Man overboard fatality: Tragic consequences of failing to follow safety procedures

Safety Flash Published on **25 January 2017** Generated on **21 January 2025** IMCA SF 02/17

The United States Coastguard (USCG) has published Marine Safety Alert 01-17 relating to a man overboard fatality.

IOGP Life Saving Rules:

- Bypassing safety controls
- Work authorisation

What happened?

Whilst a vessel was at anchor off the coast, a crew member that could not swim was working over the side in a 'bosun's chair' to paint the vessel's mid-ship draft marks and load lines. Unfortunately, when his shipmates on deck started to haul him back up, the bosun's chair rope parted and he fell into the water. He survived the fall and attempted to swim towards a life ring that had been thrown to him, but he ultimately submerged and was lost. Other crew members attempted to launch a rescue craft, but it failed to operate.

What went wrong?

This terrible incident is an example of where following safety management system procedures could have prevented a death or injury. Investigators found that the Captain and Chief Mate had met and developed a suitable work plan. This plan was later communicated to the crew involved. The plan had several important elements, including inspecting the Bosun's Chair and manila rope rigging, and requiring that the crewmember going over the rail wear a personal flotation device (PFD) and use a safety harness and lifeline.

However, the plan was not implemented. Crew members failed to adequately check the strength of the bosun's chair rope, instead simply pulling on it. Also, the deceased crew member had not been not wearing a PFD, and, even though he wore a safety harness along with a lifeline, the lifeline went untended and was not tied off to the vessel. The vessel's Bosun was not present, and it remains unknown as to who was supervising the operation. Finally, months before this tragedy, the Chief Mate had placed a requisition request for new manila rope and for PFD work vests that were designed to be worn with the vessel's safety harness; however, the request went unfilled.

Recommendations

As a result of this casualty, the USCG strongly reminds vessel owners and/or operators and all personnel on board vessels everywhere to do the following:

- Properly use safety equipment.

- Ensure adequate supervision of work teams.
- Develop workplace mind-sets that properly develop and execute plans, including those for worst case scenarios.
- Implement barriers to prevent such scenarios.
- Fully implement and adhere to Safety Management System requirements.

The full report can be found at uscg.mil/hq/cg5/cg545/alerts/0117.pdf.

Members may wish to refer to the following incident (search words: over board):

- Daughter craft man overboard incident
    - The main conclusion drawn was that the boatman did not secure his safety harness to the harness point and did not convey this to the deck crew.
    - Also, the deck crew lowered the davit wire without confirmation that the boatman was secure. Causes: failure of communication, failure to be aware of safety responsibilities, failure to use personal protective equipment (PPE) appropriately.