

# Case study for onboard safety meeting

## Case study no. 10: Working aloft

Please read the below story of an incident. Keep our procedures in mind while reading to compare with the actions of the crew below as we will discuss the factors which led to the incident occurring.

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The vessel was anchored off Singapore early one morning in mid-December.

En route from Hamburg to Singapore, the crew had found some glass fragments on the portside poop deck and, during investigations from the bridge deck level, the Master had noticed that some of the navigation light protection caps located in the X-mas tree, were damaged. He had requested that the repairs be carried out prior to arrival in Singapore.

As the weather had been adverse en route, the engineers apparently decided to carry out the repairs whilst the vessel was at anchor off Singapore. The Chief Engineer ordered one of his motormen to carry out the task. The motorman was told that it was an easy job which should only take about 10 minutes. Therefore, no further briefing was needed. The designated motorman gathered the equipment necessary and went directly from the engine room to the monkey island and started climbing the mast. The motorman carried the necessary tools in his hand while climbing up the ladder. A climbing safety device was believed not to be necessary because the motorman was told that it was only 3 metres to climb from the monkey island to the navigation lights. This was the first time the motorman had worked aloft since he started onboard a month ago.

The Chief Engineer notified the Officer of the Watch (OOW) that the engineers were planning to change the protection caps of the navigation lights that morning. The OOW, who was on anchor watch at the navigation bridge, switched off both radars.

When the Master entered the bridge around 10.45 hours, he immediately noticed that the radars were switched off. As they had previously experienced technical problems with the radars, he thought that they had become inoperative again and instinctively, before the OOW who was present on the port bridge wing could warn him, switched on the 3 cm radar.

The antenna started rotating and the motorman in the mast was hit causing him to fall over the railing and land on the monkey island, some 5.5 meters below.

The Master heard a loud bang on the monkey island and initially thought that the antenna had fallen down, but it very soon became apparent that it was the motorman.

Upon attending the monkey island, they found the motorman, who was conscious but in pain and shock and medical assistance was requested for.

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# How to improve by lessons learnt

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Based on the case, you should now perform an onboard risk assessment of the incident and the factors which led to it. Bear in mind our vessel's procedures.

1 What factors contributed to the incident in the above case?

2 Risk Assessment: Could some of the factors identified be present on board your ship?  
(How frequent could they be present? How severe could it be if they are present?)

3 In the risk transfer zone (yellow and red), what would you suggest as measures to control the risk? Any additional barriers that could be introduced?