SAFETY ALERT

OISD/SA/2026-27/E&P/02 **Date: 08.04.2026**

Title: Fatal Accident while stacking Drill Pipe
Location: Onshore Drilling Rig
Loss/ Outcome: One Fatality

INCIDENT

At drilling rig, laying down of 5" Drill pipe from rig floor to ground stack was going on with the help of truck mounted crane. The helper was attaching the drill pipe singles to the crane hook at the rig floor. The slinger was standing on the ground to detach the pipe and stack them. Suddenly sling got detached from the hook of crane and drill pipe fell on slinger (IP). Slinger received injury on his head. After first aid at drill site, he was shifted to medical hospital for treatment. During treatment, he succumbed to his injuries.

OBSERVATIONS

- The Helper, not a qualified Slinger, performed the rigging at rig floor and failed to secure the sling inside the crane hook.
- The crew used a crane for pipe lay-down, which was a direct violation of the approved company SOP that mandated the use of an air winch.
- The IP was standing on the ground directly below the suspended load.
- The IP was not wearing safety helmet at the time of the incident, as confirmed by CCTV footage.
- Bridging document defining the specific roles for the crane crew was not available at the site.
- There were similar near misses and minor incidents which had occurred in the recent past and recommendations have been issued to prevent recurrence of such incidents. Hence, it seems that the system of learning from previous similar incidents was inadequate.
- A formal Responsibility Matrix (RACI chart) was not available, creating an ambiguous system where no one had clear, documented accountability for safety compliance.
- The risk evaluation system failed to identify and correct the hazardous practice of using a crane for pipe handling.

ROOT CAUSE

- SOP violation (using a crane instead of air winch). Site supervision failed to enforce compliance with the written SOP.

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- A Helper was doing the safety critical task of a qualified Slinger, leading to inadequacy of skill for the task.
- The qualified Slinger was standing under the load without a helmet.
- The crew was in a hurry to finish the job before dinner, which possibly contributed to the helper not securing the sling properly.

RECOMMENDATIONS

- The approved Standard Operating Procedure (SOP) for pipe breaking and lay down must be strictly adhered.
- A formal Management of Change (MOC) process is to be considered mandatory for any deviation from an approved SOP.
- It must be strictly enforced that only a designated 'Slinger' performs rigging functions at all times.
- Crane service contracts are to be reviewed and revised to explicitly define the roles, responsibilities, and minimum qualifications for all crane crew members (Crane Operator, Slinger, Helper, Signalman) in accordance with OISD-RP-205.
- Lifesaving rules like wearing of PPE etc. must be followed by all personnel, including contractual employees.
- To ensure systemic failures are identified before they lead to accidents, a thorough analysis of all near-miss incidents, particularly those related to high-risk activities, must be conducted.
- All findings, learnings, and actionable corrective actions from incident investigations and near miss analyses are effectively disseminated to the entire site-level workforce, including all contractual employees. The objective of this communication is to enhance hazard awareness, reinforce correct work procedures, and prevent the recurrence of similar incidents.
- A Responsibility Matrix (RACI Chart) is to be developed and implemented, as per OISD-GDN-206 to ensure clarity in responsibility and accountability.
- A multi-disciplinary technical committee shall be constituted to conduct a comprehensive review of the "Pipe Breaking and Lay-Down Procedure" across all work centres.

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