Safety Alert

Number: 20-07 **Published:** 04/09/2020

Subject: Finger injury during wire transfer operations

What Happened / Narrative

The A/B's were assisting with over-boarding the ROV hook (connected to the lower drum tow wire) over the stern of the vessel until it could run freely on the winch. The socket and ROV hook were already over the stern but the wire needed assistance to run freely. The tow wire was dragged down the deck with the capstan by using a stopper chain double choked around it. When the wire started running freely over the stern it was all stop on both the capstan and the winch (tow wire).

The A/B's used the crowbar to try and free the stopper chain from the wire. This was done by inserting the crow bar underneath the wire to lift it up from the deck. The Injured Party (IP) was removing the stopper chain whilst the crow bar held it up. Unfortunately, the crowbar was removed too early resulting in the wire falling to the deck whilst the IP's hand was still underneath it. This resulted in a crush injury to the IP's left index finger.

The job was immediately stopped and the IP was taken into the vessel hospital to be assessed by the medical team offshore in communication with the onshore medical advisory service. The vessel sailed into port for assessment of the finger injury by the hospital.

Why Did it Happen / Cause

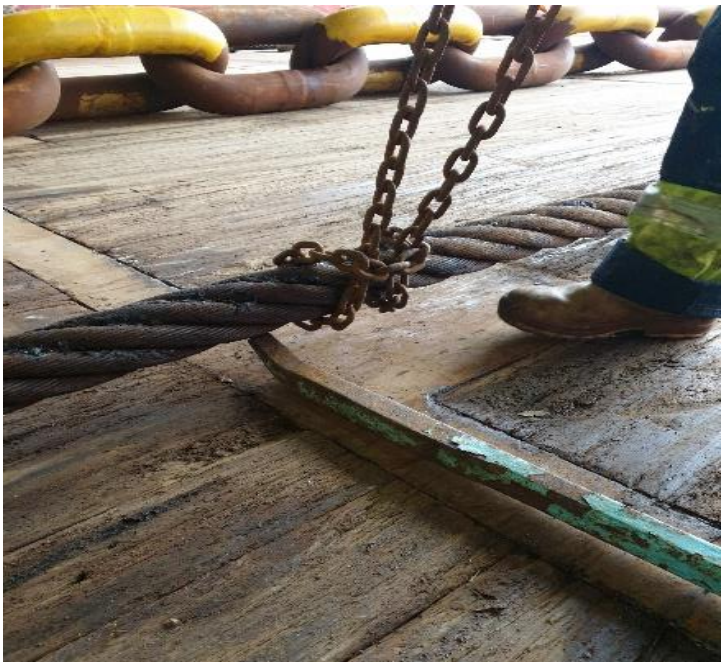
- Crow bar used to support the tow wire difficult to maintain;
- Size of chain stopper wrapped twice around the tow wire made access difficult for removal without placing hand underneath the wire;
- Tow wire was heavy to move;
- There was no alternative means to move the tow wire available;
- Not foreseen that the tow wire would move – routine activity completed many times previously.
- The risk assessment was not reviewed and did not identify risk control measure of verification of 'hands clear' from entrapment. Stop Work Triggers not defined as part of dynamic risk assessment.
- Method used to raise / support the tow wire was viewed as standard practice;
- Task had been completed on previous occasions and viewed as routine;
- Normalisation / perception of risk of finger entrapment not identified;
- Situational awareness of the line of fire hazard.
- Failsafe for the tow wire slipping not previously identified.

Corrective Actions Taken / Recommendations

- Shared the incident learnings across the organisation and wider industry. This highlighted the importance of ensuring that toolbox talks and dynamic risk assessments assess potential for line of fire hazards where these exist in operations.
- Updated toolbox talk procedure for application across the organisation.
- Reviewed areas for potential failsafe across the fleet as part of safety mindset journey.

Safety Alert

Photographs / Supporting Information



Picture 1 – Crow bar used to support the tow wire

Picture 2 – Disconnection of the chain (post-incident solution)