MARINE Safety Forum

Safety Alert

Number: 23-09 **Published:** 26/07/2023

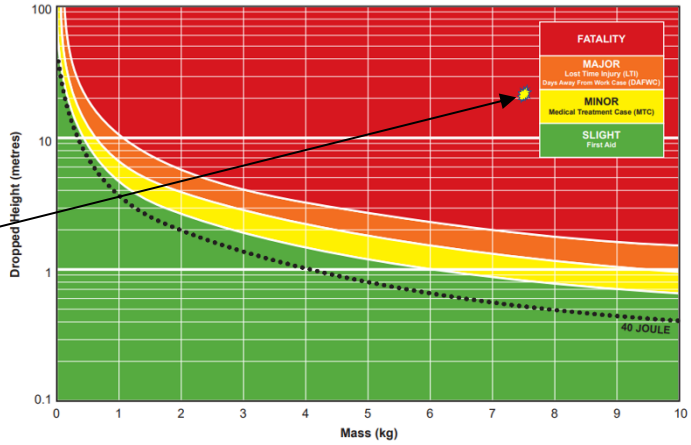
Subject: Dropped Object in Drydock

What Happened / Narrative

Whilst in drydock the vessel underwent a flag change. As part of that change, all lifebuoys needed to be remarked with the new port of registry.

As the day's first job, the Chief Officer instructed the deck crew to collect all the lifebuoys. An AB attempted to retrieve the port side man overboard (MOB) lifebuoy. Holding onto the line which connects the lifebuoy to the smoke float, he released the pin. Failing to anticipate the weight of the buoy the line slipped from his grip and fell, contacting the corner of the dock quayside before falling to the dock bottom.

The combined weight of 7.6KG fell 22m to the dock bottom below with potential shown on the Drops calculator image to the right.



At the time dock personnel were working on the dock bottom but not in the vicinity of the impact. An immediate halt was called to all work in the dock bottom and onboard the vessel. All personnel left the dock bottom whilst the smoke float discharged its contents.

Why Did it Happen / Cause

An investigation into the incident concluded that:

- The risk assessment and toolbox talk did not consider the potential for dropped objects.
- No precautions were put in place to prevent personnel from walking into the line of fire on the dock bottom.
- The AB involved was unfamiliar with the lifebuoy and smoke float arrangement, this lack of familiarity led to him not disconnecting the smoke float and not securing the lifebuoy against movement before releasing the pin.
- The required weight for MOB buoys is significantly more than the required weight of standard lifebuoys and may have been a factor not considered when anticipating the movement of the buoy.
- When discovering the job was not as simple as first anticipated the AB did not stop to ask questions or determine if there was a better way to complete the task.

Corrective Actions Taken / Recommendations

The following actions were identified and implemented by the vessel owner:

- A meeting was held to discuss the risk assessment process onboard, appropriate allocation of tasks, level of detail in pre-task briefings and analysis of simultaneous operations.
- This task should have been assigned to someone familiar with the arrangement.
- The briefing given to the AB was not detailed enough for him to complete the task safely.
- On discovering the task was more complex than initially thought the AB should have taken a step back and raised his concerns with his immediate supervisor. A meeting was held with the crew to discuss the use of Step-back in relation to the incident and emphasise the crew's obligation to speak up, ask questions and stop the job.