Fatality: struck down by falling object during lifting operation

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An incident has been reported in which a shipyard worker was struck and killed by a falling object whilst working in a ballast tank.

What happened?

The incident occurred during the dry docking of a vessel and occurred during lifting operations. A piece of steelwork fell from its rigging to the bottom of the ballast tank and hit the worker, causing fatal injuries.

Six large heavy plates, weighing approximately 100kg each, were being lifted by one team from the quay into the bottom of a ballast tank onboard the vessel.

Following a break period the lifting operation continued, although there was now other work taking place simultaneously at the bottom of the ballast tank. The first lift following the break was of a long angle plate sized 2000 x 300 x 90mm. This was initially rigged with a nylon flat webbing sling, choked around the plate.

At this point a safety officer stopped the job, noting that, in order to make the job safe, a padeye lifting point should be welded to the plate. The rigger went to see his supervisor in order to get a padeye welded on the angle iron, and the safety officer went to the permit to work office to request that the permit for this lift be put on stand-by until the padeye was welded in place.

For unexplained reasons, the lift nonetheless continued without the padeye. Workers in the bottom of the ballast tank were asked to move away as a lifting operation would shortly be in progress but not all of them did so. As the angle plate was lowered into the ballast tank, it or its web strop rigging got stuck on an obstruction, such that the plate slipped within the choked sling and then fell free. The plate fell to the bottom of the ballast tank and struck a worker who had not moved away, causing fatal injuries.

Our Member's investigation revealed the following:

Following investigation of this wholly avoidable incident the following causes were identified and actions were put in place to prevent recurrence:

- Bad rigging practices; specific rigging rules were not followed – a nylon flat webbing sling was used to rig the angle plate rather than a safe welded padeye welded as required by the safety officer.
- Lack of communication between sub-contractors and poor management of simultaneous operations.

- Instructions from safety officer were not followed.
- There was no proper control of the lifting operation:
  - the area under lift was not controlled
  - proper communications (radios) were not employed
  - a rigging supervisor was not involved.
- Insufficient personnel were involved in the operation, which involved lifting via a narrow opening, through two different levels down inside a ballast tank, with poor visibility, a load not vertical and no rigger at the landing area to receive the load.

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