

ACCIDENTAL RELEASE OF A LIFEBOAT

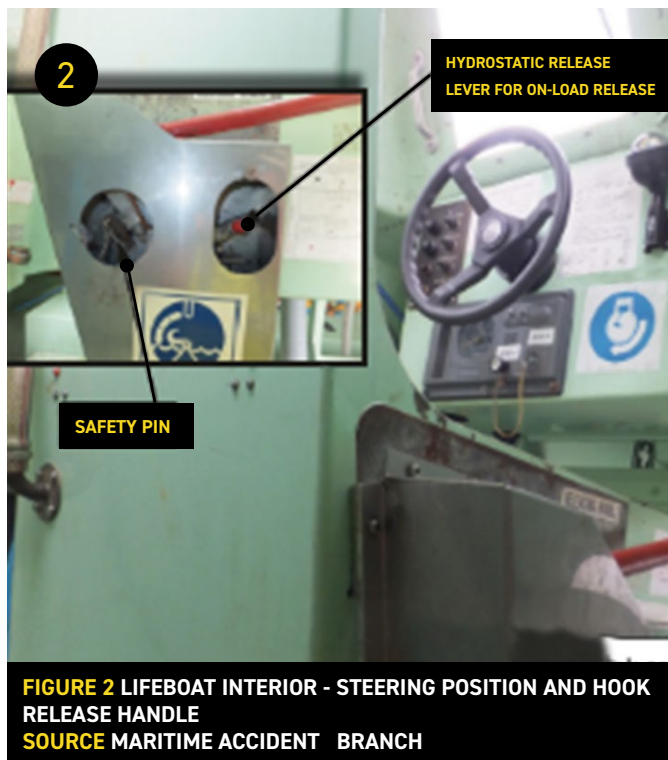
A REFRIGERATED CARGO SHIP HAD BERTHED IN SOUTHAMPTON TO DISCHARGE A CARGO OF FRUIT. ON THE DAY OF ARRIVAL THE LOCAL PORT STATE AUTHORITIES HAD BOARDED THE SHIP IN ORDER TO CONDUCT A PORT STATE CONTROL (PSC) INSPECTION, WHICH INCLUDED A LIFEBOAT DRILL. WHILE SECURING THE LIFEBOAT AFTER THE DRILL, THE SHIP'S BOSUN SUSTAINED MINOR INJURIES AS THE FORWARD END OF THE LIFEBOAT FELL FROM ITS DAVIT DUE TO IT NOT BEING CORRECTLY RESET WHEN IT WAS HOISTED FROM THE WATER (**FIGURE 1**).



FIGURE 1 PORT SIDE LIFEBOAT AFTER THE INCIDENT
SOURCE MARITIME ACCIDENT INVESTIGATION BRANCH

WHAT HAPPENED

During the port stay a Port State Control Officer (PSCO) from the Maritime and Coastguard Agency (MCA) boarded the ship in order to conduct a Port State Control (PSC) inspection. During the inspection the PSCO noted several deficiencies, which included incorrect recording of the crew's hours of rest and defective fire hydrants.



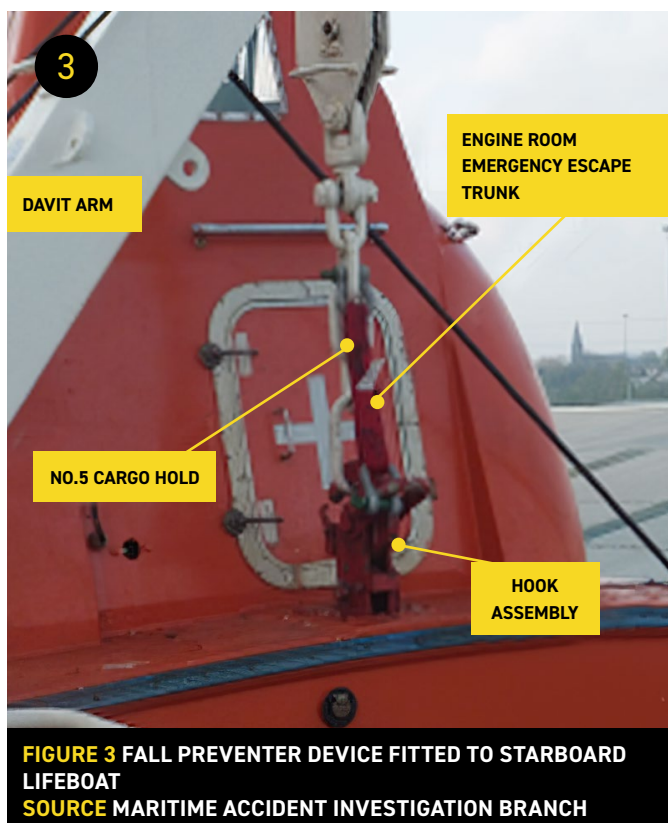
WHAT HAPPENED (CONTINUED)

On the basis of these findings, the PSCO informed the master that a more detailed inspection of the ship would be undertaken, and that the crew would be required to carry out an emergency fire drill. The conduct of this drill was deemed unsatisfactory and the ship was detained by the PSCO. The PSCO then ordered the crew to carry out an abandon ship drill using the port side lifeboat. The chief officer (C/O) was the lifeboat commander and he entered the lifeboat together with five other crew members.

The C/O used a portable Very High Frequency (VHF) radio to instruct the crewman operating the lifeboat davit winch on the embarkation deck to release the brake and lower the lifeboat into the water. When the lifeboat was in the water its engine was started and the C/O pulled the hook release handle (**FIGURE 2**) to free the boat from the davit suspension links. However, the hooks failed to open. The C/O pulled the release handle again and this time the hooks opened and released the lifeboat from the davit suspension links. The C/O took the helm and manoeuvred the lifeboat clear of the ship and sailed around for about ten minutes before returning and bringing the lifeboat alongside the ship in order to be lifted. During the preparation to be hoisted the lifeboat crew experienced difficulties resetting the hook release gear and two crewmen were required to pull on the hook release handle to force it into a position in which the safety pin could be inserted.

With the lifeboat in position below the davit arms, several attempts had to be made by the lifeboat crew before the davit suspension links were finally connected to the lifeboat hooks. Once engaged, the hooks were checked by the C/O, who then instructed the crew to connect the Fall Preventer Devices (FPD)* (**FIGURE 3**) to the forward and aft hooks. After both FPDs had been secured the lifeboat was lifted from the water, though some of the lifeboat crew were not convinced that the hooks had been correctly reset.

*The FPD comprised a synthetic sling with a shackle at each end, which was connected between the suspension link and the hook maintenance shackle of the forward and aft hook assemblies.



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FIGURE 4 GRIPE WIRES (ON STARBOARD LIFEBOAT)
SOURCE MARITIME ACCIDENT INVESTIGATION BRANCH

WHAT HAPPENED (CONTINUED)

When reaching the embarkation deck, all six crewmen disembarked from the lifeboat before it was hoisted into its davit. The lifeboat was then left unsecured in the davit for about 20 minutes while the crew took a break.

After the break the C/O instructed the ship's bosun and two crewmen to secure the lifeboat. The two crewmen boarded the lifeboat to assist in positioning the gripe wires forward and aft. The bosun instructed the men in the boat not to release the FPDs until he had connected the gripes to the davit arms (**FIGURE 4**). The aft gripe had been secured and the bosun was connecting the forward gripe when the C/O came to the lifeboat and instructed the men in the boat to release both FPDs. As soon as the forward FPD shackle pin was removed, the hook opened and the forward end of the boat fell onto the handrails on the deck below (**FIGURE 4**), striking and injuring the bosun as it fell.

The emergency services were called and the bosun was taken to a local hospital for medical assessment. It was found that his injuries were not serious and he returned to the ship the following day.

LESSONS LEARNED ON NEXT PAGE

LESSONS LEARNED

THE FOLLOWING LESSONS LEARNED HAVE BEEN IDENTIFIED. THESE ARE BASED ON THE INFORMATION AVAILABLE IN THE INVESTIGATION REPORT AND ARE NOT INTENDED TO APPORTION BLAME ON THE INDIVIDUALS OR COMPANY INVOLVED:

- The accident followed a breakdown in communications between the crew who were not empowered to challenge orders or to participate in the decision making process on board. This became evident when some of the crew members did not challenge the C/O during the hoisting of the lifeboat, even though they were not convinced about the hooks being correctly reset, and again when the C/O asked them to release the FPD contrary to the instructions given by the bosun.
- The company's Safety Management System (SMS) was ineffective and poorly implemented on board. The crew had not been adequately trained and were not familiar with the operation of safety equipment on board. This was further highlighted by the following findings identified by the investigation, although they did not directly contribute to this incident:
 - The Company had advised that the FPDs were fitted to the starboard lifeboat while the ship was on passage rendering the lifeboat inoperable in an emergency and is contrary to both the IMO's and the company's own SMS requirements demonstrating a lack of understanding of the correct use of the device.
 - The crew's performance during the fire drill requested by the PSCO was indicative of the poor level of training and the failure to undertake the requisite SOLAS emergency drills on the ship.
 - Following the incident the ship's safety committee conducted a meeting and recorded that there had been no incidents or near misses on board.
 - The manager's review of the incident identified shortcomings in the crew's emergency preparedness training but did not create an action plan to improve emergency response standards on its ships.
- The company's SMS contained comprehensive maintenance schedules for the lifeboats and their on-load release and retrieval systems (LRRS) e.g. inspecting the release gear on a monthly basis, which included checking the "status of the reset" and "that there was no dirt or foreign matter on the moving part". Just a few weeks before the accident, the ship's maintenance records indicated that the release gear had been checked and was in "good" condition. However, the investigation identified that the moving parts of the hook release mechanism on the port lifeboat were dirty and the reset indicator had also been painted over. Additionally, the release gear cables were found seized and damaged when inspected after the accident. The release gear on the starboard lifeboat was in a similarly poor condition.
- Despite records to the contrary, it was apparent that no maintenance or inspections of the LRRS had been carried out since the annual inspection and service six months prior to the incident.

CONTACT

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THIS CASE STUDY IS DRAWN FROM THE INVESTIGATION REPORT PUBLISHED BY THE MARITIME ACCIDENT INVESTIGATION BRANCH (MAIB):
https://assets.publishing.service.gov.uk/media/554a255d40f0b61589000061/MAIBInvReport_9-2015.pdf

THE PURPOSE OF THIS CASE STUDY IS TO SUPPORT AND ENCOURAGE REFLECTIVE LEARNING. THE DETAILS OF THE CASE STUDY MAY BE BASED ON, BUT NOT NECESSARILY IDENTICAL TO, FACTS RELATING TO AN ACTUAL INCIDENT. ANY LESSONS LEARNED OR COMMENTS ARE NOT INTENDED TO APPORTION BLAME ON THE INDIVIDUALS OR COMPANY INVOLVED. ANY SUGGESTED PRACTICES MAY NOT NECESSARILY BE THE ONLY WAY OF ADDRESSING THE LESSONS LEARNED, AND SHOULD ALWAYS BE SUBJECT TO THE REQUIREMENTS OF ANY APPLICABLE INTERNATIONAL OR NATIONAL REGULATIONS, AS WELL AS A COMPANY'S OWN PROCEDURES AND POLICIES.