



# Safety Alert

From the International Association of Drilling Contractors

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ALERT 08 – 34

## FATAL INCIDENT OCCURS DURING RIG MOVE ACTIVITY

### WHAT HAPPENED:

The Barge Captain onboard a Self Erecting Tender Rig was fatally injured while assisting in the landing of the Drillers Cantilever, a 55t section of the Drilling Equipment Set, which was being lowered to the Tender Bow deck during Rig Down operations.

The weather at the time was favorable and radio communications was operating without fault. The lift was going according to plan and was positioned above the raised Bow Deck. The Banksman (Signalman) (on port side) continued to give the crane operator instructions on where and when to move, stopping regularly for the load to settle and receive the all clear from the Barge Captain on Starboard side, before continuing the lowering operation.

The load had a Pipe Support Post and bracket welded onto the frame, which protruded vertically downward from the extended edge of the main load at the Starboard end. As the load was lowered to the deck, the Barge Captain watched its progress and gave advice to the Banksman. The load had become positioned further to the starboard than realized during this movement; placing the edge of the load and this bracket directly above the Barge Captain.

As the load continued to be lowered on instruction by the Banksman, following the 'all clear' advice from the Barge Captain, this single pipe bracket impacted the Barge Captains' upper left back and pushed him downward into the stairway handrail, where he was facing (most likely leaning slightly forward over it), crushing him in this position. This force resulted in a severe internal injury, from which he died at the scene.

### WHAT CAUSED IT:

- Individual positioning himself beneath load
- Poor design of the starboard bow deck stairway, penetrating through mid-deck and creating a deck obstruction for both load placement (constraint and space inefficiency) and personnel movements (crush point).
- Inadequate lighting
- Lack of landing footprint or guides

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

- Instituted design changes to stairway by removing and relocating the stairway to inboard side of deck
- Conducted a lighting level survey for normal operations as well as during 'Rigged Down' state.
- Conducted a review of company policy regarding Heavy Lift operations during night-time hours
- Conducted a review of procedures and documentation used to manage Heavy Lift operations
- Made provisions of landing guides for all rig move loads.

**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.**

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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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