High potential near miss: Guide cone funnel dropped

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An umbilical termination head (UTH) guide cone funnel fell from its sleeve connected to the UTH body.

The UTH was the 2nd end of the umbilical. It had been lifted over the vertical lay system (VLS) tower and was being prepared for deployment when the incident occurred. The UTH guide cone funnel weighed approx. 500 kg and fell more than 4 m towards the moonpool doors.

The next step prior to deployment was to fit the bend restrictors under the UTH. While lifting the UTH from the hang-off collar to fit bend restrictors, the guide cone funnel fell off.

What caused the incident?

The triggering cause was:

- The guide funnel locking mechanism failed to secure the guide funnel in vertical orientation, due to too small locking protrusion.

The underlying causes for the triggering cause were:

- **Design**:
    - the locking mechanism on guide funnel was not suitable for the vertical orientation. The locking mechanism was secured with a cable tie, and there was no designed-in secondary securing for the locking mechanism or the guide funnel
    - the outboard connection c/w guide funnel was an existing design used for installation in horizontal orientation
    - supplier design review may not have covered change in use in a proper

way. This is being investigated by the supplier

    - design review/risk assessment between client and supplier did not cover use of existing design in a new way.

- **Contractor management:**

    - During the risk assessment process onshore, it was left to the client to determine which of their contractors should attend the risk assessment sessions.

        - As a result of this, the UTH supplier had not been invited to attend the HAZID and HAZOP held by the installation contractor. The client did not appear to have guidelines or requirements with regards to which contractor should attend what design/risk session

    - There was room for improvement in the liaison between the different contractors.

        - This is a typical issue with the type of contract set-up as on this specific project (SPS and installation in separate contracts). Better interaction and cooperation between the parties will introduce additional barriers that may detect issues with design or installation method.

What actions were taken?

It was recommended that:

- Risk assessment and/or design review or re-assessment highlighting using an existing design in a new way.
- All guide funnels from this supplier with this design should be modified with a secondary securing/locking mechanism designed to withstand installation forces.
- Revision of umbilical termination head manual to further highlight risk factors (e.g. loose items and locking system etc).
- All parties involved in engineering, fabrication and installation should be included in design reviews, HAZOP, HAZIDs etc.

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