

Accident during Man Overboard drill

The RoRo vessel was planning their monthly man overboard drill in the morning. It was a pleasant summer's day with light winds and clear skies. They had received permission from the port authority, so the rescue boat crew and some crew members proceeded to the rescue boat.

The fast rescue boat was stowed about 5 meters above the surface. A man overboard doll had been thrown into the water and it was planned for the 2nd Officer, an AB and the 2nd Engineer to be the crew and pick up the doll. The bosun, two other ABs, the 1st Engineer and the Chief Officer were also present. The rescue boat crew were all wearing the required PPE such as life jackets, safety harnesses and hard hats.

The boat was put over the side and the crew boarded. The bosun was manning the crane and lowered the boat into the water. When the boat was waterborne the 2nd Officer started the engine, the AB removed the safety pin for the fall wire and the 2nd Engineer released the forward painter.

The rescue boat retrieved the MOB doll and all the crew members test drove the boat. When the drill was over the 2nd Officer drove the boat back. The painter was connected, the hook for the wire was secured and the engine was turned off. The crew also secured their safety harnesses to the boat which they had also done when the boat was lowered.

The bosun started to raise the boat using the high-speed option. When the boat was at deck level the Chief Officer told the crew not to get off until the boat was stowed in its final position. To put the boat in the stowed position the bosun used the low-



speed option. The boat came in hard to the davit, which caused the boat to hit the davit hard and this caused the fall wire to part and the rescue boat fell into the water with the crew. The three crew members were still secured to the boat with their safety harnesses, the AB and 2nd Engineer had fallen into the water and their lifejackets inflated, however the 2nd Officer had fallen straight on to the boat.

All crew members were taken to hospital. The AB and 2nd Engineer did not have any serious injuries but the 2nd Officer broke his back and was disabled for life.

The failure of the wire was caused by the sudden excess load when the boat hit the davit. This was caused by the davit's proximity switch not working properly, as it should have stopped the wire hoisting. Hoisting the boat should stop before the proximity switch is activated, but in this case it was not as the bosun continued to hoist the boat. ■

Discussion

Go to the "File" menu and select "Save as..." to save the pdf-file on your computer.

You can place the marker below each question to write the answer directly into the file.



When discussing this case please consider that the actions taken at the time made sense for all involved. Do not only judge, but also ask why you think these actions were taken and could this happen on your vessel?

1. What were the immediate causes of this accident?

2. Is there a risk that this kind of accident could happen on our vessel?

3. What could you have done to prevent this accident?

4. How often do we inspect the proximity switch for the lifeboat and rescue boat davits?

5. Do all crew members hoisting a lifeboat and rescue boat know that they need to stop before the proximity switch is activated?

6. Have the crew received training on how to hoist and secure the boats correctly?

7. Does the crew disembark the boat at the deck and not in the stowed position?

8. What sections of our SMS would have been breached, if any?

9. Does our SMS address these risks?

10. How could we improve our SMS to address these issues?

11. What do you think was the cause of this accident?

12. Is there any kind of training that we could do that addresses these issues?