



Dropped V-door - high potential event

Country: *USA - North America*

Location: *ONSHORE : Other onshore*

Incident Date: *8 October 2022 Time: ---*

Type of Activity: *Drilling, workover, well services*

Cause: *Dropped objects*

Function: *Drilling*

The rig contractor was rigging down from a well, and the logistics contractor was in the process of removing the V-door from the substructure. The lifting equipment was secured, with a tagline attached. Pins securing the V-door to the substructure were removed to allow lifting and removal of the V-door. As the load was being lifted, the crane reversed, and the load levelled. This created a bind in the load, causing one of the D-Rings to dislodge from the lifting hook. The V-door fell (approximately 3 metres) onto the drill line and managed pressure drilling line below.

All personnel were clear of the area at the time of the event, and no injuries were reported.

What went wrong?

Inadequate supervision:

- Supervisory personnel did not ensure crane inspection was conducted prior to the mechanical lift.
- Supervisory personnel did not ensure rigging equipment was adequate for the task.
- Onsite supervision failed to identify and properly manage onsite operational hazards and risks.

Violation of Procedures by Crew:

- Onsite personnel did not follow proper lifting best practices.

Inadequate Hazard Identification:

- Onsite personnel failed to identify and properly manage mechanical lifting risks.

Corrective actions and recommendations

1. Survey of Reiteration of Policy/Procedure Utilization: Management of the contractor reiterated to personnel the existing procedures for Crane lifting operations and confirm personnel understand how to apply these procedures.
2. Equipment Replacement: Contractor personnel replaced the latch on the lifting hook and implemented additional (4 leg chain sling) to avoid improper lifting angles caused by load levelling.
3. Post Incident Toolbox Talk and Sharing Lessons Learned: Shortly following the incident, onsite meeting was held with teams from both company and contractors. Event was discussed in detail

to fully understand causes, inadequacies, and where utilization of procedures and safe work practices need to be applied to prevent reoccurrence. Expectation of following established mechanical lifting procedures was re-emphasized.

4. Crane Inspection: Daily crane inspection conducted and documented prior to resuming operations.
5. Retraining Recommendation: Company requested contractor to conduct refresher training to its personnel in identifying, assessing, and mitigating hazards/risks as they apply to specific operations.

Figure 1: Lifting hook (open safety latch)

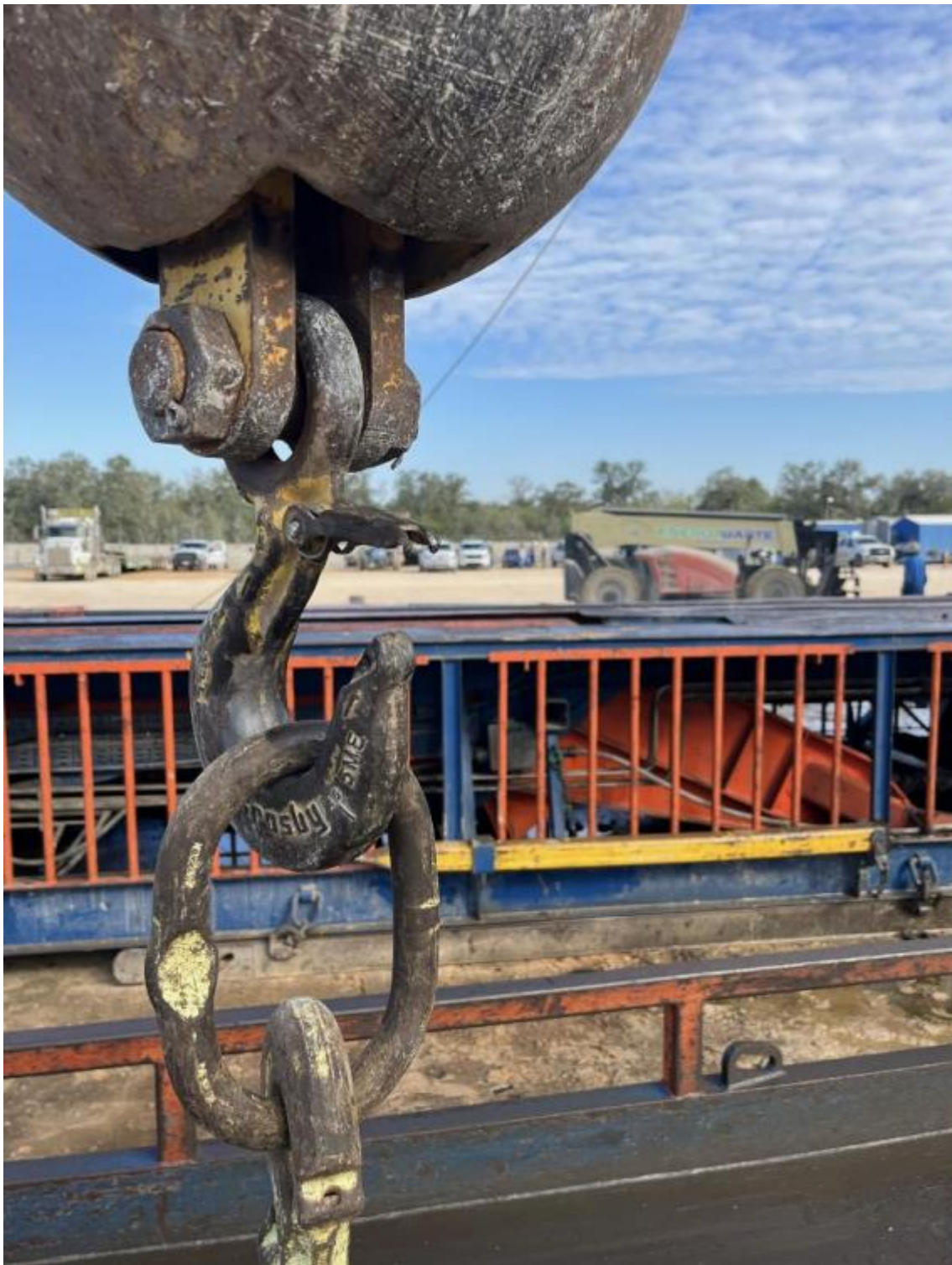


Figure 2: Improvised safety latch



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IOGP Headquarters

City Tower, 40 Basinghall St, London EC2V 5DE, United Kingdom
T: +44 (0)20 3763 9700
E: reception@iogp.org

IOGP Americas

T: +1 713 261 0411
E: reception-americas@iogp.org

IOGP Asia Pacific

T: +61 4 0910 7921
E: reception-asiapacific@iogp.org

IOGP Europe

T: +32 (0)2 790 7762
E: reception-europe@iogp.org

IOGP Middle East & Africa

T: +20 120 882 7784
E: reception-mea@iogp.org