

MONTHLY SAFETY SCENARIO

**NOVEMBER 2025** 



On the morning of the incident, the vessel was at sea. The weather was calm, with slight seas and a gentle breeze. Work had been planned on the funnel's exterior to address a job order for repainting and correcting the company logo. Prior to commencing this job, a homemade cradle, essentially a narrow segment of gangway rigged with ropes for handrails, had been prepared by the crew under the supervision of the chief officer, who verified its apparent suitability for the job.

Shortly before 09:00, two ABs gathered their equipment and required PPE. They had reviewed the relevant risk assessment and completed a work permit for working aloft.

By 09:00, one of the AB's was positioned on the cradle aloft, suspended by lines attached to the top of the funnel, while the other AB remained on the deck to assist and handle the equipment.

For approximately one hour, the AB aloft methodically sprayed the funnel's plating with high-pressure water, shifting the cradle vertically and laterally as needed. Throughout this period, the vessel maintained a steady course and speed, and the slight motion of the sea did not interfere with the work.

Shortly after 10:00, both men paused for a coffee break. After resuming work around 10:30, the AB on the cradle focused on the forward side of the funnel, continuing cleaning. While repositioning himself on the cradle, he unclipped his safety harness momentarily to move from one end of the platform to the other. In the seconds that followed, he appeared to lose his balance, possibly because his right foot slipped off the edge or became entangled. As a result, he fell from an estimated height of 6 meters onto the deck below. The other AB who had been assisting, saw him strike a portion of the railing or funnel deck structure before landing.



The crew immediately responded by calling for medical assistance on board. They placed him on a stretcher and administered oxygen and first aid in the vessel's hospital area. Meanwhile, the vessel's Master contacted the nearest MRCC, which deployed a fast rescue boat. Around 13:00, the rescue boat arrived and took the injured AB ashore for urgent medical treatment.

## **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. Does our SMS address these risks?
- 2. What sections of our SMS would have been breached if any?
- 3. How do we confirm that the staging or cradle we are using has been properly inspected and is suitable for the task?
- 4. When repositioning aloft, what techniques or equipment (e.g., double lanyards) can help us maintain continuous fall protection?
- **5.** At what point do changing environmental conditions (wind, swell, poor visibility) make it unsafe to continue

- working aloft, and who decides to suspend operations?
- 6. If a harness or lifeline appears to be damaged or worn, what is our procedure for reporting and replacing it before starting work?
- 7. How can we encourage open communication so that any crew member feels comfortable stopping the work if they see an unsafe condition or practice?
- **8.** Which key points from the risk assessment for working aloft must we pay the most attention to during everyday operations?
- **9.** How do we ensure that team members who have not previously performed this task receive the proper guidance and supervision before participating?
- 10. In addition to preventing accidents, how can we proactively create conditions that make safe behaviour the natural and easiest choice for everyone involved?
- 11. What support do we need from management (additional training, updated procedures, more resources) to strengthen our working aloft practices?
- **12.** What immediate, actionable steps can we take from today's discussion?