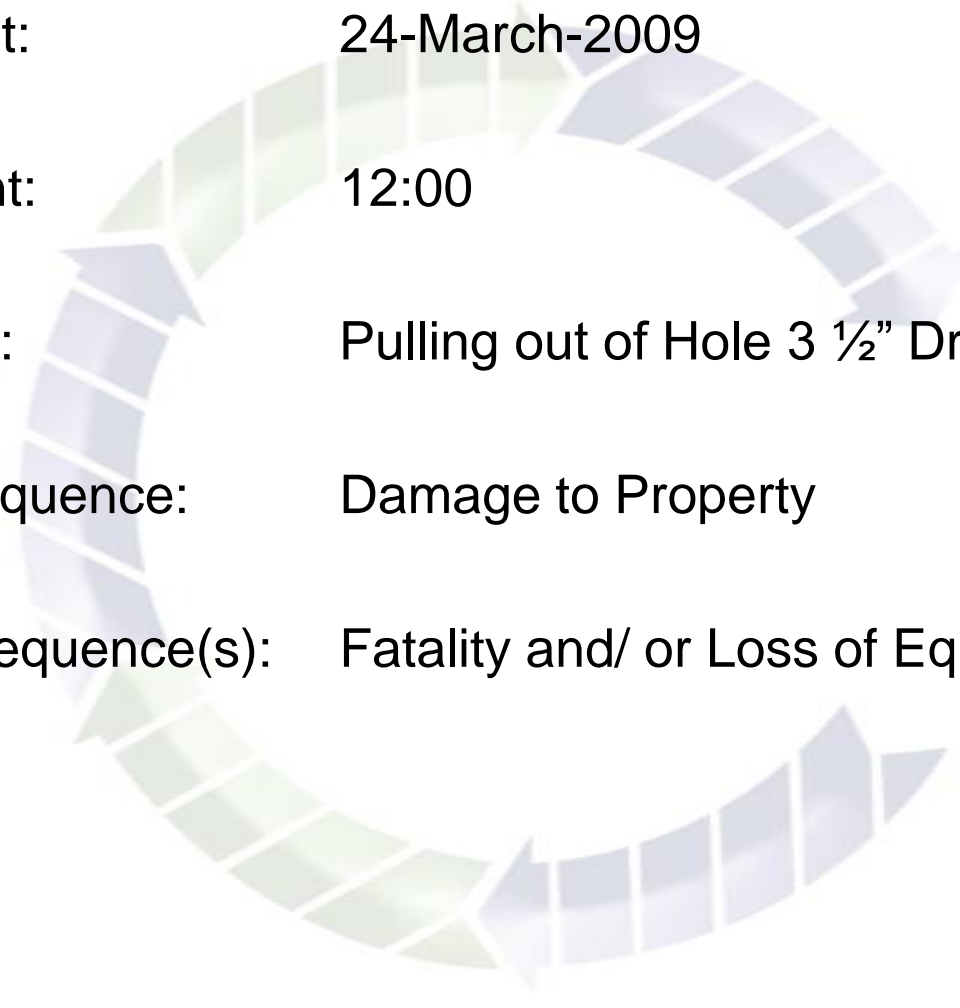


# GDI-4

## TRAVELLING BLOCK HOOK INCIDENT



# INCIDENT BASIC DETAILS

- 
- Date of Incident: 24-March-2009
  - Time of Incident: 12:00
  - Rig Operations: Pulling out of Hole 3 ½” Drill Pipes
  - Incident Consequence: Damage to Property
  - Potential Consequence(s): Fatality and/ or Loss of Equipment

# INCIDENT DESCRIPTION

- The rig was pulling 3 ½” Drill pipes out of hole and racking in the derrick.
- After racking back ten (10) stands in the derrick, driller lowered the travelling block down with the elevator at about 4ft above rotary table and suspended it.
- The Driller applied parking brake which had no anti-release latch/ lock but failed to engage the main brake that had anti-release latch (lock).
- The Driller then asked all floor men to tidy up the rig floor in preparations for crew change while himself and Asst Driller started writing their handover notes inside the drillers’ cabin.

# INCIDENT DESCRIPTION

- The parking brake got disengaged accidentally and the travelling block slowly descended until elevator hit the rotary table.
- The travelling block hook was deflected by a Derrick beam and hit the roof of the Drillers' cabin. [O](#)
- Driller immediately applied the main brake on hearing the impact of the travelling block hook on the roof of drillers' cabin.
- Investigation revealed that there was a time lag of about 39 sec between when elevator hit rotary table and when traveling block hook hit the roof of drillers' cabin.

# CAUSES

## Immediate Causes:

- Human Error: Driller failed to engage and secure main brake.
- Parking brake got disengaged accidentally due to lack of anti-release latch (lock) system.

## Root Causes:

- Poor work practice
- Design deficiency – No anti-release latch (lock) for the parking brake.
- No functional Floor 'O' Matic system. [O](#)

# CORRECTIVE ACTIONS

- Anti release latch/ lock now installed for the parking brake.
- Specific written instructions for suspending travelling block was formulated and posted inside the drillers' cabin.
- HSE flash issued to all rigs in company's fleet and discussed at crews HSE meetings.
- GDI will consider the possibility of reinstalling the Floor 'O' Matic system in GDI-4 and confirm status of same on all rigs in company's fleet.
- Tool Pusher / NTP shall be at rig floor and drillers shall overlap for about 10 - 15 min during crew change.
- Inspection was conducted on Drill line and other associated equipments.

# LESSONS LEARNED

- Basic safety features should be maintained in good functional state as per manufacturers' recommendations.



# CONCLUSION



Thanks for your kind audience

# INCIDENT BASIC DETAILS

- 
- Date of Incident: 06-March-2009
  - Time of Incident: 13:15
  - Rig Operations: Rigging Up Wireline Equipments
  - Incident Consequence: Lost Time Injury
  - Potential Consequence(s): Permanent Disability

# INCIDENT DESCRIPTION

- Wireline crew were removing pressure lubricator of about 20ft length and approximately 500kg from the wireline truck with GDI crane.
- Wireline crew decided to sling the pressure lubricator at the middle with a lifting single sling by chocker hitch.
- Crane operator was in a blind spot to load as the crane was positioned at the other side of the wireline truck.
- Injured party was controlling load with his left hand at one end instead of using a tag line.
- As the load was lifted off the brackets, IP attempted to prevent it from swinging and in the process his left middle finger was pinched against the truck's body as result of which he suffered superficial amputation.



Approximately 20ft

Position were IP's left middle finger was pinched against truck's body

Chocker hitch slinging with a single sling

# CAUSES

## Immediate Causes:

- Improper body/ hand position.
- Deviation from lifting procedures.

## Root Causes:

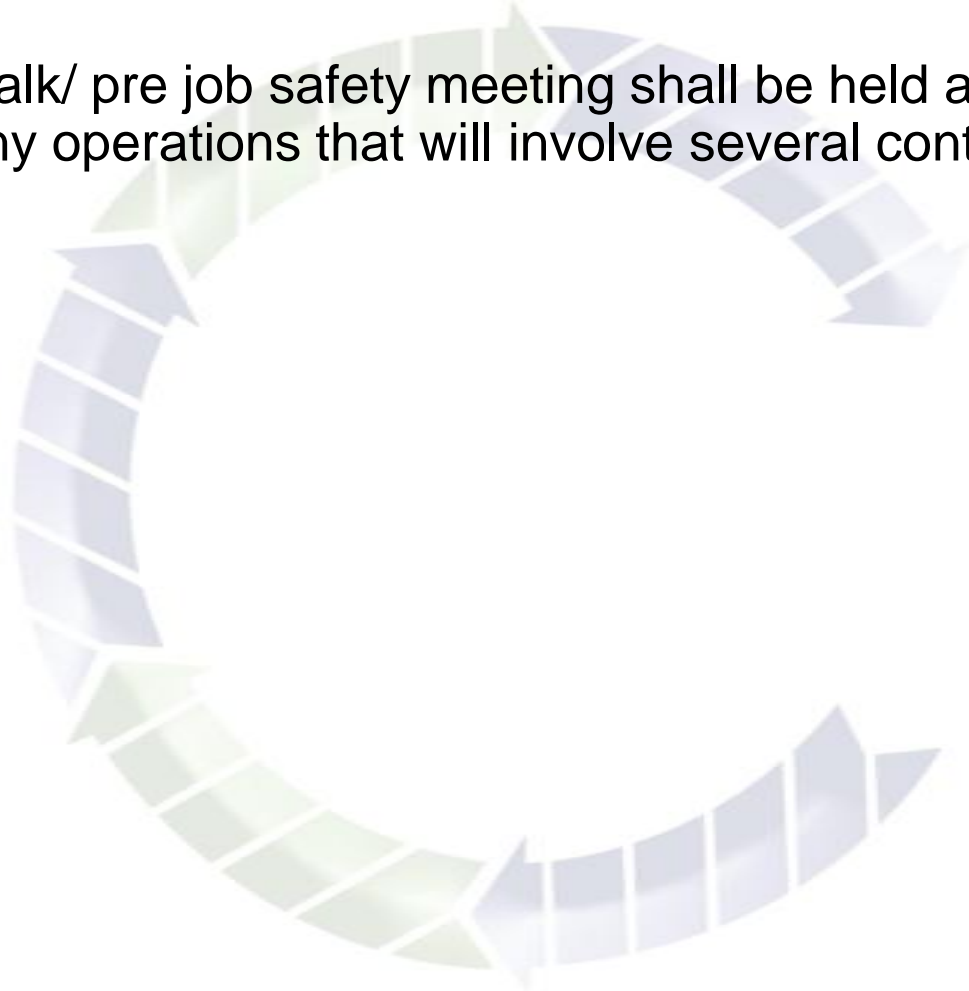
- Inadequate JSA.
- Poor pre-job planning.
- Lack of training (Rigging and Slings).
- Failure to identify the hazards.
- Tag lines not used.
- Using single sling instead of two
- Simultaneous crane operations

# CORRECTIVE ACTIONS

- Train and certify crews on Safe Rigging/ Slings operations.
- Review / revise Lifting procedures and Job Safety Analysis to address use of tag lines and safe slinging.
- QP and all SOS crews had a workshop with practical demonstrations on safe slinging and lifting operations with emphasis on the same tool.
- All simultaneous operations shall be discussed, risk assessed and approved by key personnel on the rig prior to commencement.

# LESSONS LEARNED

- A joint Toolbox talk/ pre job safety meeting shall be held and attended by all concerned for any operations that will involve several contractors.

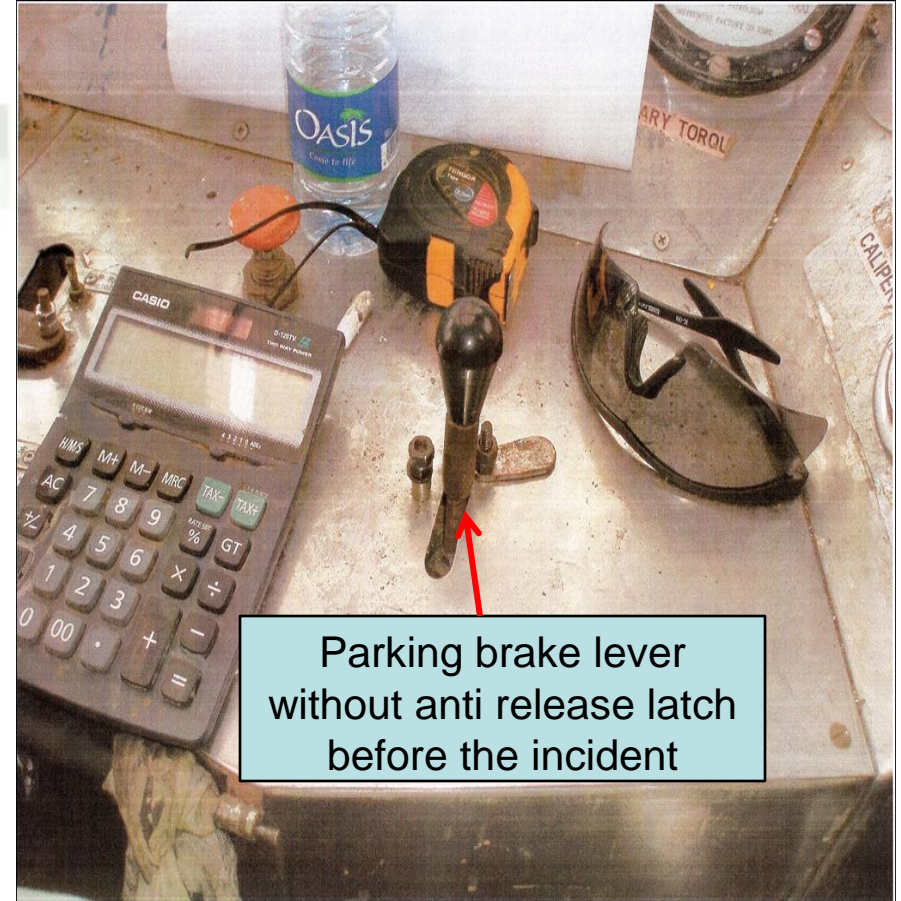
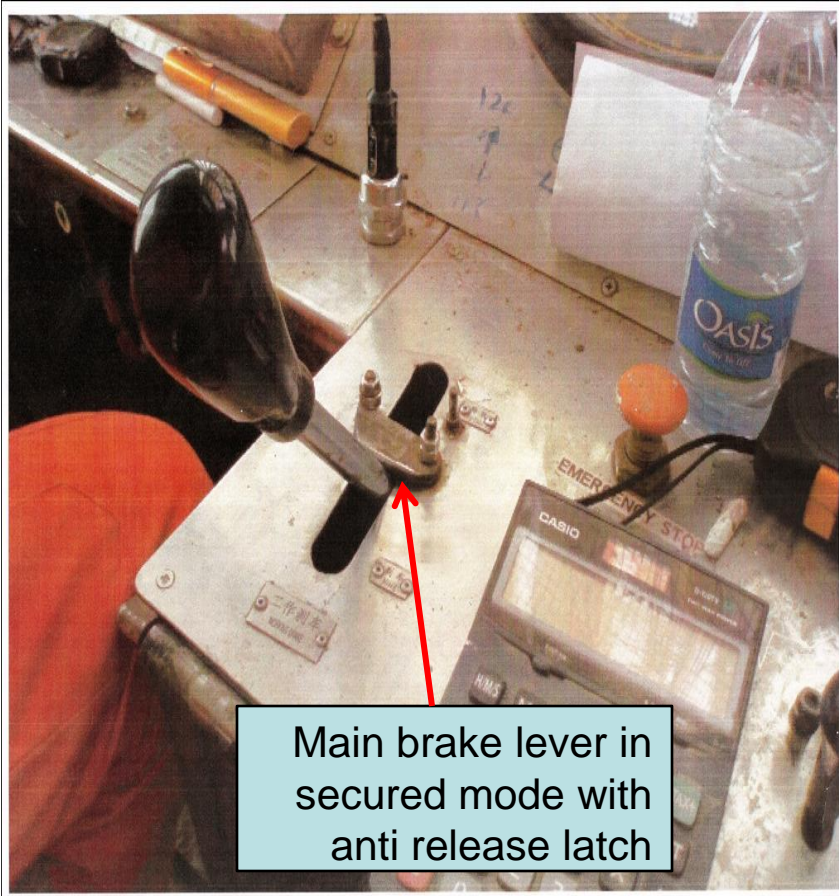


# CONCLUSION



Thanks for your audience.

# PICTURES OF BRAKES LEVERS



# PICTURE OF INCIDENT

