MARINE Safety Forum

Safety Alert

Number: 21-18 **Published:** 11/11/2021

Subject: LTI – Fall from Height

What Happened / Narrative

On the day of the incident there were 2 x two men teams working on maintenance of the superstructure. The IP and his teammate were working on the Monkey Island and the other work party at the Bridge level gantry, removing gratings and working on the steel frame of the gantry.

When the IP and his teammate completed their task on Monkey Island, they went down to the bridge level when the IP removed his safety harness and spotted an old paint drip that needed scraped. He thought a check around the bridge to finish off the job before the break was a good use of time. This was a separate task, and additional work that he knew would need to be undertaken shortly within the scope of maintenance of superstructure work. IP started at the bridge door, working around the back of the bridge and his teammate was asked to go to the starboard side of the Bridge.

As the IP reached the back windows of the Bridge, he turned around as the area was tight to work in. From this point he worked moving backwards, not looking behind to see if there were any obstacles.

He was aware of the other team working on the same level and that they had been working on gratings but did not assess the area to confirm where exactly they were at this moment. He was fully focused on his task at hand.

When moving backwards IP took a confident step backwards, which led him to fall through the opening left by the lifted section of grating down to the boat deck, approximately 3.2m.

Why Did it Happen / Cause

1. Control of Work and Permit to Work Systems weren't correctly and effectively implemented on board:
   - There was no proper Toolbox Talks carried out at the work site for the planned tasks and no review of the tasks specific risk assessments, so the control measures were not fully implemented.
   - Permits to work and Toolbox Talk Meeting Record cards were prepared a night before the tasks were taking place. Issuing authority, without verifying put his initials against requirements like: ''risks assessments reviewed, discussed and agreed'' or ''Toolbox Talk taken place at work site''.
   - IP did not report completion of the Monkey Island task and continued to work on the Bridge level without a formal approval and authorization from his superiors.
2. There were no barriers or signage in the area of the incident. A fall hazard was introduced by removing Bridge gantry gratings.
3. IP presented lack of situational awareness and risk perception. When he decided to continue with maintenance on the Bridge level, he did not assess the area for any potential hazards, deciding to turn around and move backwards, not looking behind to see if there were any obstacles.
4. The key personnel on board failed to ensure that the Control of Work System is correctly implemented by the work supervisor, if the toolbox talks with risk assessments review were carried out at work sites as required by the company procedures and to measure the performance of the crew and evaluate the correctness of implementation of the company procedures.
5. It can be questioned if the SIMOPS were stressed to the crew enough to realize to them that there would be hazards and risks introduced by both tasks and that each crew should respect it, not interfering with the other team. Communication between deck personnel in charge and deck crew, between two teams working in the same area was insufficient. That contributed to the incident.

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Corrective Actions Taken / Recommendations

Make the crew aware what were the causes of the accident that had a potential for much more serious outcome.

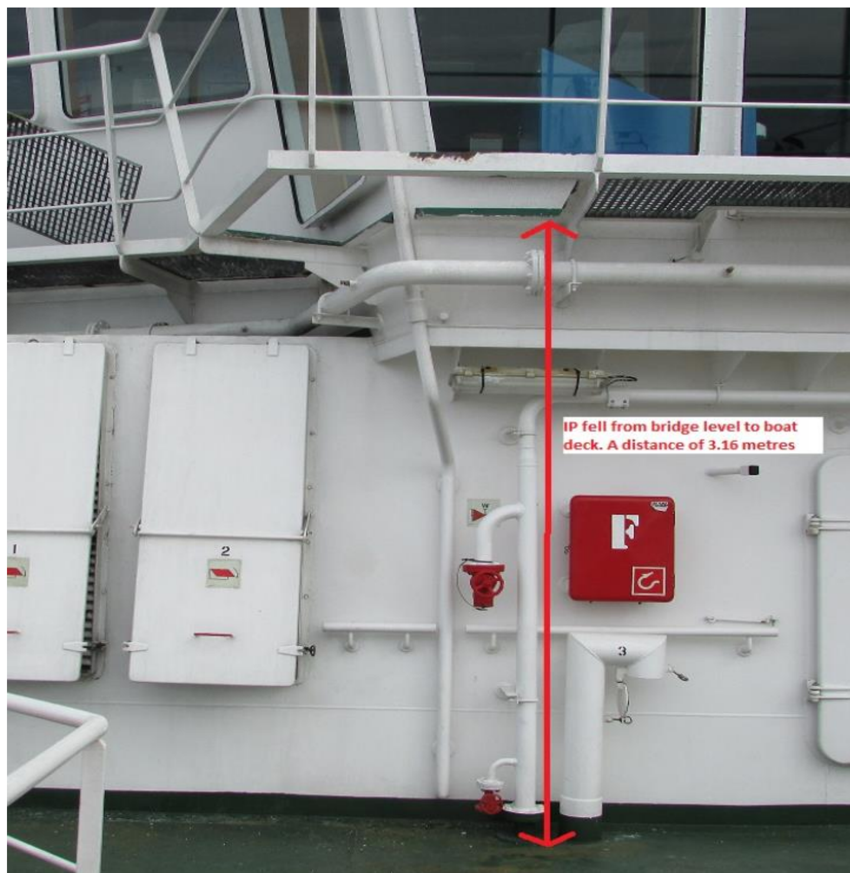
1. Masters and Chief Officers/Chief Engineers (if they do not lead toolbox talks) – to attend random toolbox talks carried out by the crew.
2. Those for non-routine tasks, when Toolbox Talk Meeting Record cards are used and those for routine tasks when crew discuss between each other the task and review risk assessment, all foreseeable hazards and available control measures.
3. To ensure that the company COW and PTW Systems are correctly and fully implemented.

Simultaneous Operations (SIMOPS) occur when two or more potentially conflicting activities are being executed in the same location at the same time. Please include the discussion on that subject in your TOFS meeting bringing to the attention of your crew below 5 step approach which will assist you to have control over SIMOPS on board Your vessel.

5-Step approach to SIMOPS

- During scope of work planning, please identify the combined operations and any additional hazards introduced by the SIMOPS. Can SIMOPS be avoided, and task executed at different time?
- Carefully assess the relevant level of risk associated to SIMOPS.
- Verify the adequacy of the planned control measure.
- Identify additional risk reduction measures and update relevant risk assessments.
- Provide input to Permit to Work / Control of Work process for embedding additional controls.

Photographs / Supporting Information



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