

# Al Doha Fatality Incident

Date of Incident: 09-January-2010

Classification: Fatality

Rig/ Location: Al Doha

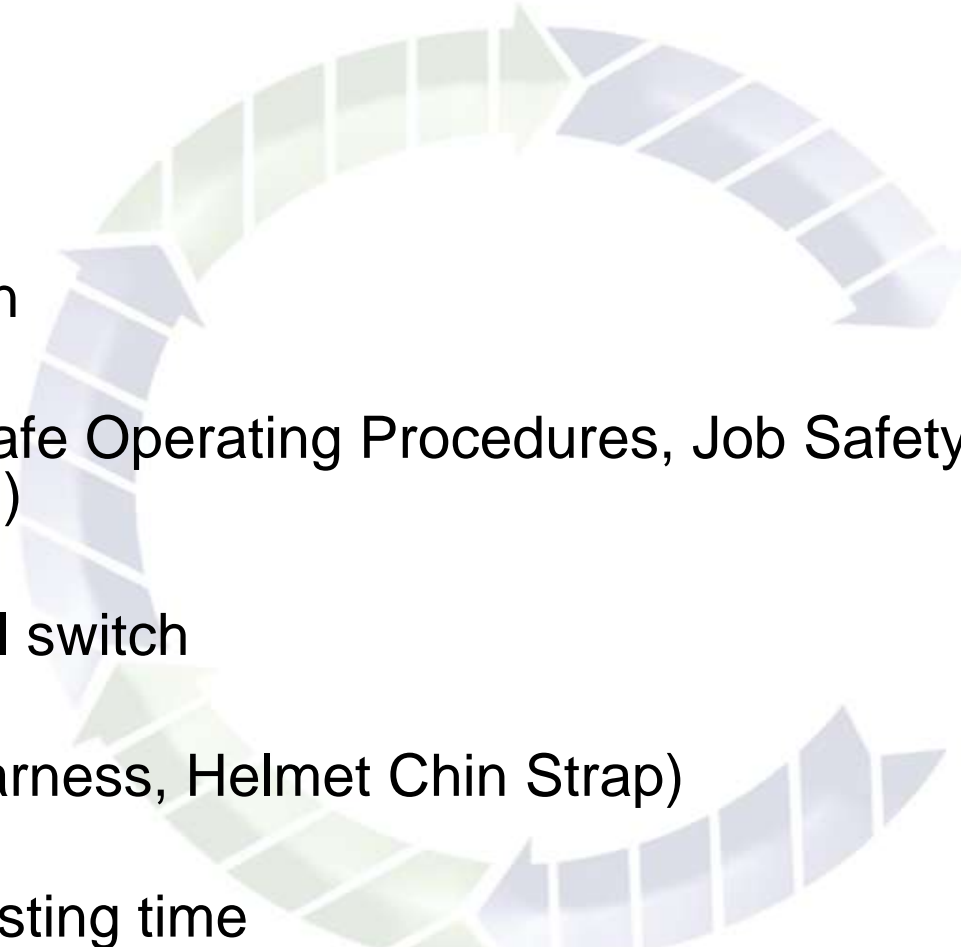
Incident Description:

The rig was to pull three stands of 5” DPs out of hole after displacement and rack back in the derrick. The floorman (deceased) was assigned by the Toolpusher to carry out derrickman’s job since none of the three qualified derrickmen on shift was available. (Two on dinner break and the third in pump room).

After unlatching the first stand of DP from the elevator and pulling with remote controlled electric winch, driller started to lower top drive system. There was a sudden slack of the winch wire allowing the DP to move back into the path of the descending Top Drive System and made contact with it. Energy was transferred causing the DP to deflect which created tension on the winch wire. IP was hit by either the pipe and the winch wire or only the wire.

# Incident Timeline

- 18:40hrs – IP got the approval of TP to go to monkey board and rack back pipes in the derrick where the incident happened.
- 18:45hrs – IP was hit at the monkey board and AD immediately went up to assess the condition where he found him in crouched position.
- 18:50hrs – IP was brought down to the rig floor in a basket where he was attended to by rig doctor and then transferred to clinic.
- IP was conscious and there were no significant external injuries on his body.
- 20:45hrs – IP's condition suddenly started to show signs of deterioration after being stable during the two hours of continuous monitoring
- 21:10hrs – Medivac was initiated.
- 21:30hrs – Doctor declared IP dead.
- 23:15hrs – Medivac helicopter arrived at rig and conveyed the corpse to Hamad hospital.

- 
- Competence
  - Line of sight
  - Communication
  - Procedures (Safe Operating Procedures, Job Safety Analysis, Prejob Safety Meeting)
  - Remote control switch
  - PPE (Chest Harness, Helmet Chin Strap)
  - Medivac requesting time

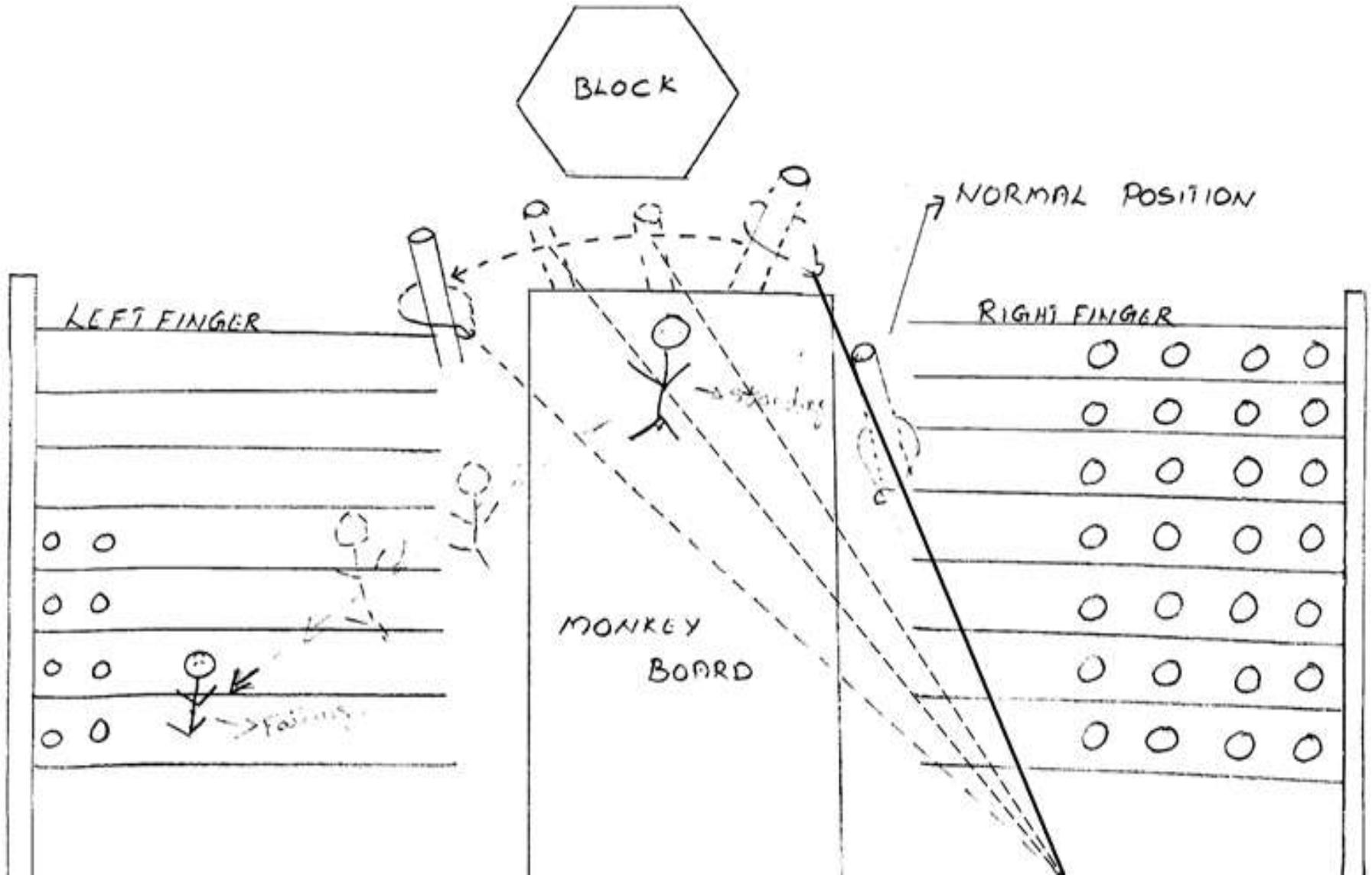
# Immediate Actions Taken

- Work was immediately suspended and safety meeting was conveyed on the rig involved and subsequently on other rigs in company fleet.
- A joint investigation was carried out by representatives of QP and GDI management.
- A memo was issued by management to all rigs to ensure that crews are not assigned to carry out tasks outside their job descriptions unless considered competent to do so and with the documented approval of the Rig Supt.
- All Drillers were instructed to maintain clear line of sight with derrickmen in addition to the display monitor and ensure that there are no obstructions in the path of TDS prior to descending/ ascending.
- Drillers and derrickmen were instructed to ensure two way communication at all time and to include communication procedures in toolbox talks.
- Standing instructions were issued to rig medics to immediately activate medivac for any impact on head, chest or abdomen in addition to other emergency needs.


## Main Recommendations/ Correction Actions

- A formal procedure for on-the-job training and competency assessment for rig crews is being developed for implementation.
- Video recording systems to be installed for monkey board operations.
- To consider replacing existing remote control switches for winches with distinguishing buttons type to reduce the chances of error.
- Use of hands free talk back device for derrick operations to enhance communications with drillers.
- Revise Safe Operating Procedures and JSA to adequately address all potential hazards in monkey board operations.
- Issue and cascade HSE Alert with lateral learning.

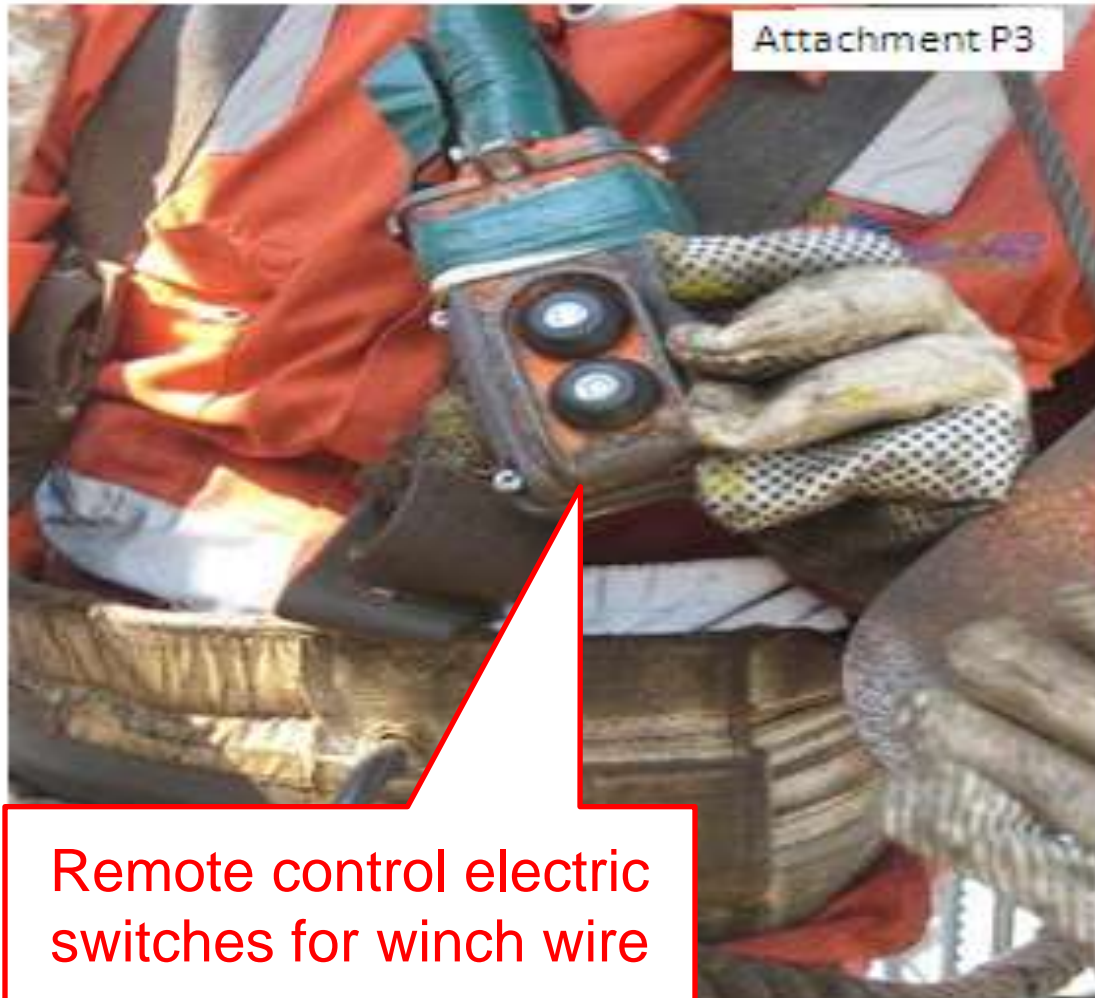
# Schematic sequence of Incident



Attachment P4



IP's was found in a crouched position after the incident





Hands free talk back  
communication system



**THANK YOU**