# COS SAFETY SHARE

### WHAT WILL WE DO TO PREVENT THIS FROM HAPPENING HERE?

# WORKERS "BORROW" AIR TUGGER LEADING TO NEAR HIT

# What happened?

A crew of 3 technicians were tasked with installing a deployment guide funnel onto guide wires. The crew successfully installed the forward guide wire and proceeded onto the installation of the aft guide wire. The aft guide wire was not near the deployment guide funnel and in order to proceed, the crew made the decision to use a rig air tugger that was nearby. They attached a shackle to the wire and tied a rope to the top of the shackle to prevent it from riding up the guide wire. As they were pulling tension with the air tugger, the rope broke, and the shackle was able to travel up the wire. This resulted in the deployment guide funnel pivoting approximately 3 to 4 feet towards a technician. The technician was not struck by the item, nor was there any damage to any equipment.

#### What went wrong?

As they were pulling tension with the air tugger, the rope broke, and the shackle was able to travel up the wire. This resulted in the deployment guide funnel pivoting approximately 3 to 4 feet towards a technician.

## Why did it happen?

Crew did not do a pre-job review, site assessment, or planning session... the opportunity to identify the placement of the guide wires ahead of time was missed.

The crew used a tugger that was not owned by their company but was near the work area. The crew should have received prior approval to use the air tugger and had rig personnel operate it.

Stop Work Authority was not used before the task began.

#### What areas were identified for improvement?

Updated work instructions/procedures.

MOC was created to capture changes in work scope.

Risk assessment/JSEA was updated to address use of air tugger and assigned rig personnel to operate tugger.



