Safety Alert

Number: 23-06 **Published:** 23/05/2023

Subject: Injuries Sustained from a 2m Fall Between Decks

What Happened / Narrative

A members Achor Handling Vessel was alongside in port and had just finishing off a demob for a contract.

The Bosun and Chief Officer who were on the main deck heard a loud bang from inside the winch hanger. Upon investigation they found the IP in the port chain Shute on the main deck. IP was conscious but disoriented and had a small cut to the back, left side of their head. IP said he had fallen from A-deck, height of approx. 2m.

IP was able to walk on his own with assistance and was escorted inside the accommodation. Master was alerted and instructed the 2/O clean the cut and monitor the IP's condition. Master called the vessel superintendent and ships agent who arranged for an ambulance. Ambulance arrived and IP departed the vessel for hospital.

Upon assisting the IP inside the accommodation, the Bosun went to A-deck and found the safety chain was not in place. Safety chain could not be confirmed to be in place as it was found in the down position with a link missing. A carabiner was still in place at one end and a a welded link in place on the other. Missing link on welded end could not be located.

IP is an experienced Client Marine Representative with over 30 years' experience in Maritime and offshore sectors. Working worldwide as an independent Client Marine Representative.

On examination in hospital the IP had suffered one broken vertebrae, several broken ribs, a fractured wrist, cut to the back of head and internal bruising to the kidneys.

Why Did it Happen / Cause

IP had been fully rested prior to the Incident and was not distracted at the time of the Incident.

IP was off duty at the time and had proceeded to the winch hanger to check on activity on deck and have a cigarette. IP had used his mobile phone and was returning to his cabin. He recalls taking a few steps, falling forward, and landing on his back approximately 2m below. A-deck grating has a raised edge approximately 76mm high that is highlighted with yellow paint. IP said he "may have clipped the raised edge but not sure".

As the IP was off shift he went on deck with no PPE and fell between the winch gyspy and the deck grating. It could not be determined if the safety chain at the edge of the deck grating was actually in place prior to the Incident.

Corrective Actions Taken / Recommendations

Following the investigation the following actions were recommended:

1. Improved barriers to be installed around port and starboard gypsies
2. Shipboard/Contractor Familiarisations Inductions to be updated to include identification of restricted and working areas
3. Vessel to replace all chain barriers with gates or solid railings. All restricted/working areas to be identified and signage posted
4. Install barriers and signage to clearly identify working areas
5. Temporary chain barriers and signage have been put in place as a short term measure until soild hand rails can be fabricated and fitted

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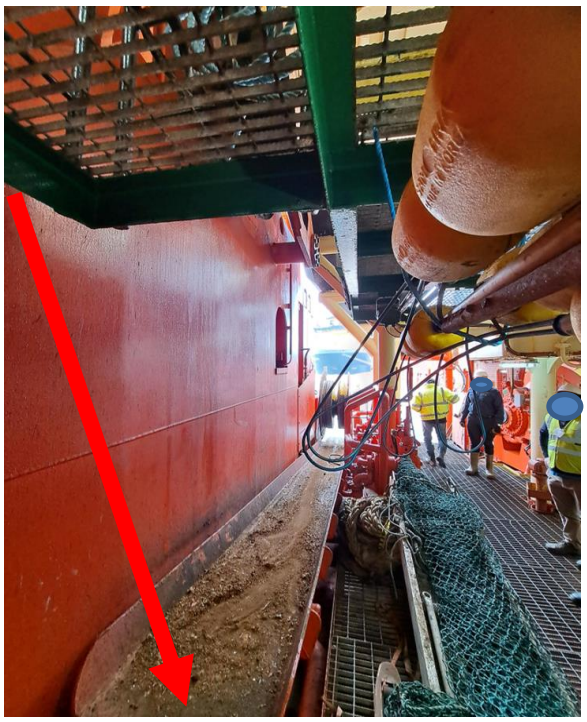
Photographs / Supporting Information

Picture 1 – 'A' Deck



Picture 2 - Main Deck

Picture 1 – 'A' deck showing the area around the gypsy and grating walkway including different levels highlighted by yellow paint. The yellow arrow denotes the space in which the IP fell between winch gypsy and grating.

Picture 2 – Main deck showing chute where IP landed from the grating above (height of approximately 2m). Red arrow depicts the drop zone and area where IP landed.