Casualty Circular No. 9 of 2005

NO: 11-NT(79)/2005

Sub: Unsafe practices during launching of lifeboats leading to casualties

OBJECTIVE:

To create awareness amongst the ship operators, Masters and seafarers on the established procedure to conduct lifeboat-launching drill without causing any damage to the vessel or to the life saving appliances or losing any valuable lives for causing injury to any persons on the ship.

SCOPE:

Functional tests of life saving appliances as per International regulations and national rules prevailing.

CASE HISTORY:

A Bahamanian Flag reefer ship engaged in the carriage of refrigerated fruits on pallets arrived in one of the European ports to discharge this cargo. As a part of internal audit, a lifeboat drill was conducted under the supervision of Chief Officer with the support of 2 Officers, 1 cadet and 1 Bosun. While conducting this drill this team boarded the lifeboat with life jackets from the stowage position of the board which happens to be board's embarkation deck at the level of the stowage position. Though the Master was not present during such exercise, but was aware of such operations. However, the lowering of the lifeboat was being undertaken in the presence of owner's auditor. Upon receipt of orders from the Chief Officer, the lifeboat was lowered with the remote operating wire from inside the boat by Third Officer and Bosun. The process of lowering was smooth along the siding track at the initial stages. The lowering continued to reach the davit arm resting position and at this point of time the aft block suddenly got released from the hook by itself that resulted in the suspension of the boat on the forward hook and falls. With the weight of the boat and gravitational pull, the forward hook was uprooted and the boat came down crashing into the water with stern side first. The boat floated in inverted position and water flooded. The ship's crew was alerted by the attending officers on boat deck and the rescue agencies swung into action. During the operation, Bosun and a cadet were found to be trapped in the lifeboat. After being brought ;out from the boat, they were found to be dead.

OBSERVATIONS:

1. The lifeboat drill was conducted from its stowed position with ships crew inside the boat.

2. The complete release mechanism of the lifeboat was tested and serviced during the vessels dry-dock about 1.5 years ago.

3. The life boat was lowered and maneuvered in the water about 2 months ago from the date of incident.

4. None of the crew members was seated with seat belts.

5. During launching operation, the lose gear inside the boat was not secured.

Based on these observations and findings, it is recommended that:

1. The Regulation 20.6.3 as amended of SOLAS Chapter 3, should be strictly followed:-

   Quote. "Lifeboats except free fall lifeboat, on cargo ships. Shall be moved from their stowed persons without any persons on board, to the extent necessary to demonstrate satisfactory operation of launching appliances, if weather and sea conditions so allow." Unquote.

2. The established safe working practice by the crew members in the lifeboat by wearing seat belts during the lowering operation shall be adhered to.

3. Adequate training measures on basic seamanship such as securing loose gear, familiarization with release gear and its limitation and periodical through inspection of the lifeboats and its attachment shall be undertaken by the designated person and Master of the ship.

4. Launching of lifeboats is considered as critical operations and therefore such operations shall be performed under direct supervision of the Master.

5. The Designated Person and Master shall ensure that the statutory training manual provides adequate procedures for such type of operations.

Sd/-

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