Fatality Caused by Snagged Stabbing Board

Recently, as a casing crew was laying down casing, a prototype mobile hydraulic stabbing board (HSB), operated by the casing crew “stabber,” was caught on the ascending top drive. The personnel bucket was flipped, pinning the “stabber” against the HSB arm, causing his death. A complete account of the accident is available on the MMS website at http://www.gomr.mms.gov/homepg/offshore/safety/acc_repo/accindex.html

The MMS investigation concluded that the HSB exhibited a significant “delay” before reacting to the controls, and the “stabber” attempted to shorten the work cycle by timing the passage of the block and top drive. The “stabber” activated the controls too early, driving the personnel bucket into the ascending top drive.

It was also concluded the delayed control reaction was caused primarily by improper maintenance or setup. The delay in control reaction had been recognized but not repaired, because all field personnel believed the delay was a designed safety element of the system. In fact, no hydraulic control delay was designed into the HSB and the delayed reaction was likely caused by common hydraulic issues.

The MMS recommends the Operators ensure the following:

- Operators should conduct a hazard analysis prior to deploying new equipment.
- Field personnel should have formal training and a full understanding of operation, maintenance, and trouble-shooting of any new or prototype equipment.
- Written procedures for the operation, maintenance, and monitoring of new or prototype equipment should be in place and in use before new or prototype equipment are used.
- When using new or prototype equipment, field personnel should have a formal method for reporting unusual or anomalous operating characteristics and receiving timely support.
- New or prototype equipment should be formally inspected when it is initially installed, and should be confirmed to be operating to design specifications before being used.