



# Safety Alert

From the International Association of Drilling Contractors

ALERT 04 – 50

## STABBING BOARD FALL TO RIG FLOOR RESULTED IN A FATALITY AND SERIOUS INJURY

### WHAT HAPPENED:

While running 14” casing the electrical hoist of the casing stabbing board failed. After a first attempt to repair the motor without success, the management onboard the rig decided to proceed with the operations replacing the electrical hoist with a manual chain block. The derrick man with the help of the driller and of an electrician connected the manual hoist to the electrical hoist at approx. 15 meters (50 ft) above the rig floor. As soon this operation was completed the casing job resumed. The derrick man had to lift the casing stabbing board to disconnect the single joint elevator and connect the elevator. To lift the board, he disengaged the upper safety dogs that were keeping the platform in position. As soon he completed this operation the stabbing board slipped approximately 40 cm (16 in) before the chain snapped and the stabbing board fell. The driller who was standing between the doghouse and the rotary table in order to supervise the casing operation was struck and thrown to the drill floor. He struck his head against the platform used for the casing operations located near the rotary table and sustained fatal injuries. The derrick man was seriously injured and was evacuated by helicopter.



Stabbing Board



Chain Snapped



Stopper plate not in position

### WHAT CAUSED IT:

- The stabbing board was installed without the safety stopper plate at the bottom of the rail
- The lifting gear used was not part of the rig's lifting register
- The Derrick man did not connect properly the safety belt he was wearing
- The safety working load of the manual chain block was not in accordance with the requirements
- The derrick man did not use the primary safety dogs to keep the stabbing board in position and the chain was not in tension at the moment he released the upper safety dogs.

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

- Introduced Management of Change procedure
- Improved the procedure to install the stabbing board
- Improved the onboard management of the lifting appliances and include all the hoisting gear in the lifting register.

**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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- Upgraded the stabbing board safety lower dogs system
- Improved the safety awareness on board through training sessions.

IADC Note: See Safety Alerts: 00-11, 00-32, 02-45, 04-40; Also see: Paragraph 3.25 and Section 20 of the IADC HSE Reference Guide.

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