



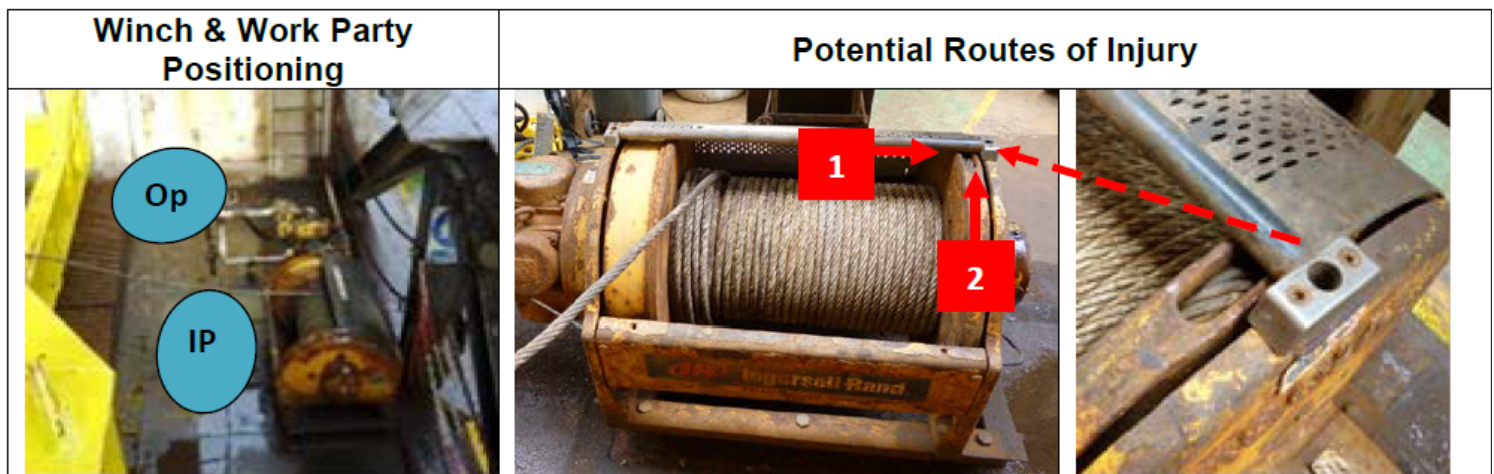
Description: Severed Finger while inspecting winch wire

Date of Incident: 20/04/2012

What happened?

Two members of a 3rd party inspection team were preparing to spool wire back onto a winch on the BOP deck. The Injured Party (IP), who was standing in front of the winch pulled back immediately as the winch started to turn; it was apparent he had come into contact with the drum. When the IP turned round the person operating the winch (Op) could see part of the IP's index finger was missing.

It was the teams 2nd day of work on the platform, a Task Risk Identification Card (TRIC) was completed at the start of shift which did not specifically include the winch. The discussion at the worksite prior to commencing the inspection did not consider the hazards and required controls associated with that specific task. At the time of the incident the team were positioned in such a way that the winch operator could not fully see the winch.



Findings:

- **Failure to perceive risk** – neither of the team recognised the potential for accidental contact with the winch or the need to stop and consider the hazards prior to starting.
- **Normalisation of risk** – Operation of winches was considered a low risk, routine task.
- **Ineffective planning** – basic safe working practices (communication & positioning) were not discussed prior to the task.
- **Inadequate guard design** – the guarding arrangement did not provide protection against moving parts.
- **Inadequate control of 3rd parties** – regarding familiarisation & supervision.

What can WE do?

- Think about how to control the risk at the planning stage and discuss this at onsite Tool Box Talks. Discuss physical barriers on the plant.
- As well as scanning our work environment for hazards, ask others to do the same. There is no shame in pointing out what you think is obvious.
- Consider how 3rd parties are controlled and supervised on your site. Raise any concerns to the responsible person.