



# Safety Alert

From the International Association of Drilling Contractors

**ALERT 05 – 09**

## IMPROPER RIGGING RESULTS IN FATALITY

### WHAT HAPPENED:

During the start-up phase of a drilling program, it was necessary to stand back the diverter assembly on the drill floor. In an attempt to stand back the diverter assembly, the crew attached a snatch-block and sling to a guardrail which was then connected to an air-hoist. When the load was applied from the air-hoist, the guard rail broke free from the deck and flew across the drill floor, where it struck the IP in the head, resulting in a fatality.

### WHAT CAUSED IT:

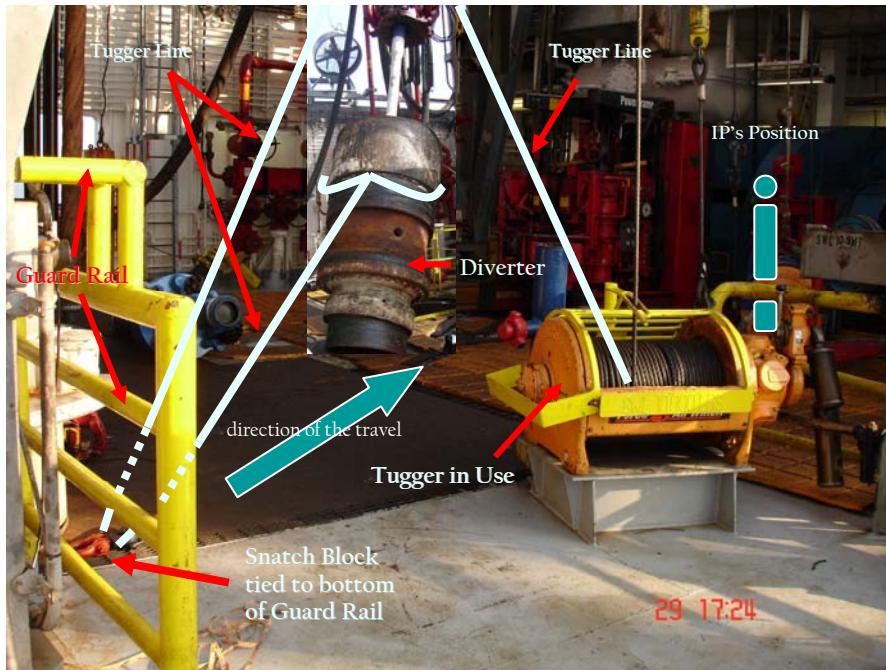
- The IP was attempting to re-locate the diverter assembly to an area of the drill floor that was not a standard "stand-back" area, so anchor points and pad-eyes were not available. (The area routinely used to stand back the diverter assembly is equipped with fit for purpose anchor points and pad-eyes.) A new JSA was not initiated to cover this change in the job.
- The selection of a guardrail as an anchor point was not consistent with standards and procedures for rigging.
- Safe Work Procedures and JSA procedures for this job were not followed.
- The IP (supervisor in charge) was reluctant to accept suggestions from subordinates to stop the job.

### ROOT CAUSE:

Failure to identify and assess risks associated with work related to handling the diverter assembly and failure to follow established procedures for planning such work.

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

- Communicated details of incident to the fleet and industry
- Instructed rig supervisors to ensure that adequate planning and communications are conducted for all tasks.
- Communicated employee responsibility to stop work if unsafe.
- Reviewed JSA's and Safe Work Procedures to ensure they are adequate for handling diverter assemblies.
- Instituted a program of follow-up training for Safety Leadership and Risk Assessment at all levels.



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.

This material is presented for information purposes only. Managers & Supervisors should evaluate this information to determine if it can be applied to their own situations and practices

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Issued March 2005