High Potential Incident
- FINGER INJURY -
DESCRIPTION OF INCIDENT

During a planned visit to a 3rd Party support vessel whilst in port the 3rd Party’s Technical Member (TM) took advantage of his visit to participate in the routine maintenance task of Auxiliary Engine No. 1. (AE1)

AE1 was isolated as per procedure to allow the safe removal of the turbo charger air filter. Once the air filter was removed the engine was de-isolated and operated allowing the TM to assess if the impeller was operating as intended. Without consultation the TM attempted to reinstall the filter whilst the impeller was still rotating. The TM right index finger contacted the impeller blade of the turbo charger, resulting in the amputation to the end of his index finger (up to the distal inter-phalangeal joint).
INVESTIGATION AND ANALYSIS

The investigation concluded that the permit to work, isolation procedures and toolbox meeting report were appropriate and if followed would have prevented the incident from occurring. It is concluded that the causes of the Incident were:

1. Failure to isolate AE1 energy source.
2. Inadequate appreciation of the risk.
3. Failure to follow permit to work, isolation procedures and implement all toolbox meeting controls.
4. Inadequate management and induction of temporary personnel on projects.
CORRECTIVE ACTIONS

1. Tasks requiring Isolation and/or LOTO of energy sources to be completed under vessel PTW.
   a) Complete refresher Isolation/LOTO training for all vessels.

2. Safety stand down on all vessels focused on Hand Safety, management of Energy Sources (Isolation/LOTO) and communication of this safety alert.

3. Use of Safety Card System and Management Monitoring to be reinforced on support vessels.

4. Masters and Project Management to complete a weekly sample of project support vessel documentation:
   a) Toolbox Talk’s and Task Risk Assessments.
   b) Safety Cards and Management Monitoring/Task Audits.

5. Support vessels to inform client of any unplanned and/or Temporary visitors and to confirm they have completed an induction including project expectations and company HSE principles/ Golden Rules.
CONCLUDING COMMENTS

The investigation concluded that the permit to work, isolation procedures and toolbox meeting report were appropriate and if followed would have prevented the incident from occurring. The investigation also concluded that due to inadequate appreciation of the risk, the employee took the decision to refit the air filter to the turbo charger with the impeller rotating, believing that he could do so without injury despite no time pressure for the task to be completed.

In addition, the investigation also found there to be opportunities for improvement in:
- the induction process of visitors to projects (specifically related to the support fleet)
- the 3rd Party permit to work system and energy isolation system in place related to the maintenance scope of work carried out

The specific maintenance activity on Auxiliary Engine No. 1 was viewed as routine by the crew which is considered a contributing factor as to why the team did not effectively implement all the additional controls identified in the toolbox meeting report. The toolbox meeting report stipulated the need for a permit to work and additional isolation (Lock Out/Tag Out) controls to be put in place for the duration of the maintenance work.
THANK YOU