



Safety Alert

CMS LTI

Description

On April 28TH 2001, a **Junior Field Engineer** was lifting a tool using a **manual winch** when the handle slipped from his hand. Instinctively, he tried to stop the abrupt movement of the handle by holding it. His **hand** was then **struck by** the handle and **caught between** the handle and the winch gear. As a consequence, he sustained **three fractured fingers and a deep cut in the palm** of his hand. Employee will be at least **two months away from work**.

Root Causes

1- Lack of knowledge / poor communication / lack of supervision:

Unexperienced personnel executing the task (first time). Supervisor knew the risk involved but was not present at the moment of the lifting.

2- Innapropriate risk reporting / inadequate equipment:

The risk was well known at the location but not formally reported. All operators recognized that the winch was unsafe to operate but knew their way around it and thought this was sufficient to avoid an accident.



WHAT HAVE WE LEARNED FROM THIS ACCIDENT?

- ✓ **UNSAFE CONDITIONS MUST BE FORMALLY REPORTED.**
- ✓ **THE EXISTING RISK MUST BE ASSESSED AND LOWERED TO ACCEPTABLE LEVELS.**
- ✓ **SAFE OPERATING PROCEDURES MUST BE COMMUNICATED TO ALL INVOLVED IN THE TASK.**
- ✓ **SUPERVISORS MUST BE PERSONALLY INVOLVED UNTIL THE HIGH RISK ACTIVITY IS COMPLETED SAFELY.**

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