



SAFETY BULLETIN

Safety at Survey Sites



1st July 2026

1. PURPOSE & OVERVIEW

This Safety Bulletin has been prepared following a review of Accident, Incident and Near Miss (AINM) reports received from survey stations and Head Office. The objective is to share lessons learnt, reinforce safe behaviours and prevent recurrence of similar events through improved hazard recognition, effective risk assessment and consistent application of safe working practices.

The report considers both completed and ongoing reports so as to bring out the safety learnings at the earliest opportunity. As a result, certain incidents may be referred to in successive Safety Bulletins.

The review identified **confined space safety, access and working at height, boarding and transfer arrangements, electrical safety, housekeeping, lifting operations, travel safety, equipment integrity and behavioural safety** as the principal recurring risk areas.

The reports demonstrate the effectiveness of proactive intervention by surveyors through the exercise of **STOP WORK Authority, independent verification of safety arrangements and refusal to proceed until acceptable safety standards had been established.**

2. ACCIDENTS (RESULTING IN INJURY)

No accidents resulting in injury or loss of man-hours were reported during the review period. While this is encouraging, the number of high-potential unsafe conditions and near misses reinforces the need for continued vigilance and proactive hazard identification.

3. KEY INCIDENT CATEGORIES & OBSERVATIONS

The reported incidents have been grouped according to the principal hazard involved to facilitate identification of recurring trends and reinforce key safety learnings.

3.1 Access, Boarding & Working at Height

Reported Incidents

- Gangway was not fully lowered to the jetty and temporary access was provided using unsecured wooden planks, resulting in unstable boarding conditions.
- Gangway shifted during boarding because of inadequate securing arrangements.
- Pilot ladder was rigged beyond safe reaching distance from the accommodation ladder; embarkation was postponed until correctly rigged.
- Accommodation ladder stanchion was found loose before boarding and rectified prior to use.
- Damaged gangway safety net identified during boarding and reported immediately.
- Hatch cover fell due to ineffective securing pin while personnel were exiting a steering gear compartment.
- Missing bulwark and guardrails were identified adjacent to active work areas.
- Work-at-height platform found without adequate edge protection.
- During disembarkation, the gangway damaged due to contact with the service boat fender and twisted significantly, with the surveyor prevented from falling overboard by the safety net.

Potential Consequences

Falls from height, falling overboard, drowning, fractures, multiple serious injuries or fatalities.

3.2 Confined Space Entry

Reported Incidents

- Ventilation ducting terminated at the first stringer and did not extend into the double-bottom space.
- Personnel entered enclosed spaces without a valid permit.
- Standby personnel were absent.
- Adequate lighting had not been provided.
- Gas testing was attempted before satisfactory ventilation had been established.

Potential Consequences

Oxygen deficiency, toxic atmosphere exposure, delayed rescue, multiple fatalities.

3.3 Housekeeping, Slips & Trips

Reported Incidents

- Oil accumulation on engine-room ladders resulted in a surveyor slipping while descending.
- Debris obstructed designated access routes within shipyards.
- Electrical cables crossed walkways creating trip hazards.
- Open deck penetrations and poor housekeeping created fall hazards.

Potential Consequences

Slips, trips, falls, fractures, head injuries, delayed emergency evacuation.

3.4 Electrical Safety

Reported Incidents

- Live electrical cable was found lying in standing water during shipyard attendance.
- Office MCB failure resulted in loss of lighting and network connectivity.
- Defective electrical fittings observed onboard, required replacement before safe operation could resume.

Potential Consequences

Electric shock, arc flash, fire, interruption of emergency systems and communications.

3.5 Lifting Operations & Suspended Loads

Reported Incidents

- Synthetic rope parted during bollard pull testing.
- Sling shifted during slewing of a heavy propeller boss.
- Air hose coupling blew-off under pressure.
- Hydraulic hose disconnected during pressure testing.
- Lifeboat launching operation was suspended after lashing gripes became entangled.
- Unsafe relief valve testing arrangements observed, however testing was stopped before commencement.

Potential Consequences

Dropped loads, hose whip, crushing injuries, impact injuries, fatalities.

3.6 Travel & Transportation Safety

Reported Incidents

- Vehicle aquaplaned during severe rainfall.
- Vehicle tyre burst after striking a protruding manhole cover.
- Surveyor experienced detention by immigration authorities due to deficiencies associated with the transport provider's documentation.
- Boarding operations were postponed because of adverse weather, excessive vessel movement and unsafe transfer arrangements.

Potential Consequences

Road traffic accidents, personal injury, detention, security risks, delayed emergency response.

3.7 Office & Workplace Safety

Reported Incidents

- Visitor entered office premises without authorisation and attempted forced re-entry.
- Office chair collapsed due to structural failure of wheel supports.
- Personnel continued to use a designated landslide-prone area despite warning notices.

Potential Consequences

Security breaches, musculoskeletal injuries, falls, unauthorised access, environmental injury.

3.8 Equipment Integrity & Maintenance

Reported Incidents

- Accommodation ladder defects identified prior to boarding.
- Damaged gangway safety net detected during access.
- Office furniture failure highlighted need for periodic inspection.
- Defective electrical installations required immediate repair.

Potential Consequences

Equipment failure, falls, injuries during access, loss of confidence in safety-critical equipment.

3.9 Behavioural Safety & Positive Interventions

Reported Incidents

- Surveyors exercised STOP WORK Authority on multiple occasions.
- Unsafe enclosed space entry was prevented before work commenced.
- Unsafe boarding arrangements were rejected until rectified.
- Unsafe work-at-height arrangements were corrected before surveys proceeded.
- Unsafe lifting operations were suspended pending implementation of safe controls.
- Unsafe conditions were promptly reported to vessel crews, shipyard personnel and office management.

Potential Consequences

Failure to intervene could have resulted in serious injuries, fatalities, equipment damage and significant organisational consequences.

4. KEY LEARNINGS & SAFETY EXPECTATIONS

- Surveyors shall independently verify all safety arrangements before commencing work and shall not rely solely on assurances from others.
- Safe access arrangements must be inspected before every boarding, transfer and work-at-height activity.
- Confined space entry shall only proceed after confirming valid permits, effective ventilation, satisfactory atmospheric testing, rescue arrangements and continuous standby attendance.
- STOP WORK Authority shall be exercised immediately whenever unsafe conditions are identified. Timely intervention continues to be the most effective means of preventing accidents.
- Good housekeeping is a fundamental safety control. Access routes shall remain free from oil, debris, loose materials and trailing cables.
- Electrical hazards, including temporary installations, damaged equipment and water ingress, shall be treated as potentially life-threatening until confirmed safe.

- Lifting operations shall only proceed when exclusion zones are maintained and all lifting equipment has been verified as fit for purpose.
- Travel risks shall be managed through appropriate journey planning, safe transport arrangements and continuous situational awareness.
- Office safety, security and visitor management are integral components of the organisation's safety management system and require the same level of attention as operational activities.
- Surveyors shall continuously reassess workplace conditions throughout the survey. Conditions verified as safe at the commencement of work may change rapidly due to concurrent activities, weather, vessel movement or changes in shipyard operations.
- Every accident, incident, near miss and unsafe condition provides an opportunity for organisational learning. Timely reporting and sharing of lessons learnt remain essential for continual improvement.

5. CONCLUSION

The combined review of completed and ongoing AINM reports demonstrates that **most serious risks originate from identifiable unsafe conditions, unsafe acts and procedural deviations rather than unforeseen events**. The proactive actions taken by surveyors in recognising hazards, challenging unsafe practices and exercising STOP WORK Authority prevented numerous potentially serious incidents from escalating into accidents.

