

## Near Miss: Personnel nearly struck by rotating chain attached to flexible pipe

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Crew were involved in the second end transfer of a 4" (10cm) production flexible up to the top module of the pipelay system.

### What happened?

As the second end was being transferred, the tensioners were in the following position: upper tensioner – open, lower tensioner – closed.

To allow the weight to be transferred onto the A&R wire the lower tensioners were opened.

This then resulted in the production flexible rotating due to the residual torsion that had been built up within the line.

A 16.5te chain used for the transfer of the second end was still attached to the pull-in head, as the flexible pipe began to rotate, this chain also spun.

Two crew members who were observing the operation were stood nearby and were almost struck by the spinning chain.

#### IOGP Life Saving Rules:

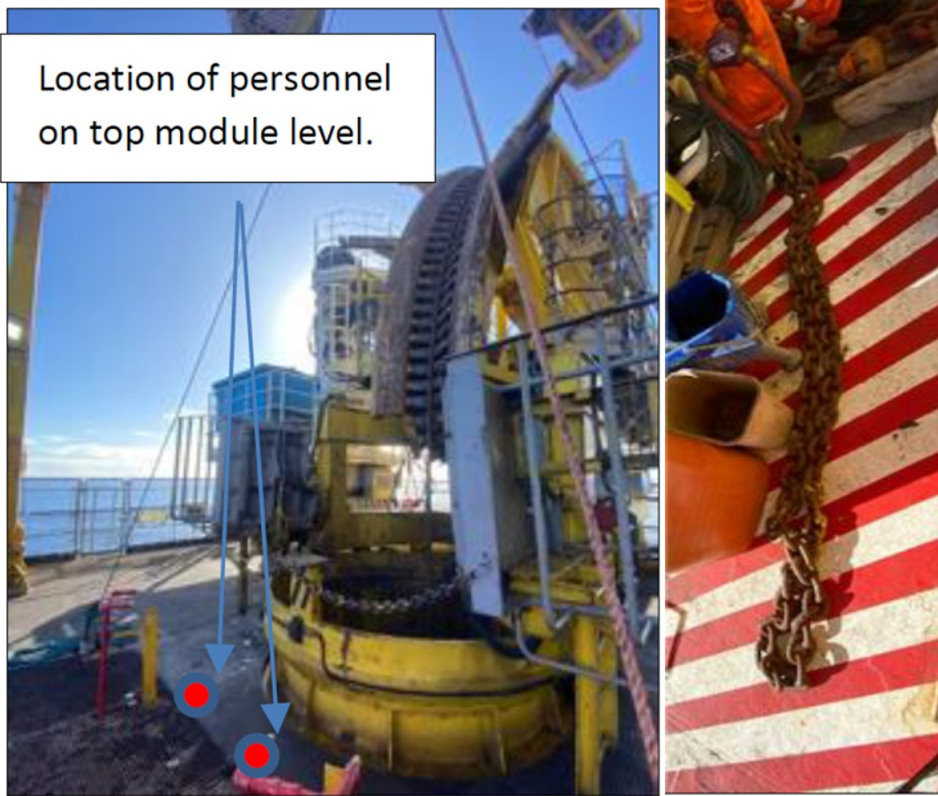


Line of fire



Energy isolation





## What was the underlying cause?

- Key people involved were inexperienced in this specific activity and were not familiar with the task in hand
- There was a failure to identify the risk posed from the chain still being attached to the flexible pipe.
- There was a language barrier:
  - Some of the team were unable to speak English.
  - The Task Risk Assessment for this operation was only available in English.
- The procedure did not identify when the chain should be removed nor other mitigation measures.

## Lessons learned

- Ensure important documentation such as Task Risk Assessment, procedures and checklists are available in the languages of the crew doing the work.
- Ensure it is specified in procedures or checklists when rigging or any other items are to be attached or removed.
- Always remove the rigging after transferring loads to the A&R; when removal of rigging is not possible, suggest additional mitigation actions in the Task Risk Assessment.

- One mitigating measure was to install a gate with signage restricting access to the top module.

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