

Safety Flash

LTI: Fall from height during FRC maintenance

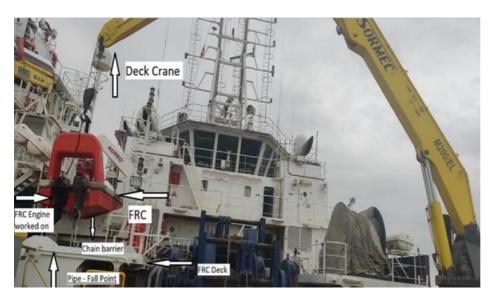
Safety Flash Published on 20 February 2025 Generated on 3 April 2025 IMCA SF 03/25

A worker fell 2.3 m to deck from a small boat in the davit, and broke a leg as a result.

What happened?

The incident occurred on a laid-up vessel when workers were re-installing an engine which had been previously removed from the Fast Rescue Boat (FRC).

Workers used the crane to lift the engine from the quay into the FRC on the port side of the vessel. The mechanic climbed into the FRC to fix the suspended engine in place, but was not successful. The mechanic found it necessary to work on bolting the engine in place while standing in an unsafe position. While doing so, he lost balance and fell 2.33 m to the main deck. First aid was administered onboard and then the mechanic was evacuated to the hospital for further medical examination, resulting in a diagnosis of fracture of the left leg and further surgery required.



Area where incident occurred

IOGP Life Saving Rules:



Bypassing safety controls



Working at height



Showing line of fall

What went wrong?

CCTV footage from the port revealed that several times the mechanic failed to secure the engine in place from inside the FRC (aft) due to restricted access. Afterwards, he crossed the chain barriers of the FRC deck and attempted to bolt the FRC engine in place while standing on a small diameter pipe designed to cover electrical cables. There was no use of fall protection equipment.

- There was no on-site verification and supervision of the activity neither by shore-based nor vessel management team.
- There was no risk assessment nor toolbox talk before work started.
- The mechanic took the risk that he might fall, making the decision to stand on the pipe with no fall protection.

Lessons learned

- Ensure work is properly planned and that there is a thorough, comprehensive and detailed risk assessment.
 - In this case, the requirement for work-at-height equipment (fall arrest harnesses, etc.) for persons working in an FRC on a davit, was quite foreseeable.
- Ensure that there is a Toolbox Talk:
 - Stop and discuss the job before we begin.
 - Stop and identify hazards and controls before starting.
 - Don't just dive in.
- Ensure all crew understand that they can STOP THE JOB.

- Appropriate supervision should be provided, particularly of high-risk activities.
 - What this could mean on a vessel in lay-up ought to have been taken into account beforehand.
- It was easier for the mechanic to take the risk and try to do the job unsafely.
 - How do we make it easy for workers to do the job safely?

IMCA Safety Flashes summarise key safety matters and incidents, allowing lessons to be more easily learnt for the benefit of the entire offshore industry.

The effectiveness of the IMCA Safety Flash system depends on the industry sharing information and so avoiding repeat incidents. Incidents are classified according to IOGP's Life Saving Rules.

All information is anonymised or sanitised, as appropriate, and warnings for graphic content included where possible.

IMCA makes every effort to ensure both the accuracy and reliability of the information shared, but is not be liable for any guidance and/or recommendation and/or statement herein contained.

The information contained in this document does not fulfil or replace any individual's or Member's legal, regulatory or other duties or obligations in respect of their operations. Individuals and Members remain solely responsible for the safe, lawful and proper conduct of their operations.

Share your safety incidents with IMCA online. Sign-up to receive Safety Flashes straight to your email.