

## **FATAL ALERT**

**February 14, 2006**

A large oil well drilling company was in the process of doing some directional drilling. The rig had just been skidded some 25 feet to the next well drilling site. The rig crew had spudded the hole and had conducted some directional survey measurements. The crew made a new connection and started drilling again. The rig crew went off to do various tasks associated with typical work needing to be done after a rig move.

The individuals working on the drilling rig ranged in experience from one day to six years. A crewmember passing through the substructure observed the Motor Hand lying in the cellar. After trying to get the Motor Hand's attention and not getting a response, the crewmember went to alert the Driller of the injured worker in the cellar. Although it may never be known for sure, it appeared as though the Motor Hand was looking for tools or checking the rig for leaks when he chose to travel under the rig's drilling floor using a grated walk way.

The grated walking surface runs along both sides of the rig with a catwalk on the front and back side of the conductor pipe/mouse hole. The walking surface and catwalk did not have adequate guarding and posed a fall hazard of some sixteen feet to ground level and some twenty-five feet to the lower level of the cellar. All indications are the Motor Hand fell through the opening in the grated catwalk between the conductor pipe and mouse-hole pipe and landed in the cellar, suffering fatal injuries.

The demonstrated fall protection available but not being used included a double lanyard system that required the user to tie off to the frogs (structure support members) under the rig's drilling floor as they traveled on the walking surface. When the worker reached the catwalk area surrounding the conductor pipe and mouse hole itself, there were two large wire rope loops available for tie off. This method of tying off is not very practical and was not being used at the time of the accident.

All crewmembers interviewed indicated they understood the fall protection rules but felt there were grey areas, like the substructure's catwalks. They also stated they were not sure why the Motor Hand was not tied off or why he was in the area under the drilling floor. All crewmembers considered themselves safety conscious. The Motor Hand had been observed not wearing the required fall protection before and was verbally reprimanded for it. Coworkers characterized the Motor Hand as being clumsy at times.

### **Significant Factors:**

- The deceased was not using any form of fall protection at the time of the accident.
- The employer had not provided adequate fall protection for the area associated with the substructure of the drilling rig.
- The employer was not enforcing the Wyoming Oil and Gas OSHA rules relating to fall protection.
- Some employees indicated fall protection requirements associated with the walking/working surfaces in the substructure as described above were not very clear.

### **Recommendations:**

- Brief all employees on the facts and circumstances of this fatal mishap.
- Ensure all employees understand the Wyoming Oil and Gas OSHA rules.
- Enforce the Wyoming Oil and Gas OSHA rules and document all non-compliance.
- Document all training accomplished relating to fall protection.
- Reevaluate the fall hazards under the rig's drilling floor and substructure area.
- Implement a more practical method of fall protection for the substructure area.
- Some employees suggested a net system might be installed in the substructure area of the drilling rig.