The Swedish Club

MONTHLY SAFETY SCENARIO

MAY 2022

AB fell to his death

It was an early spring morning with clear skies and calm seas and the vessel was sailing in the open seas. The Chief Officer had assembled the deck crew in the deck office and instructed them about the planned job for the day which was to change the wire of one of the deck cranes. All members were designated a job and the risk assessment was discussed and signed by all crew members.

Three Abs were stationed in the crane to direct the wire. They had safety harnesses when they climbed up the crane's ladder.

The crew started the job by releasing the safety pin of the old wire on the drum and then welding the old wire to the new wire and fitting a protective sleeve over the welded joint. This would facilitate the mounting of the new wire on the drum of the crane. The crew would monitor the wrapping of the new wire on the drum and the unwrapping of the old wire from the drum storage space.

The work progressed well but after a couple of hours the new wire became stuck on the aft crossbeam of the boom. The Chief Officer saw the problem, and immediately signalled to the crane operator to stop the winch, by both using his hand and calling on his radio.

One of the ABs who was up in the crane climbed over the safety railing at the drum storage space and out onto the boom. He sat straddling the boom and used his hands to quickly push himself forward and out onto the boom towards the aft crossbeam where the wire was stuck.

As the Chief Officer was engaged in instructing the crew on the deck, he did not see the AB climbing out onto the boom. The AB apparently acted spontaneously without any instructions to climb out on the boom to try to unhook the wire where it had snagged on the crossbeam.

When the Chief Officer finished instructing the crew on the deck, he turned back to the boom and saw the AB out on the boom at the point where the crossbeam was located. He immediately called out to the AB, saying: “Stop! Please stop! We need to get a rope to fasten it to the wire”.

The AB lost his balance and fell onto the hatch cover from a height of about 8 metres.

He lost consciousness from which he never recovered. After he was air lifted to a hospital, he was pronounced dead.

Questions

When discussing this case please consider that the actions taken at the time made sense for all involved. Do not only judge, but also ask why you think these actions were taken and could this happen on your vessel?

1. What were the immediate causes of this accident?
2. Is there a risk that this kind of accident could happen on our vessel?
3. What would you have done to prevent this accident?
4. When working at height is it a requirement to wear a safety harness?
5. Are we required to wear a safety harness when climbing?
6. Do we train our crew and explain the consequences of not wearing safety harness?
7. What are our procedures if we see a crew member doing anything unsafe on board?
8. How do we ensure that our crew members follow the required safety practices?
9. What sections of our SMS would have been breached if any?
10. Does our SMS address these risks?
11. How could we improve our SMS to address these issues?
12. What do you think was the cause of this accident?
13. Is there any kind of training that we could do that addresses these issues?