# S-703 : Finger Injury incident

## INCIDENT PRESENTATION

**Restricted Work Case**

**"Hydraulic cutting tool failure – Finger injury"**

**(April 24th, 2008)**

**Presented by: Lindy Fullwood**



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## Operation : Drawworks drill line “ Slip and Cut”

Standard Procedure:

- Place hydraulic cutter on drawworks equalizer bar
- Thread the wire rope through the cutter blade
- Lock wire and commence cutting




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## Sequence of events that led to the injury

- IP ( Floorman -AS) performing second cut on the drill line
- Found that the exerted pressure on the handle was not adequate
- Driller (ML) assisted by applying additional force on the handle
- The operating handle suddenly came down trapping the IP's left hand between the cutter body and the operating handle




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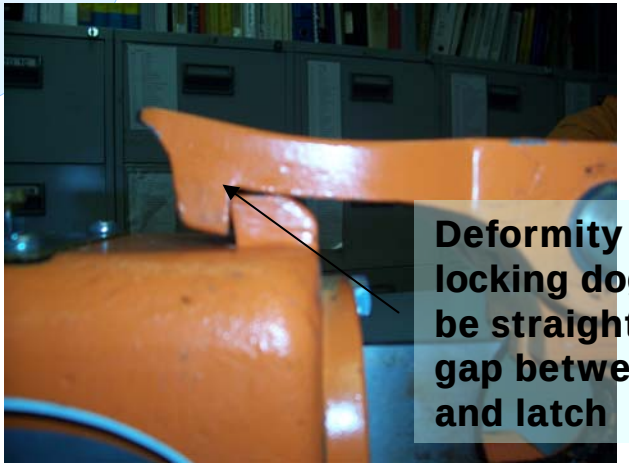
## What had happened ?

- The attempts that were made to cut the line to cut the line had caused the locking dog on the cutting tool to come loose resulting in a loss of hydraulic force
- A metal object was placed between the locking dog and the lock stop mechanism, which caused the dog to disengage under tension.
- Condition of the cutting blade was dull (worn out) after cutting the line the first time

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## Investigation results : Plans

| Details of the incident using the THINK Process | |
|---|---|
| Was there a plan? What was the Plan? | Yes plan was to perform Slip and Cut operations |
| Who Developed the plan? | Driller |
| Who was Informed about the Plan? | All the floor crew and Asst Driller |
| What equipment/ Material/Tool were inspected? | All the required equipment was checked, cutter was new |
| Who Conducted the Inspections? | Floorman - AS |
| What were the findings of the Inspections? | All equipment in good order to carry out the task |
| What Potential Hazards were identified before, during and after the incident occurred? | Debris off wire striking personnel during the cutting operation |
| Who Identified these potential hazards? | Floor Crew and Driller |
| Who was informed of the Potential Hazards? | All involved in the operation |
| What Control Measures were used to ensure the job was conducted safely (PPE, Guards, Barriers, warning, PTW, Isolation, supervision..) | Correct tools for the job used, cutting tool covered with hessian type material to prevent and retain any debris coming off the line during the cutting of the wire |
| Does the individual(s) involved consistently use the THINK Planning Process? | Yes |
| Does supervisor(s) involved consistently promote and use the THINK Planning Process? | Yes |



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## Investigation results : Immediate causes

- Cutter operated incorrectly resulting in the cutters components being damaged
- Poor quality of cutting blade
- Object placed behind locking dog and the lock stop
- Failure by crew to recognize that there was a problem and not stopping the job to investigate
- Incorrect hand placement



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## Investigation results : Corrective actions carried out

- Reviewed and updated TSTP for Slipping and Cutting Drill Line operation to cover tool inspection and operating procedure for wire cutting equipment as well as hazards related to incorrect hand placement whilst using this equipment

- Sourced alternative cutting tool with a Air over Hydraulic Cutter head to eliminate using this type of manual equipment. (Sedco 703 shared the specs of sourced tool to the Jack Bates)

- Discussed incident with Drill Crew during Safety Meetings, and utilize “Hand & Finger Injury awareness ” as Weekly Safety Themes



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ANY COMMENTS OR QUESTIONS??



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