CASE STUDY

OISD/CS/2026-27/E&P/05 **Date: 15.05.2026**

INTRODUCTION

Title: Fatal Fall Involving Psychological Distress
Location: Offshore process platform.
Loss/ Outcome: Fatal injury.

BRIEF OF INCIDENT

An offshore employee reported for duty on 20.02.2026 and carried out routine operational and maintenance related activities throughout his day shift. After completion of duty, the individual was observed at different locations on the offshore installation. He made calls to his home from control room and left shortly after midnight. Subsequently, urgent calls were received from his family member saying that the individual was unwell and required immediate contact. However, all attempts to establish communication with him were unsuccessful.

A search operation was initiated, following which the individual was found in injured condition at the lower deck loading area. Emergency response measures, including CPR and medical evacuation, were immediately undertaken. Individual was evacuated to shore and was later declared dead on arrival at the hospital as per the medical report.

A suicide note was also recovered, indicating that the fall was linked to psychological distress the individual had been experiencing.

OBSERVATIONS/ SHORTCOMINGS

- Non-recognition of Behavioural Indicators: Observable signs such as withdrawal, reduced interaction, and a tendency toward isolation were not identified or interpreted as potential indicators of distress, resulting in a missed opportunity for early intervention.
- Absence of a Structured Mental Health Monitoring Mechanism: There is currently no formal system in place to periodically assess, identify, or track the psychological well-being of offshore personnel.

Provided for information purpose only. This information should be evaluated to determine if it is applicable in your operations, to avoid recurrence of such incidents.

- Challenges of Offshore Isolation: Offshore working conditions are inherently demanding and isolating. Adequate mitigation measures such as counselling support and structured engagement activities were found deficit.

ROOT CAUSE OF THE INCIDENT

The primary contributing factor in this case appears to be significant psychological distress or emotional disturbance, which may have developed over a period of time. These conditions might have created a sustained internal burden, leading to feelings of anxiety, helplessness, or internal conflict. He was probably unable to effectively cope with or manage the stress, affecting both mental stability and decision-making capacity.

RECOMMENDATIONS

- All personnel may be sensitized and encouraged to remain mindful in identifying signs of distress among colleagues, with a clear protocol for promptly reporting such concerns to the Offshore Installation Manager/HSE/Medical Officer for appropriate intervention.
- It is recommended to institute a structured induction and mentoring framework, including a formal mentor–mentee program to provide support system and guidance.
- Regular informal interaction sessions may be conducted by key officials with all personnel to foster open communication, enhance morale, and provide an avenue for sharing concerns.
- It is recommended to arrange periodic sessions with qualified professional counsellors/psychologists, in both online and offline modes, to provide employees with mental health support.
- Regular mental wellness initiatives, such as meditation programs, may be conducted to promote overall well-being and stress management among personnel.

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