Marine Safety Forum – Safety Flash 15-19

Issued: 26th June 2015

Subject: Daughter Craft – Man Overboard Incident

Event Description

An ERRV was on location performing routine duties. The Daughter Craft (DC) had been used for a drill and was in the process of being recovered when the boat man, after attaching the davit wire 'O' ring to the Cranston hook, fell backwards into the water when the DC jerked to starboard. He was recovered and suffered no physical injuries. No other party was injured during the incident.

The boatman had moved forward, attached his safety harness to the securing point in the bow of the DC, and collected the bowline from the vessel. He then attached the bowline to the DC, unclipped his harness and moved aft to get the davit O ring in order to connect it to the DC Cranston hook.

Once in position at the aft end of the DC the Boatman climbed up onto the step to receive the 'O' ring but did not secured his harness to the securing point on top of the DC.

He got hold of the 'O' ring and insert it into the Cranston hook. At this point the vessel rolled to stbd causing the davit wire to tighten and pull the DC. He was caught off balance and fell into the water. He was recovered to the DC uninjured; however he spent an estimated 10 minutes in the water. On return to the mother craft he was checked by the AMA given a change of clothing and a hot drink.

Due to the incident potential a full and detailed investigation was carried out. Whilst we don't wish this alert to replicate the investigation we have listed some of the findings conclusions and recommendations.

Findings / Root causes:

Findings

- PPE not used as required;- not clipped on, however there were no reported defects with the PPE utilised
- The crew of the DC were experienced in the launch and recovery of the DC and FRC.
- This was a routine operation in good conditions and an opportunity to assess and train the crew.
- The DC is fitted with fixed securing points for clipping on harnesses not slide rails as fitted to most DC's.

Conclusions

- The Boatman did not secure his safety harness to the harness point and did not convey this to the deck crew.
- Deck crew lowered the davit wire without confirmation of the Boatman being secure.

Failure to clip on is a breach of our safety procedures; however we do know that people do not go out of their way to be involved in an incident or get injured. We also know the majority of people do not purposely break the rules or disregard procedures. In this case it is considered that a slide rail securing system would have been used if fitted.

It is often assumed that people see and evaluate risk in the same way, this is simply not true! People are unique individuals and do not perceive hazards in the same way. Some people perceive danger in nearly every situation and some people rarely see it. We need to make hazard recognition a habit.

Actions / Recommendations:

Operating companies recommendations

- Safety Coach to attend sea trials, witness launch and recovery exercises and coach and advise as necessary
- Specific Time out for Safety meeting to be held on-board to discuss the incident
- Crew to be made aware of PPE responsibilities
- Investigate retro fitting of slide rails.

Note, since this incident slide rails have been fitted to all DC's in the fleet.