SAFETY INVESTIGATION REPORT
OCCUPATIONAL ACCIDENT ON RO-RO VESSEL UND ATILIM

VESSEL NAME and IMO No	**:**	UND ATILIM - 9242388
FLAG OF THE VESSEL	**:**	Turkey
LOCATION OF ACCIDENT	**:**	Port of Mersin/MERSİN
DATE OF ACCIDENT	**:**	10.03.2020/16:35 LT
CASUALTIES	**:**	1/-
DAMAGE and POLLUTION	**:**	-/-

Board Decision No: 14/DNZ- 04/2021 *Date: 12/07/2021*

The sole objective of this investigation is to make recommendations for the prevention of similar accidents and incidents within the framework of the Transport Safety Investigation Center regulation. This report neither has the value of judiciary and administrative investigation nor bears the purpose to apportion blame or liability.

BASIS

This marine accident has been examined by the provisions of the “DIRECTIVE OF INVESTIGATION of MARINE ACCIDENTS and INCIDENTS” published and enacted in the Official Gazette dated 27.11.2019 and numbered 30961.

International Standards for Safety Investigations into Marine Accidents or Incidents (MSC 255(84) and Resolution A.1075 (28) and International Maritime Organization Decisions on Recommended Practices (Accident Investigation Code) and Directive 2009/18/EC of the European Union have also been taken into account for the procedures and principles of the investigation.

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LIST OF PICTURES

SUMMARY

Picture 1: Accident Location

Note: All times used in the report are local time (GMT[1] +3)

The vessel named UND ATILIM[2] berthed to the dock MIP.9 the Port of at Mersin for unloading/loading operations on 9th March 2020. After the unloading operations have been completed, the loading operations began on 10th March 2020 at 14.30. Meanwhile, the workers of a contractor, which had been contracted to replace and maintain the sprinkler nozzles, began working on the mobile scaffolding on the main deck.

At 16.35, the trailer that was tracked by the loading MAFI crushed into the mobile scaffold and caused the worker on the mobile scaffold to lose his balance and fall from a height of 5 meters onto the main deck ground. Immediately following the accident, the medical practitioners arrived at the scene in a short span of time and delivered the initial intervention, and the casualty was referred to the hospital. However, the casualty passed away despite all attempts to save him.

In consequence of the accident investigation, no risk assessment was accomplished for the impact of loading operations when planning the work aloft, that the work was not properly

[1] GMT: Greenwich Mean Solar Time Over the Prime Meridian
[2] The name of the vessel was changed to CAPPADOCIA SEAWAYS and shall be referred to as UND ATILIM in this report.

controlled and supervised while it was in progress, and that the workers' personal protective equipment was insufficient for working aloft.

UEİM[3] made recommendations to the Ship's Operator and the Contractor based on the results of the accident investigation.

[3] Transport Safety Investigation Center of TURKEY

SECTION 1 - FINDINGS

1.1 Information on the Vessel

1.1.1. Basic Information on the Vessel

UND ATILIM (CAPPADOCIA SEAWAYS)

Flag	Turkey
Class Society	Lloyd Register (LR)
IMO Number	9242388
Type	Ro-Ro/Cargo
Place and Year of Building	Germany-2002
Gross Tonnage	26469
Length Over All	183,27 meters
Main Engine Power	2x8100 kW (MAK 9M43)

Picture 2: UND ATILIM

1.1.2. Information on Vessel Navigation

UND ATILIM (CAPPADOCIA SEAWAYS)

Port of Departure	Trieste/ITALY
Port of Arrival	Mersin/TURKEY
Number of Passengers	-
Number of Crew	25
Minimum Number of Seaman	16/18
Type of Navigation	Near Coastal Voyage/Oceangoing Voyage
Cargo Condition	TRUCK/Trailer/Bus

1.1.3. Safety Management System

A class society recognized by the Administration issued a Safety Management Certificate (SMC), dated 10th May 2017 for the vessel, valid for five years. Also, another class society recognized by the Administration issued a Document of Compliance (DoC), dated 15th February 2019 for the vessel, valid for five years, and conducted an annual audit of the vessel in Istanbul on 27th February 2019.

1.2 Information on Manning and Key Crew

Maritime Administration, according to SOLAS V/14, issued a Safe Manning Certificate dated 9th August 2019 for the vessel. Based on the Certificates, the vessel was observed to have been sufficiently manned oceangoing and near-coastal voyage.

All ship crew are Turkish citizens and the working language on board is Turkish. No problems with communication amongst ship crew members were reported. There were 25 people on board at the time of the accident, including the captain. There was one able

seaman, MAFI[4] operator and contractor's workers to accompany loading in the accident location.

1.2.1 1st Officer/SSO

1st Officer is a Turkish citizen. He was 35 years old at the time of the accident. He is certified as Oceangoing Watchkeeping 1st Officer. He has been working for the same company as a 1st Officer for six months. We have learned that he has been working at the company for 7.5 years and has served permanently as a first officer on the vessel UND ATILIM since May 2017, and his last boarding to the ship was 6th February 2020. He was at the Ship Office at the time of the accident.

1.2.2 MAFI Operator

The MAFI Operator is a Turkish citizen. He is certified for operating MAFI with an E-Class licence. The port authority trained him for all occupational safety issues. He was fully using personal protective equipment at the time of the accident. he has been operating the vehicle called MAFI for 11 years and is experienced in loading/unloading operations on the vessel UND ATILIM. He was appointed for loading trailers on the main deck at the time of the accident.

1.2.3 Casualty

The casualty was a Turkish citizen. He was 45 years old at the time of the accident. He was awarded a certificate by attending 8-hour Occupational Health and Safety training on 5th February 2020. He had a medical report on January 28th 2019, indicating that he could work in similar works. It was also discovered that he participated in Occupational Safety Training on 3rd October 2019, where all information on "Working Aloft and In Confined Spaces" was provided. It was found that he was provided with PPE for the works in which he would work as a "Chief Worker" on 25th September 2019. At the time of the accident, he had been replacing the sprinkler nozzles and maintaining the circuits on the mobile scaffolding on the main deck.

[4] Vehicle used for loading/unloading cargo by tracking or towing trailers.

1.3 Information on Accident

Date/Time of Accident	10.03.2020/16.35 Local time
Accident Type	Very serious marine accident
Type of Accident	Fall from Height
Location of Accident	Port of Mersin/MERSİN
Casualties	-/1/-
Damage	-
Pollution	-

1.4 Information on Environment Conditions

Wind	Four knots from the northwest
Sea Condition	Tranquil
Visibility	Clear
Weather Condition	Partly cloudy

SECTION 2 – NARRATIVE

Note: The sequence and time of the incident that leads to the marine accident under investigation and the location of people mostly depend on the eyewitness statements and interviews.

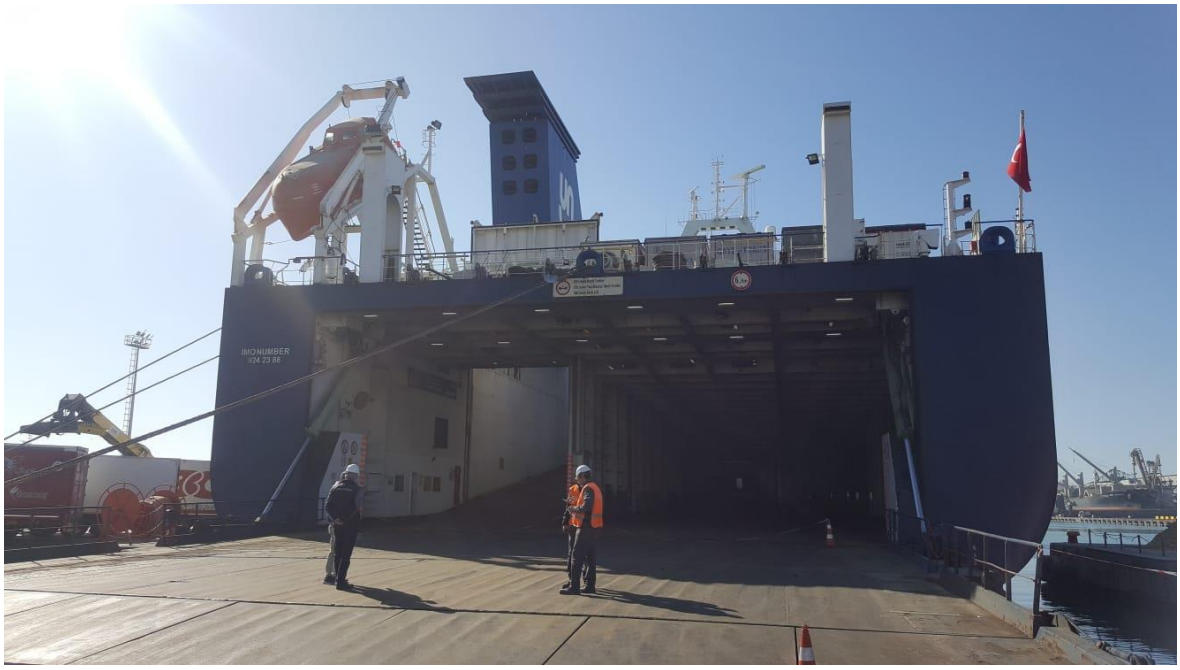
2.1 Course of Events

The vessel, UND ATILIM, which sailed through Trieste (Italy) - Mersin, moored to the port of Mersin on 9th March 2020 at 13.30. After being instructed for berthing the vessel berthed to the dock MIP.9 at 16.54. The loading operation began at 17.52 following the completion of other administrative procedures. The loading operation was completed at 23.30 without any problems.

A meeting was held between an official from a contractor who had previously been contracted to replace sprinkler circuit nozzles on the ship's main deck and maintain their circuits and the vessel's crew to assess the risks of working aloft before the repair work began. The ship and contractor officials signed and approved the meeting minutes (RAV0000018) and the work permit (V0000774) on 10th March 2020 at 13.25 after the controls. The contractor's workers then set up the mobile scaffold given by the vessel on the designated work site on the main deck, and the repair work began at 13.30. A total of three workers were deployed on the scaffold; two at the top and one at the bottom, to carry out the assigned works.

Meanwhile, loading operations began on 10th March 2020 at 14.20. The Ro-Ro field pointer of MIC General Cargo checked the safety of the operation field at 16.10 and proceeded with the loading operation upon mutual agreement with the ship's operation officer. The loading of 15 trailers was completed with the tow trucks called MAFI.

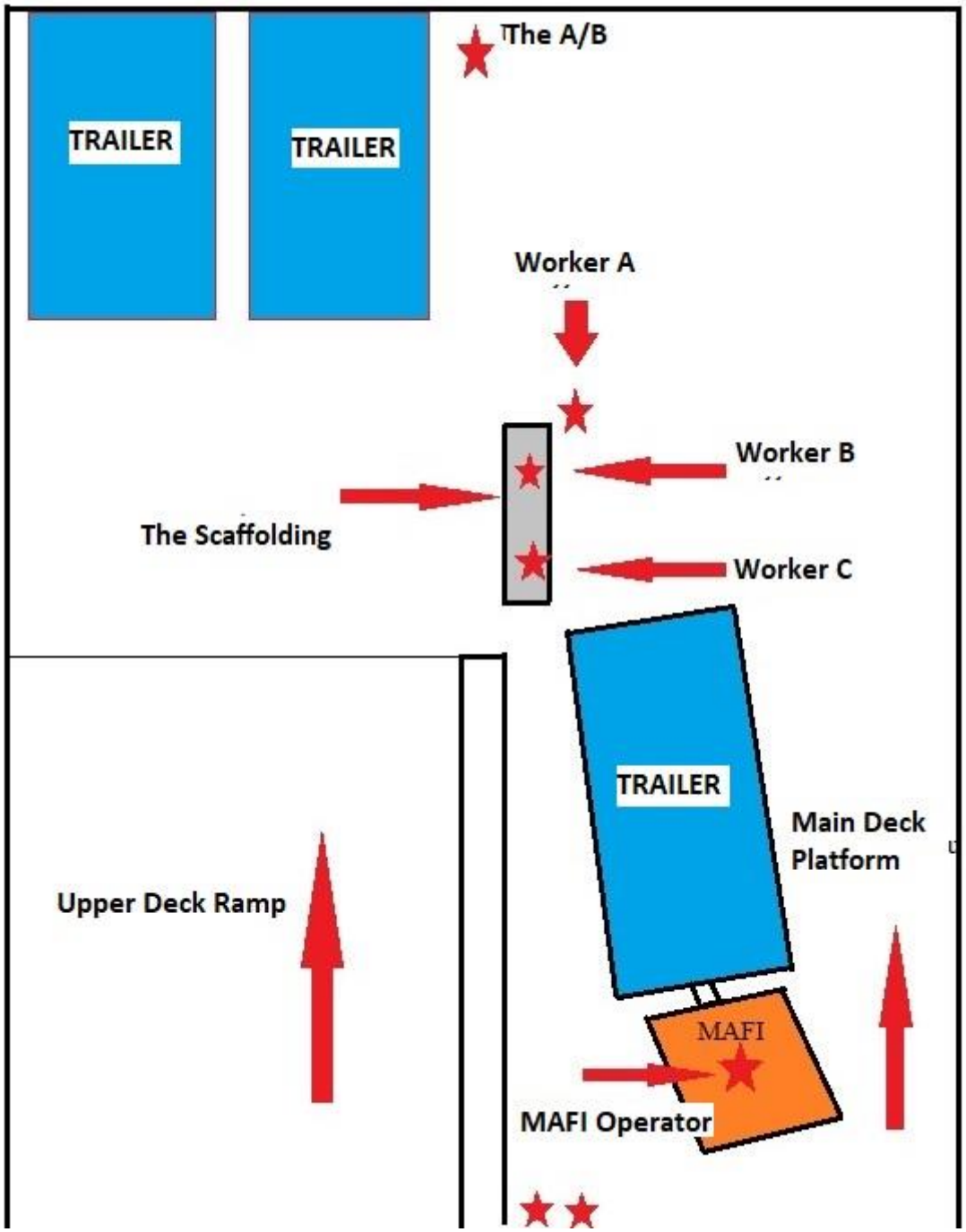
Meanwhile, the mobile scaffold was being displaced and the sprinkler nozzles were being replaced and circuits were being maintained on the main deck. Around 16:35, the trailer that was tracked by the loading MAFI and boarded the main deck from the ship's ramp touched the mobile scaffold, , and caused one of the two workers on the mobile scaffold to lose his balance and fall from a height of 5 meters onto the ground. The other worker was hanged by holding the pipe at the moment and narrowly escaped from falling ***(Photo 3 – 4 – 5 - 6)***.



Picture 3: UND ATILIM Boarding Ramps

Picture 4: The Moment When the MAFI and the Tracked Trailer That Caused the Accident Approach the Ship

Picture 5: The Moment When the MAFI and the Tracked Trailer That Caused the Accident Get on The Ship's Ramp



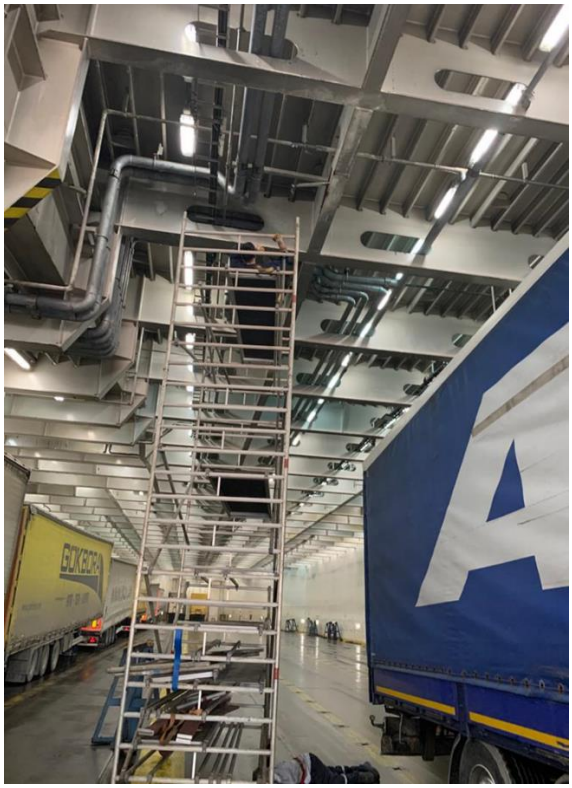
Picture 6: Bird's eye chart of the accident location (Scale has not been accurately calculated.)

2.2 The Course of Events After the Accident

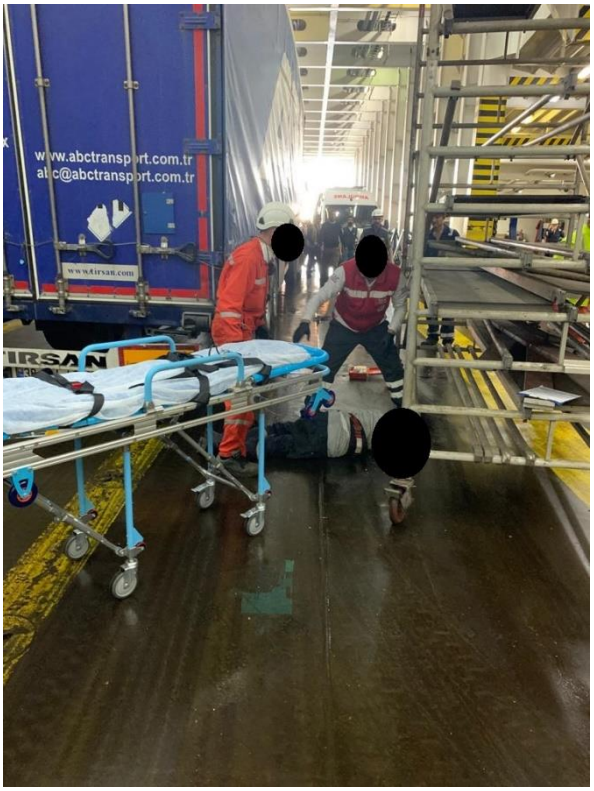
The seafarer on the main deck, who had witnessed the accident notified the deck officer by radio immediately after the accident. The accident was, respectively, reported to first the deck officer and the master and 1st Officer by the Deck Officer. The worker who was hanged by holding the pipe at the last minute and narrowly escaped from falling safely moved down with the help of the other worker on the ground.

The port operation unit immediately called for the workers who fell on the ground and requested an ambulance. The ambulance stationed in the port arrived at the scene in a short time around 4:40 PM and transported the casualty to the hospital following the first intervention. ***(Photo 7 - 8)***

However, the casualty passed away in the hospital he was referred to despite all the interventions.



Picture 7: A post-accident photo



Picture 8: Photo of the Initial Intervention to the Casualty

SECTION 3 – ANALYZES

While analyzing the marine accident under investigation, it is aimed to identify and determine the factors that caused the accident by considering the sequence of events and data obtained during the investigation and as well as to draw useful conclusions that lead to the safety recommendations on root causes.

3.1 Safe Working Aloft

Working Aloft is the leading cause of death and serious injury. Fall from height often takes place at unprotected edges or gaps, as well as temporary access vehicles, such as scaffolds. As the falling height increases, the consequence is usually more severe, however, falls from low heights can also be lethal.

It is essential to plan and organize the works aloft for their safe performance. Employers should first assess the risks and take into account factors such as the height of the work site, the duration and frequency of the work, and the condition of the working surface. Preparing a checklist for the risks associated with each work aloft and then following their condition on the checklist as well as the status of the worksite would make a great contribution to ensure a safe working environment.

Accordingly, staff who work aloft must be instructed and trained on the hazards, risks, control measures and safe working methods of working aloft. Finally, works aloft must be supervised and controlled by a competent person appointed by the employer.

3.1.1 Works Aloft on UND ATILIM

According to the data from the Accident Investigation, it was observed that the "*Work Aloft*" was planned according to specific procedures to be followed through the Safe Management Manual on UND ATILIM. Following are the assessments made on the planned work.

3.1.1.1 Risk Assessment Procedures for UND ATILIM

ISM Code Part A Art. 1.2.2.2 specifies:

"Safety-management objectives of the Company should, inter alia, assess all identified risks to its ships, personnel and the environment and establish appropriate safeguards."

The ISM Code does not make any explicit reference to risk assessment or risk analysis, save for the above, nonetheless, it is essential to most of the Code requirements, notably in compliance with Section 7 "Ship Procedures".

Associated risks are those that can reasonably be expected and relate to procedures or operations on the vessel with respect to:

- The health and safety of all persons directly or indirectly involved or otherwise affected by the operations;
- Ownership of the Company and others;
- Environment.

Hazard can be defined as a circumstance or practice that has the potential to cause harm. Therefore, a risk analysis process may briefly include the following stages:

- ✓ Identifying the hazards;
- ✓ Assessing risks associated with those hazards;
- ✓ Implementing the controls to minimize unavoidable risks. Controls can be implemented to minimize the occurrence probability of an undesirable event or to mitigate the severity of the consequences;
- ✓ Monitoring the effectiveness of controls.

The ISM Code establishes no particular spatial model for risk management, and the company must therefore design a system and methods under organizational structure and ship operations. Methods, if it is able to assess and evaluate, should be systematic.

It must be documented by procedures to ensure completeness and effectiveness of interference and to provide evidence for the decision-making process, as well as for inspections and audits conducted by the Operator, Competent Authorities and interested parties.

Having said that and under the ISM Code, ship operations on UND ATILIM were carried out under control measures frequently indicated by the Risk Assessment procedure, as mentioned in the Safety Management Manual to minimize the risks to human life, the environment and property.

Prior to the start of the operation on 10th March 2020, when the marine accident took place, the Risk Assessment for the work was accomplished and documented in the standard *"Risk Assessment Form"* annexed to the Section ***(APPENDIX - 1).***

However, Risk Assessment Form showed that what could be the impact of loading operation to be performed on the works on the same field while *"Working aloft"* and possible risks were not assessed. This is considered to be one of the factors that contributed to the accident.

3.1.1.2. Content of Work Aloft

Having to regard the statements on the *"Toolbox Safety Meeting"* before starting operations during the interview and based on the completed *"Form"*, the working team concluded that the terms of reference of "Permit to Work Aloft" referred to the replacement of sprinkler nozzles and maintenance of circuits.

Nevertheless, it has been noted from the interviews that the terms of reference did not include hot work to be carried out in the operating area and therefore, potential hazards and risks were not assessed. Failure to establish a broad statement of the work to be performed is considered another factor that contributed to the accident.

3.1.1.3: Permit to Work Aloft

A "Permit to Work aloft" was issued on 10th March 2020 for the replacement of sprinkler nozzles and maintenance of circuits in accordance with the Company Safe Management Manual. The working permit was also based on the UND ATILIM risk assessment process of "*Working Aloft"* as analysed in paragraph 3.1.1.1. ***(ANNEX - 2)***

"Permit to Work Aloft" was documented in the *"V0000774"* Form and produced by the 1st Officer. More specifically, the Form contains the following information:

- Terms of reference as "replacement of sprinkler nozzles and maintenance of circuits";

- Working team (four contractor's workers);
- Responsible person (contractor's representative);
- A table of checkboxes showing the availability and condition of the equipment to be used;
- Name and signature of the Supervisory Officer (1st Officer);
- Name and signature of the person responsible for preparation (1st Officer).

Neither the safety of the operating area nor the information on other workers was clearly stated in the relevant document. However, no checkboxes were noticed related to the lighting conditions of the worksite.

Despite the fact that the Form indicated that "four" workers would be deployed, there was no fourth worker on the scene of the accident. Moreover, it is noticeable that the other three workers did not sign the spaces reserved for their signatures.

The circumstances stated above are considered to be the factors that contributed to the accident.

3.1.1.4 Use of Personal Protective Equipment

Inspections conducted following the accident showed that the worksheet contained the records on the worksheet for the equipment that would be used in the works. However, it did not clearly specify what was equipment to be used.

It was found that the casualty wore *"Work Positioning Harness"* and the scaffold was not anchored as it was displaced during the accident. A work positioning harness is required for the employee to work within a specific site and is designed to work safely on that site. ***(Photo 9 - 10)***

However, when it is considered that such types of harnesses should be continuously unhooked from the anchor points in dynamic work sites, it is obvious that they are unable to provide highly efficient works and prevent fatal injuries when the risk of falling escalates. On the contrary, statements indicate that the worker's safety harnesses were not hooked to a fixed point since the scaffold was displaced during the accident. The risk will be minimized if the parachute type safety harnesses are used along with fall arrest systems, especially in the site where the operations are dynamic or constant change is necessary. ***(Photo – 11)***

Picture 9: Safety Harness and Helmet on the Casualty

Picture 10: Work Positioning Harness

Picture 12: Parachute Type Safety Harness

The statements and photographs also show that the helmet came off the casualty's head after the fall and was broken. The chin straps of such helmets keep them balanced and prevent them from coming off easily in cases, such as trips, overturns, and falls. Although there is no evidence of how the casualty utilized his helmet throughout the operation, the discovery of a broken helmet indicates that it did not come off during the fall.

Failure to deploy the parachute type safety harnesses along with fall arrest systems is considered to be one of the factors that contributed to the accident.

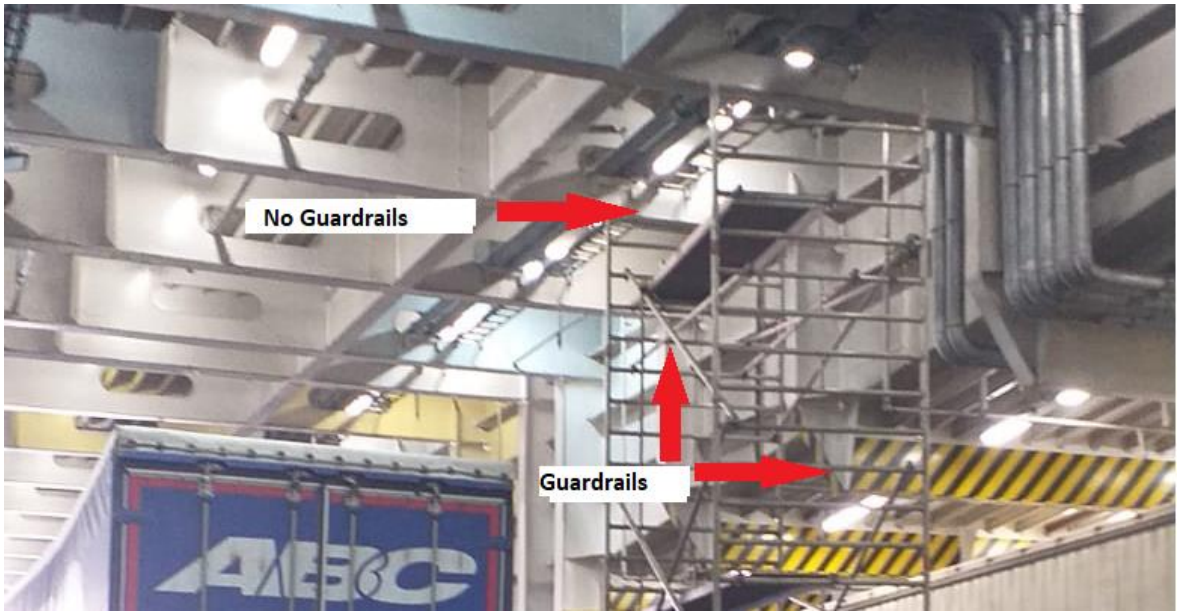
3.1.1.5. Equipment Used for Working Aloft

The mobile scaffold that was used in the operation was provided to the workers by the ship. Although there is no reference to the scaffold in the "Permit to Work aloft" form, the box *"Equipment in Good Order"* indicated that the scaffold was delivered after being checked for serviceability and well-maintenance.

However, when the site where workers work on the mobile scaffold in ***Photo -14*** was examined, the front and rear guardrails, shown in ***Photo -13*** were seen to be missing. It was found that although the workers who appeared to be unavoidable to work on the top had the chance to place the mobile braces and guardrails in the lower parts according to the worksite, they didn't do so, and they were not warned on such issue.

Improper use of the mobile scaffold delivered for work is considered to be one of the factors that contributed to the accident.

Picture 13: Mobile Scaffold (Figurative Photo)



Picture 14: Top of Mobile Scaffold where Workers Work

3.1.1.6. Surveillance and Control

No explicit data was found in Appendix 2 on how to make the operating area safe and whom to follow up on the *"Permit to Work aloft"* issued in accordance with the Company Safe Management Manual. Only the signatures of the 1st Officer who had produced the form as the auditor and the contractor's representative who was in charge of the work were available.

Examining the operating area during the accident, the MAFI operator stated that they were not informed or guided on working aloft in that area. The ship crew who is assigned on each deck guides MAFI that bring trailers on the loading floors. The seafarer on the main deck stated that the MAFI operator did not wait for his guidance. However, the MAFI operator's statement that he could not see his left side while boarding due to the structure and manoeuvre of MAFI suggests that the warning and guidance of those carrying out simultaneous loading operations were not well-planned when a Permit to Work Aloft had been planned, or the assigned work was not fulfilled.

Nonetheless, given that surrounding the perimeter of the scaffold by barriers or safety tapes would raise awareness among other employees when the operating area was being prepared, it was found that nothing was planned and exercised thereof.

Having considered the foregoing circumstances, the lack of clear data on how and who would supervise/control the operations while planning the *"Work aloft"*, failure to fulfil the work properly even if it was stated, and failure to surround the perimeter of the worksite by safety tapes are considered to the most important factors contributing to the accident.

3.2 Fatigue

It was learned from the statements of the MAFI operator that he has 10 years of experience in loading and unloading operations of UND ATILIM and similar vessels. Having considered that the vessel UND ATILIM began to be unloaded at 17.52 the day before and completed at 23.30, she began to be loaded at 14.30 the day after and the accident took place at 16.35, the accident investigation team was not satisfied that the fatigue was one of the factors that contributed to the accident.

SECTION 4 – CONCLUSIONS

4.1 The Risk Assessment Form showed that what could be the impact of loading operation to be performed on the works on the same field while *"Working Aloft"* and possible risks were not assessed.

4.2 It was found that the terms of reference did not include hot work to be carried out in the operating area and therefore, potential hazards and risks were not assessed.

4.3 The *"Permit to Work Aloft"* form did not include any information on who would coordinate the safety of the operating area and inform other workers.

4.4 There is no specific indication on the checkbox related to the lighting condition of the worksite.

4.5 Despite the fact that the Form indicated that *"four"* workers would be deployed, only *"three"* workers' signatures were available.

4.6 The casualty was working with a *"Work Positioning Harness"* provided to him however, it was not hooked to a fixed point at that moment.

4.7 The helmet of the worker was on his head while he was falling and damaged by the fall.

4.8 Mobile scaffold equipment delivered for the work was not properly used.

4.9 There is no data on the proper performance of the work even if how and who would supervise/control the operations was stated while planning the *"Work aloft"*

4.10 The work site was not surrounded by safety barriers or tapes.

4.11 When the working hours of the MAFI operator were examined, fatigue is not considered as one of the factors that contributed to the accident.

SECTION 5 – RECOMMENDATIONS

The following recommendations are made by considering the analysis and conclusions derived from the accident investigation.

The Ship Operator is recommended;

18/04-21 To consider the appropriate PPE (features/restrictions); reviewing the *"Risk Assessment"* and *"Permit to Work Aloft"* procedures throughout the fleet to ensure that planned operations are adapted to the operational needs,

The Contractor is recommended;

19/04-21 To support workers with the appropriate PPE for the working at heights and taking measures to raise awareness of your employees for potential risks by considering this accident report,

APPENDICES

APPENDIX-1

Risk Assessment - UND ATILIM

Title	Working Aloft		
Operation	Risk Assessments - Deck Department - Maintenance Deck Department		
Location	Above deck at height	**Department**	D
Duration		**Frequency**	
Operators at Risk	Crew	**Assessment ID**	RAV0000018
Other persons at Risk	Contractors		

DESCRIPTION OF ACTIVITY

Personnel working at height may not be able to give their full attention to the job and at the same time guard themselves against falling. Proper precautions should therefore always be taken to ensure personal safety whenwork has to be done aloft or when working outboard. It must be remembered that the movement of a ship in a seaway and extreme weather conditions even when alongside, will add to the hazards involved in work of this type. A stage or ladder should also be utilised when work is to be done beyond normal reach.

Personnel under 18 years of age or with less than 12 months experience at sea, should not work aloft unless accompanied by an experienced person or other wise adequately supervised.

Personnel working aloft should wear safety harness with lifeline or other attesting device at all times. A safety net should be rigged where necessary and appropriate. Additionnally, where work is done overside, buoyancy garments should be worn and a lifebuoy with sufficient line attched should be kept ready for immediate use. Personnel should be under observation from a person on deck.

HAZARDS, RISKS AND ASSESSMENT OF RISK

Overall Risk Factor: TOLERABLE(2)

No	Hazard	Existing Controls	Control References	Likelihood x Severity = Risk Factor
01	Use of sharp tools	Provide suitable PPE	Code of Safe working Practice (UK MCA)	Highly Unlikely 1 Harmful 2 TOLERABLE(2)
02	Use of tools and other equipment	Avoid working alone where possible	Company Procedures	Highly Unlikely 1 Harmful 2 TOLERABLE(2)
03	Exposure to noise	Provide hearing protection - Ear defenders, disposable ear plug	Code of Safe working Practice (UK MCA)	Highly Unlikely 1 Slightly Harmful 1 TRIVIAL (1)
04	Extremes of temperature	Provide / wear suitable PPE	Code of Safe working Practice (UK MCA)	Highly Unlikely 1 Slightly Harmful 1 TRIVIAL (1)
05	Working at height	No lone working	Code of Safe working Practice (UK MCA)	Highly Unlikely 1 Harmful 2 TOLERABLE(2)
06	Working at height	Provide / wear suitable PPE	Code of Safe working Practice (UK MCA)	Highly Unlikely 1 Harmful 2 TOLERABLE(2)
07	Working at height	Establish a safe system of work	Code of Safe working Practice (UK MCA)	Highly Unlikely 1 Slightly Harmful 1 TRIVIAL (1)
08	Working at height	Harness, attachments, safety lines in good working order	Code of Safe working Practice (UK MCA)	Highly Unlikely 1 Slightly Harmful 1 TRIVIAL (1)
09	Working at height	Ladders at correct angle	Code of Safe working Practice (UK MCA)	Highly Unlikely 1 Harmful 2 TOLERABLE(2)
10	Objects or falling debris	Warning signs displayed	Code of Safe working Practice (UK MCA)	Highly Unlikely 1 Harmful 2 TOLERABLE(2)
11	Fatigue	Sufficient rest to be ensured	Code of Safe working Practice (UK MCA)	Highly Unlikely 1 Harmful 2 TOLERABLE(2)
12	Time constraints / Pressure	Take time to work safely . Safety First.	Code of Safe working Practice (UK MCA)	Highly Unlikely 1 Harmful 2 TOLERABLE(2)
13	Working over water	Lifejackets available and be worn		Highly Unlikely 1 Harmful 2 TOLERABLE(2)
14	Working over water	Rescue personnel available on hand and easily accessible		Highly Unlikely 1 Harmful 2 TOLERABLE(2)

ADDITIONAL CONTROLS

No	Additional Controls	Action Date	Completed
01		/ /	/ /
02		/ /	/ /
03		/ /	/ /

ADDITIONAL CONTROLS			
No	Additional Controls	Action Date	Completed
04		/ /	/ /
05		/ /	/ /
06		/ /	/ /
07		/ /	/ /
08		/ /	/ /
09		/ /	/ /
10		/ /	/ /
11		/ /	/ /
12		/ /	/ /
13		/ /	/ /
14		/ /	/ /

Vessel Additional Information
Office Additional Information

SIGNATORIES			
Assessed by	Rank	Date	Review by
[redacted]	CHF.OFF.	10/03/2020	
Confirmed by	Rank	Date	
[redacted]	MASTER	10/03/2020	10/03/2021

[redacted]

APPENDIX-2

[redacted]

Permit to Work

Title	Working Aloft				
Permit Number	V0000774	Date	10/03/2020	Vessel	UND ATILIM
Issued by	[redacted]	Date	10/03/2020	Time	13:24:55

PERMIT DETAILS

Type of Permit	Working Aloft
Equipment to be worked on	Domestic Services
Location of Work	Main deck
Description of Work undertaken	SPRINKLER NOZZLE RENEWING, PIPE MAINTENANCE

PRE START CHECK LIST

Work must not start until pre-start checks have been carried out satisfactorily and Authorisation received

No	Checks to carry out	Completed
01	Duty Officer Informed	✓
02	Warning notices posted	
03	Equipment in good order	✓
04	Duty Engineer advised	✓
05	Safety net rigged	✓
06	Whistle isolated	✓
07	Radar scanner isolated and notice re not starting posted	✓
08	Personnel protective equipment adequate and in use.	✓
09	Tools taken aloft secured by lanyard / belt / bag.	✓
10	If ladder used is condition good	✓
11	If ladder used is it correctly secured.	✓
12	Assistant standing by	✓
13	Person going aloft in good health and does not suffer from vertigo.	✓
14	Risk assessment carried out and risk rating acceptable	✓
15	Weather conditions suitable	✓
16	Motion of the ship suitable	✓
17	Operational conditions suitable i.e not maneuvering or carrying out major course changes	✓

CREW/CONTRACTOR DETAILS

Permit issued to (PIC)	[redacted]		
Period of Validity	FROM 10/03/2020 13:21 TO 10/03/2020 23:59	Company	RMN
Additional Personnel	[redacted]	Telephone No	

CERTIFICATE OF CHECKS: I am satisfied that all precautions have been taken and that safety arrangements will be maintained.

PIC Signature	[redacted]	Rank	RMN
		Date	10/03/2020

AUTHORISATION FOR WORK TO COMMENCE

I am satisfied that all required pre-start checks have been carried out by the PIC and/or AO.
I now authorise the PIC to commence work relating to this permit.

Authorising Officer (AO)	[redacted]	Rank	CHF.OFF.	Date	10/03/2020	Time	13:29
Risk Assessment in Place	YES	Risk Assessment ID		RA-V18			

COMPLETION

On completion of the work, this form will be returned to the Authorising Officer for cancellation.

Work on Equipment/Item Completed? Y/N		Has the Equipment/Item been tested? Y/N	
Comments			

CANCELLATION

PIC Signature		AO Signature	
Date & Time	/ / -	Date & Time	/ / -

[redacted]

Printed:-10 Mart 2020 Salı