EMPLOYEE COMMUNICATION

Although we closed out 2004 just short of our targets on lost time incident frequency rate (LTIFR) of 0.12 versus 0.1 and total recordable case frequency (TRCF) of 0.69 versus 0.60 there has been an air of complacency creeping in over the past number of months. We were beginning to believe in our statistics that continuous improvement was ongoing and we were best in class. I have been concerned about this for quite a while and considering that the December Safety result was the worst month for Subsea 7 in 2004, with 2 lost time incidents and 7 total recordable cases there is good reason for concern. Also note, we started 2005 with a lost time incident. Having made my concerns known to the team at the beginning of January and mandated a call for action, not words, the incident that occurred on the Polaris last week during a mobilisation of an ROV system for BP West of Shetland highlighted the urgent need for this action. **We nearly killed one of our electrical sub-contractors.**

This has had an immediate effect on the Polaris team and all those involved in the investigation. One man was relieved of his duties and many others received warnings for their lack of accountability for safety. I personally met with the Polaris team and discussed where both individual and company responsibility broke down. I left the vessel very certain that all involved were much stronger and clearer about their responsibility for safety for themselves and those working around them.

I have put in place an immediate management action/response so that all of our sites/work locations can benefit from the impact that this has had on the Polaris team. It is very simple what we need to do – every person needs to be clear about their responsibility, each supervisor needs to regularly check that his people are clear on responsibilities and understand the procedures they must follow. There are a few top level items/issues that must be followed, some examples:

- the basic understanding and implementation of Permit to Work, and what falls under this,
- the clarity of organisation and responsibilities on each work site especially during times of change, which includes mobilisation,
- the implementation of tool box talks,
- risk assessments and,
- lifting plans etc

The incident highlighted procedural faults in our system. A key area was the isolation procedure, the responsibility and consistency across the work sites was not clear. To ensure this is happening right across our global sites I have assigned Ian Cobban to work primarily with Robin Davies, Alan Forsyth and Inge Gabrielsen to undertake a high level audit to ensure that we are confident in our systems, training and competency. In addition, senior management will be visiting all our vessels and work sites for discussions on improving and communicating our safety responsibilities and actions.

For me, something very positive came out of my discussion with Dave Pye, who was involved in the incident. Here was a man that has great pride in his work and had constantly delivered quality performance. He was visibly knocked by his part in this incident. I asked Dave if he would share the impact this incident had on him personally with all of the Subsea 7 people and I was delighted that he had the courage to do so. Please read Dave's very powerful Safety message below and reflect on it.

Regards,
Mel Fitzgerald
CEO

Note: I have requested this be included also in our Subsea 7 Corporate Newsletter

SAFETY MESSAGE FROM DAVE PYE

HOW NOT TO KILL SOMEONE

My name is Dave Pye and I recently received my twenty year service award from Subsea 7. Not long after that award I was leading a team involved in an incident which nearly killed someone. I would like to pass on my experiences, thoughts and reflections which arose from this event.

I work as an ROV offshore manager responsible for a team of fellow employees varying in number from about 10 to 20 guys. In this incident I had a team of 12 and our task was to mobilise a couple of ROV systems on the Toisa Polaris in Aberdeen for operations West of Shetland for BP. One ROV system had been on board since 1999, the other we transferred from another vessel on which I have worked for the last three years.

I had worked closely over the last few years with four of the team and knew some of the others while a few were strangers to me. Apart from a weeks visit some years ago I had not worked on the Toisa Polaris before.

Mobilisations are by their very nature extremely busy and accompanied with the pressures of progressing the job towards the goal of sailing with fully functioning systems on board. Mobilisation days are long and packed with events requiring judgement calls, delegation, monitoring, problem solving, logistics and personnel management, its hard but its great and that's what makes it all so rewarding when the job is done.

With all that is going on it is only natural that occasionally mistakes will be made and wrong judgement calls made. What I have learned is that the one area you cannot afford to drop the ball is with regard to safety. Safety management is not just one of the roles which fall within a manager's remit, it is the PRIME role which should be at the front of any job which we undertake.

The incident details are well documented elsewhere but in summary a chain of events took place which except for what can only be described as exceptional good luck could have resulted in the death of a sub-contractor electrician working with our team. I can't speak for the others involved but I know that I personally would not have been able to handle the consequences had an actual death occurred. I have given some thought to the consequences:

A wife and children saying goodbye in the morning to a loved one they would never see again.
Family and relatives questioning why and how such a thing could happen.
The police, the court enquiry, the publicity.
How would my own family and friends react?
The personal damage to my own self belief and confidence.

How can you look someone in the eye when you realise intervention on your part could have stopped the whole sorry state of affairs. How many times have you regretted something you have done? Let me tell you that it is just as bad, maybe worse to regret something you did not do. I dwell on this because as the incident developed towards its climax there were a number of occasions when action by any one person could have halted the chain of events. I was one of those people, I dropped the ball on safety. I should have checked that what I requested and expected from my team was actually taking place across all areas. I should have spotted the discrepancies between company procedures and what was actually taking place on board. I should not have assumed that all company safety systems were in place, I should have checked. In effect I was managing without closing the loop on all safety issues.

When I give advice to new supervisors I suggest that they take a step back when things are getting busy and take a look at what is really going on, don't get lost in the detail, look at the bigger picture. On this occasion I did not heed my own advice. We were only about 36 hours into the mobilisation proper but I had hit the ground running and got lost in the daily activities already alluded to. I was not alone in this but I have a personal responsibility towards safety, it is the same responsibility as anyone else in the company. Safety comes first!

Confusion over roles and responsibilities among team members was a major contributory factor in this incident and we have all had to re-examine both with regard to this project and our place within the organisation. I have re-learned that even though familiar team members may know how things work in their normal environment, all team members need to be reminded of their roles and responsibilities at the beginning of any job and reminded throughout the job.

There is also often reluctance among people to "do the paperwork". Believe me the paperwork is an essential part of the process in performing a task, it is a definite part of the job. The paperwork forces the team to think about safety and ensure that we are not operating on an informal ad-hoc basis. This incident came about in just such an ad-hoc manner, with the procedures and paperwork going out the window imagine how weak that would look as an excuse to a victim, or a relative or in a court of law. Next time you think about skipping the company systems just stop for a moment and ask yourself how you would cope with someone being hurt from your inaction, perhaps a colleague, or, think about it, even yourself – none of us are bullet-proof.

I was asked if this experience had made me stronger. Yes, I have learned a lot and I have had to re-examine how I do things. Believe me I know the theory, but being involved really hits home. Theory is necessary but personal experience is the real teacher. Next time you see a safety presentation or read a safety notice, try personalising it, put yourself, your colleagues and your family into the equation. It's just possible then that you may get a clearer picture of what people feel when they really are involved.

We were lucky this time, no one was hurt. However I can personally vouch for the fact that being involved in a three day investigation with most of our senior management present, and a high level delegation from our client is not a pleasant experience. Your professional pride takes quite a hit and you realise that it is not difficult for the investigation team to find the flaws and omissions in your work and procedures. When those flaws are related to failure to comply with basic and core safety procedures then its all the worse. It doesn't matter that you did not trigger the final action in the incident; you are responsible for the team actions and adherence to company safety throughout the job. It is your responsibility to ensure that events can never lead to that final trigger moment.

Finally to others in supervisory positions my advice from personal experience is one ball you must never ever drop is the one labelled safety.