



# Safety Alert

From the International Association of Drilling Contractors

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ALERT 03 – 46

## PROPER JOB PLANNING AND REVIEW

### WHAT HAPPENED:

The company had several incidents recently where the root cause was determined to be a failure in the job planning process or failure to recognize that the job steps had changed and no action was taken to revise the J.S.A.

### WHAT CAUSED IT:

**J.S.A covered changing out the BOP rams:** The employees had loosened the bonnet bolts while the stack was sitting on the stump. The stack was removed from the stump and moved by the trolley over to the wellhead and stabbed. The third party employees had started to tighten the BOP bolts as the company's employees continued to work on the bonnets. A 1-½ ton come-along was used to pull the stack over so that the bonnets could be opened without hitting the BOP stack.

1. The step of using the 1-½ ton come-along was not mentioned in the J.S.A. and risks not analyzed.
2. The come-along slipped and an employee was pinned in between the BOPs and the rig tank.

**J.S.A. covered changing out pump swab rod assembly:** The employees had covered the steps in the J.S.A. and had begun the job. None of the persons involved in the job realized that a step in the J.S.A. was a complete violation of company's Policy on lock out and tag out.

- One of the steps in the J.S.A. required the employees to remove the pump from its locked out status and to activate it from a remote location and use the power of the traction motor to push the swab out.
- When the pump was activated a piece of the Pony rod chipped off of the hub and struck an employee above the right eye requiring 11 stitches.

**CORRECTIVE ACTIONS:** To address this incident, this company instructed rig personnel:

- It is ultimately the responsibility of the employees and the supervisor to critique the steps of any job before it is undertaken.
- It is everyone's responsibility to IDENTIFY HAZARDS and shut down a job when the job scope changes.
- Every employee must take the initiative to protect himself and others when he recognizes a hazard.

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**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.**



# Safety Alert

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ALERT 03 – 45

## FILLING CASING WITH HIGH PRESSURE MUD PUMP RESULTS IN A LOST TIME INCIDENT

### WHAT HAPPENED:

The rig was in the process of running casing. While filling the casing with mud, a floorman closed the fill line valve when the casing was full. When he closed the valve, the pressure build up in the line surpassed the working pressure of the valve causing line failure. The floorman was struck with debris and required medical attention. The result was a Lost Time Incident.

### WHAT CAUSED IT:

The investigation showed that the rig was using its high-pressure mud pump to fill casing. The fill line components did not meet the pressure requirements of the high-pressure mud pump.

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

- Directed the Rig Managers to ensure that the only centrifugal mud pumps are directly connected to the casing fill line on all of the company rigs.
- Instructed rig personnel to use a ball type valve with a 90-degree filling extension on the end of the fill line.
- Instructed rig personnel that casing fill line should not allow for main mud pumps to be used to fill casing.
- Instructed rig personnel that only in an emergency situation should the main mud pumps be used to fill casing.
- Suggested that on rigs with Top Drives, the use of the Top Drive may eliminate this problem.

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