

# Case study for onboard safety meeting

## Lifeboat safety drills and maintenance

Please read the below story of an incident. Keep our company's standards and 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 ship berthed early one morning to discharge a cargo of fruit from the Canary Islands.

The following morning a port state control officer (PSCO) began an initial port state control inspection of the vessel. During the inspection the PSCO noted several deficiencies, including incorrect recording of the crew's hours of rest and defective fire hydrants. The PSCO informed the master that a more detailed inspection of the vessel would be carried out, and that he required the crew to carry out an abandon ship drill using the vessel's port lifeboat.

The chief officer was in charge of the boat during the drill and entered the boat together with five other crew members. He used a portable VHF radio to instruct the crew member operating the lifeboat davit winch on the embarkation deck to release the brake and lower the lifeboat into the water. Once the boat was in the water its engine was started and the chief officer pulled the hook release handle to free the boat from the falls. However, the hooks failed to open.

The winch operator was instructed to lift the boat slightly and then pull the release handle again. This time the hooks opened and released the boat from the davit suspension links.

The chief officer took the helm and manoeuvred the lifeboat clear of the ship for about 10 minutes before returning it alongside for hoisting. The boat's crew experienced difficulty in resetting the hook release gear and two crew members were required to pull on the hook release handle to force it into a position where the safety pin could be inserted.

With the boat in position under the davit arms, the davit suspension links were finally connected to the lifeboat hooks after several attempts. Once engaged, the hooks were checked by the chief officer, who instructed the crew to connect the Fall Preventer Devices (FPDs).

Once both FPDs had been secured the lifeboat was lifted from the water. Some of the boat's crew were not convinced that the hooks had been correctly reset and were nervous while the boat was being retrieved. The six crew members disembarked from the boat at the embarkation deck level and the boat was then hoisted into its davit. The lifeboat was left unsecured in the davit for about 20 minutes while the crew took a break.

After the break, the chief officer instructed the bosun and two crew members to secure the boat in the davit. Two members of the crew boarded the boat to assist with positioning the gripe wires fore and aft; the bosun instructed the crew members in the boat not to release the FPDs until he had connected the gripes to the davit arms.

The aft gripe had been secured and the bosun was connecting the forward gripe when the chief officer came to the area and instructed the crew members 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, striking and injuring the bosun as it fell.

The emergency services were called to attend and the bosun was taken to a local hospital for medical assessment. His injuries were found not to be serious and he returned to the vessel the following day.

# How to improve by lessons learnt

Keywords for discussion:

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- Do you know which type of on-load release hook is installed in your lifeboats?
- Have you been trained in the operation of release hooks of this type?
- Do you understand the working of the release hooks and the hydrostatic interlocking device?
- Do you have a proper training manual for the on-load release hooks on board?
- Are the lifeboats and hook systems serviced annually?
- Have such service been performed by a specialist approved by the manufacturer?
- Should you use excessive force on the release handle to reset the system?

**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?**