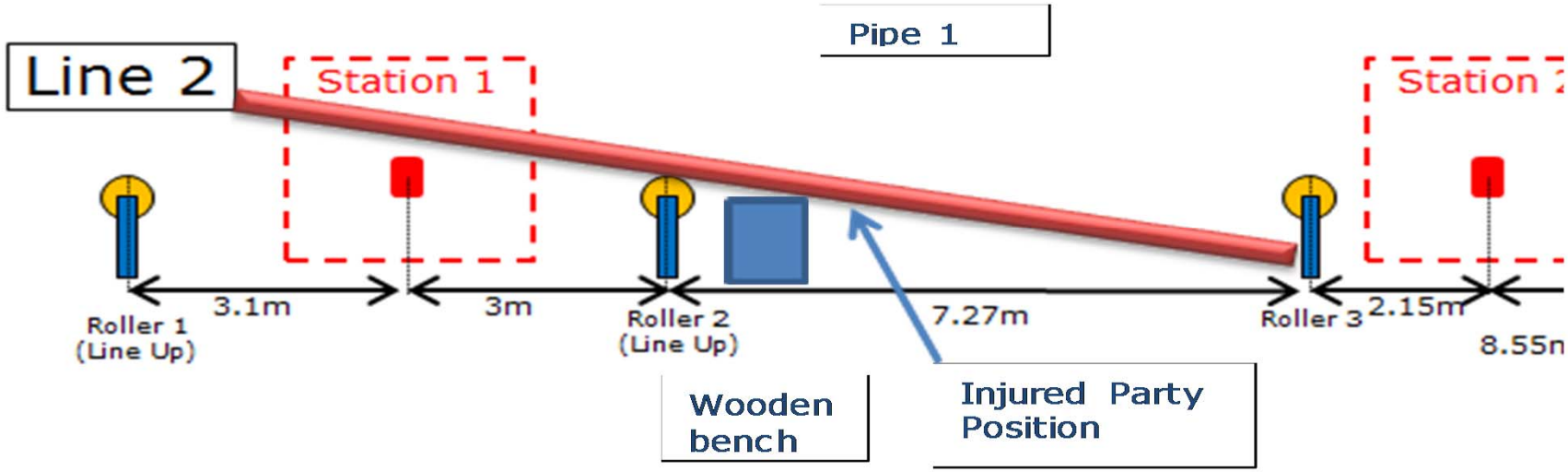
24th JUNE 2013

- **PIPE FALLS FROM ROLLERS**

  Whilst reversing pipe along rollers back towards Weld Station1, 12.2m long pipe passes roller with 7.23m gap between rollers

  Pipe pivots and hits employee on thigh putting downward pressure on leg causing fracture to ankle (Pipe weight approx 1.1 tonne)



24th JUNE 2013

- **EMPLOYEE**

  Four days in hospital

  Operation to insert two pins and plates in ankle

  In plaster for six weeks

  Course of physiotherapy required once plaster removed

  Minimum 35 man-days lost

LESSONS LEARNED

- Failure of shielding gas delivery caused defects in runs deposited in first two welds

  ACTIVITY STOPPED

- Defects discussed at length by Management and Customer resulting in the decision to cut-out the two welds and reverse and remove the pipes to recycle them

  CHANGE MANAGED

- Change was not fully communicated to workforce by Supervision and Management

  CHANGE NOT MANAGED – OPPORTUNITY FOR INTERVENTION

- Team started to carry out a non-routine activity

  OPPORTUNITY FOR INTERVENTION

- Certain people involved in the operation were unaware that this was a non-routine activity

  OPPORTUNITY FOR INTERVENTION

- The pipe handling roller system set-up is not designed for reversing pipe and could not sustain safe pipe movement in reverse

  OPPORTUNITY FOR INTERVENTION

- No Task Instruction or Task Risk Assessment in place to reverse pipe.

  OPPORTUNITY FOR INTERVENTION

LESSONS LEARNED

- Plan was to lift out all pipes with overhead cranes - Plan not followed by those carrying out the activity – decision taken to back-up final pipe manually
  OPPORTUNITY FOR INTERVENTION
- Layout of Weld Station 2 impeded view (dark green screens in place on welding habitat to prevent arc-eye cannot be seen through)
  OPPORTUNITY FOR INTERVENTION
- Layout of cable trays restricted crane access to pipe - this may have contributed to decision to back pipe up 1m manually
  OPPORTUNITY FOR INTERVENTION
- No pressure exerted by supervision however the desire to correct weld defects likely to have created motivation of those involved to act quickly (perceived pressure)
  OPPORTUNITY FOR INTERVENTION
- Point of contact for the immediate work area (the Spacer) not classed as a 'Supervisor' however due to the nature of his activity is actually responsible for supervising up to 28 people in the immediate area during this activity.
  OPPORTUNITY FOR INTERVENTION
- Additional personnel came to assist in the task unaware of the actual planned activity
  OPPORTUNITY FOR INTERVENTION

LESSONS LEARNED

- **OUR SAFE SYSTEMS OF WORK HAVE IN-BUILT STANDARD**
  ‘STOP THE JOB TRIGGERS’

  1. **ANY CHANGE TO THE PLANNED ACTIVITY**

  2. **ANY CHANGE IN PERSONNEL**

- **ELEVEN OPPORTUNITIES FOR INTERVENTION**

- **NOT ONE TAKEN**

- **ANY ONE PERSON MAKING AN INTERVENTION AT ANY POINT THROUGHOUT THIS PROCESS WOULD HAVE PREVENTED THIS INJURY FROM OCCURRING**

- **PLEASE REINFORCE WITH YOUR PEOPLE THE NEED TO**
  STOP THE JOB IF ANYTHING CHANGES

WHY?

they expect us to send their loved ones home safe…

…please don’t disappoint them