# Pipe stacking fatality

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**The following incident occurred at an onshore fabrication facility, but provides an important reminder of areas that must be considered when planning for situations where loads and stacks have the potential to become unstable.**

## What happened?

A rigging crew, made up of one crane operator and two riggers, had been assigned to removal several 24-inch diameter steel tubulars from a random stack in a warehouse stock yard. The pipes had been stacked and chocked to be no more than three layers high. During the operation, a tubular in the middle of the bottom layer needed to be retrieved. To gain access, the crew began rearranging the other tubulars. The two riggers were positioned on each end of the stack to assist the crane operator with hook-up and to guide the tubulars out using tag lines.

When the required tubular had been removed, it left an open slot with two unstable stacks either side of it. For reasons that cannot be verified, one of the riggers then stepped into the slot – it is believed he was either placing chocks or following the tag line on the tubular just removed from the slot.

While his foot was in the slot, the force of a tubular on the second row pushed down, causing the tubular to one side of the slot to roll into the slot. The rigger was caught between the two pipes and received severe crushing injuries to his pelvic area. He was transported to the local hospital, but later died from the injuries he had sustained.

## The following investigation identified the following areas for concern:

- The warehouse stockyard, not being an area of regular production activity, had not been regularly inspected to ensure the proper storage of tubulars.
- On the day of the incident, the entire rigging crew, including those involved in this incident, had met to conduct a pre-shift ‘toolbox talk’ meeting and job safety analysis (JSA), but the JSA had only covered work being done at a project site in another part of the yard, which at the time had been considered a higher risk – this task had been considered routine.
- Best industry practice is to remove all pipe from upper layers before removing a tubular from the bottom. This had not been routine at the yard prior to this incident.

## The company involved has noted the following action points resulting from its investigations:

- All areas are to ensure that detailed rigging procedures, coupled with a comprehensive rigging training programme, are developed and implemented, to cover best industry practices of handling, stacking and storage of materials.
- Existing field safety assessment programmes are to be reviewed to ensure all areas of the yard (and of vessels) are covered, including non-production areas such as warehouses and stock yards.
- All areas are to ensure, through proper training, that employees (particularly supervisors) know how to conduct task risk assessments/JSAs for all of their daily jobs, including inspections of work areas as part of the JSA and identification of adequate controls for lowering risk to as low as reasonably practicable.
- Each area's management is to stress to its employees the company's expectations that any unsafe work be stopped immediately.

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