Man overboard from stinger

Safety Flash Published on **23 June 2020** Generated on **12 January 2025** IMCA SF 19/20

IOGP Life Saving Rules:


Bypassing safety controls


Working at height


Work authorisation

What happened?

A member of the crew fell overboard through an opening in the stinger.

The incident occurred with the vessel alongside in port. A team of three electricians were conducting function checks on a new roller box camera on the stinger.

One of the team fell about 2 metres into the water through an opening in the stinger floor grating.

The person remained conscious and was able to swim to a lifebuoy that had been pre-deployed as part of the task.

He was recovered via the quayside ladder and was given first aid treatment for minor scratches on his neck and ear.

What were the causes? What went wrong?

- A requirement to move the vessel prevented the work on the stinger being completed on the quayside, which would have removed the fall potential.
- Two weeks before the incident, a management inspection of the stinger had identified damage to handrails and walkway grating including the section from which the fall occurred. Repair was considered low priority because this area was not one that was normally accessed, and remedial work was neither planned nor immediately actioned.
- The controls identified in the risk assessment were not verified by the supervising persons at the site.
- The Permit to Work (PTW) was authorised without review or confirmation of control measures.
- “Task seen as routine”- there was no task-specific Toolbox Talk (TBT) conducted; a ‘pre-shift’ briefing was considered adequate. The persons involved saw the task as “routine and simple”.
- The work team involved in the incident observed unsafe conditions, including openings in walkways and missing handrails, *but did not stop the job* to re-assess, or apply any Management of Change procedure.

What actions were taken?

- Adequate planning and risk assessment before starting work.
- Appropriate review of work area before start to ensure the specified controls provide safe working conditions.

- Stop work authority should be re-emphasised as an obligation and responsibility for all.
- Specific risk of falling overboard should be considered not only for work over the side but also for work near the side.

Members may wish to refer to:

- Near Miss: Man Overboard
- Lost Time Injury (LTI): Fall Overboard/Fall From Height
- Near-Miss: Mooring Without Port Assistance