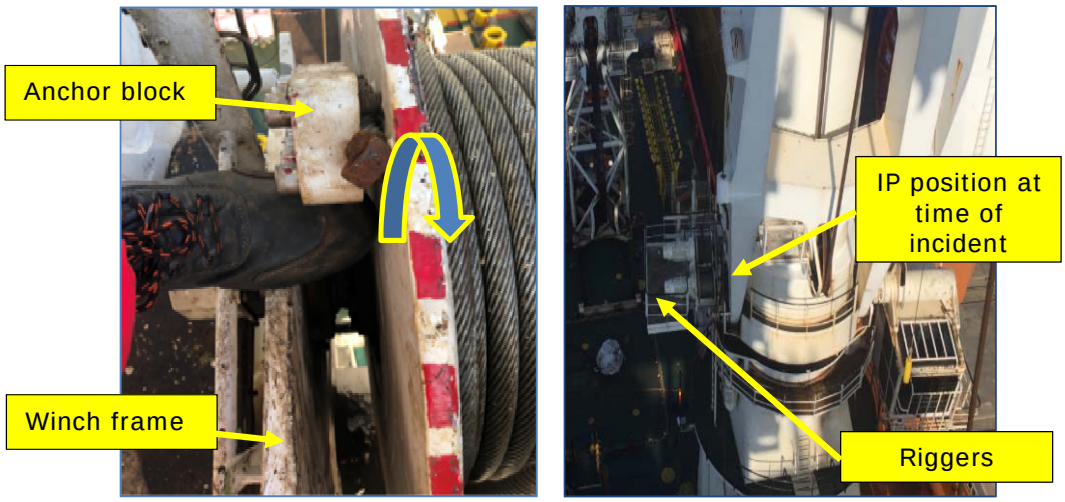
Subsea 7 HSEQ Alert

Alert No. SA00082018
Serious injury from rotating winch

What Happened?

The Injured Party (IP) was involved in spooling a wire onto the main crane forward tugger winch drum. To facilitate the operation he positioned himself in a restricted space, inboard of the winch and opposite to the supporting riggers on the crane tugger platform.

When the IP decided to leave this location he placed his left foot on the winch frame to help step over a protrusion. This resulted in his foot being placed directly into a line of fire position, extending beyond the handrail. The anchor block, fitted to the outside of the still rotating winch drum, struck the extended boot which resulted in all five toes being amputated.



Findings

- The Task Risk Assessment (TRA) was inadequate for the work and did not recognise hazards associated with rotating equipment during the spooling operation.
- The Toolbox Talks (TBT) did not discuss positioning for the personnel involved in the task and did not emphasise the rotating block as a hazard.
- The rotating anchor block was unguarded as it was thought to be safe and barriered by the handrail.
- Safer options were available to the work team but not taken.
- There was no time pressure to complete the task.

What you must do

- Conduct a hazard hunt on winches to identify potential line of fire hazards.
- Assess the effectiveness of the existing safety controls and barriers and implement any required improvements. Vessels are required to send findings to their Vessel Superintendent.
- Reinforce the importance of specific risk assessments, effective TBT preparation and delivery for every activity.
- Whenever possible the TRA should be reviewed at the working area to ensure that all hazards have been identified prior to work starting.
- STOP THE JOB if you see anyone in a position where you could be injured. Repeat this every day in every TBT.

Date of issue: **7th August 2018** | Prepared by: **HSEQ Director GPC** | Approved by: **Group HSEQ Director**