

COS SAFETY SHARE

WHAT WILL WE DO TO PREVENT THIS FROM HAPPENING HERE?

IMPROPER USE OF CUTTING TOOL RESULTS IN INJURY

What happened?

A diver was in dive control attempting to mount the DP (dynamic positioning) lights. The employee was attempting to remove a plastic zip tie with an alternative cutting device and could not get the cutter to engage the zip tie. The employee proceeded to open the alternate cutting device and tried to pull the blade across and through the zip tie. As the employee was pulling the blade in a downward motion, it contacted the left index finger which resulted in a laceration. The employee was transported to shore, where the laceration was cauterized, and a prescription issued by the medical facility.

What went wrong?

The cutter tool that the employee was using was not used in the way it was designed for use.

No gloves were worn at the time of the incident.

Why did it happen?

The injured party (IP) - a contract diver with 20+ years of experience - was not assigned to the task and decided to complete the task on their own without direction.

Employee also made the independent decision to use a tool that was not correct for the task or in a manner it was designed for.

There was not a clear understanding of what level of safety orientation the employee received prior to arrival.

What areas were identified for improvement?

Task assignments were evaluated and correct tool for the task was identified.

JSEA updated to identify the correct tool to be used for the task.

Contractor/Contract Employee onboarding/orientation program to be updated and implemented.

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