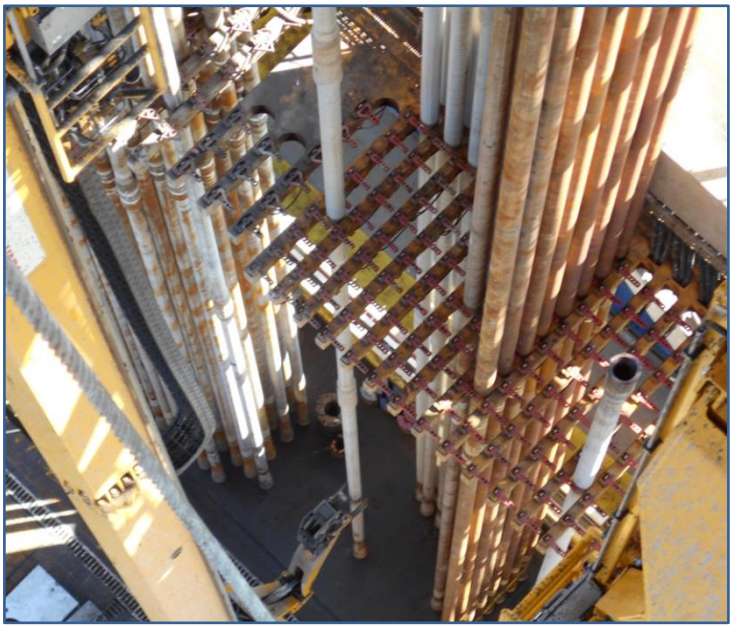
SAFETY BULLETIN

Safety Bulletin No. 002
March 3, 2017

Contact: Michael Idziorek
Phone: 202-208-4858
Email: Michael.Idziorek@bsee.gov

Fatality During Pipe Handling

An incident resulting in a single fatality occurred onboard a drillship in the Gulf of Mexico during pipe-handling operations. A floor hand, standing in the setback area, died when he was struck in the head by the bottom end of a 6⅝-inch drill pipe as it was being moved from its storage location to the main drill center.



The drill crew was in the process of tripping drill pipe in the hole. The victim had been assigned to spot for the assistant driller who operated the main pipe racker from inside the drill shack. The victim was responsible for visually verifying that the latches on the lower and upper fingerboards were in the open position prior to the retracting of the racker arms. The victim who was not in the direct line of sight of the assistant driller would verbally convey the position of the latches (open or closed) via hand-held radio. In addition to spotting, the victim had also been tasked with keeping the setback area clean, applying thread lubricant to the stands and re-numbering the stands with a paint stick.

The victim was newly promoted from roustabout to floor hand. The day of the incident was the victim's first day in the new position.

After the victim reported that the latches were in an open position, the assistant driller began the process of removing a drill pipe stand with the main pipe racker. However, as the pipe racker arms retracted, the stand was obstructed by a closed latch on the lower fingerboard. The stand of pipe began to bow as it was pulled against the closed fingerboard latch. The victim was standing in the setback area. The stored energy from the stand being bowed was released and it recoiled toward the setback area striking the victim. From the start of the sequence to the time the victim was struck, six to eight seconds had passed.

The BSEE panel investigation concluded that this fatality was the direct result of the finger board latch not opening properly and the victim being in the setback area when the stand being held under tension released. Multiple tasks were assigned to the victim that required that he enter the setback area. His inexperience and lack of consistent training about when it was permissible to enter the setback area may have contributed to the victim's decision to step into the setback area when he did.

Therefore, BSEE recommends that companies operating on the U.S. Outer Continental Shelf:

- Evaluate all tasks included in an operation when making work assignments and evaluate how each planned task relates to the others.

- Review Short Service Employee programs to orient personnel new to a position.

- Review on-the-job training programs. Consider formalizing the programs to provide continuity between those conducting the training and the content of the training.

- When using a spotter to verify the position of finger board latches, review where that task can be safely performed. Consideration should be given to the spotter's proximity to the moving pipe stands. No tasks should be assigned to a spotter that places the spotter in setback areas during pipe handling operations.

A **Safety Bulletin** is a tool used by BSEE to share the lessons learned from an incident or a near miss. It also contains recommendations that should help prevent the recurrence of such an incident on the Outer Continental Shelf.