

# Safetyfocus

The Confidential Hazardous Incident Reporting Programme – CHIRP – is an independent system for all those involved in the maritime industry to report incidents of concern. CHIRP's Maritime Advisory Board has joined forces with *Safety at Sea* to provide regular insights into topical safety issues.

## CHIRP

## Lifeboat lessons

► **Near misses can teach us more about safety** than is often realised. Many seafarers are familiar with hazards associated with launching lifeboats and some may have had the unfortunate experience of being in an accident.

However, there is a lack of evidence from such incidents to help bring about change. Meanwhile, accident investigations can sometimes focus on a single cause, therefore ignoring other factors that may have been at play.

The findings of casualty reports can provide lessons and give seafarers and ship managers a chance to take action to prevent similar incidents. The ideal is to identify potential hazards before accidents occur.

Lifeboat drills are required at least once every three months, so the chance to spot risks during these could be considered high. There must be a number of near misses in these drills that could be usefully reported and ultimately learned from to encourage safer practices.

There should be no shame in reporting something going wrong and that an accident was narrowly avoided. The shame should be in not reporting it.

Most reported accidents involving conventional davit-launched lifeboats actually occur when the boat is being recovered. This tends to draw attention to the competence of the crew in reconnecting the boat. The frequent conclusion is that the accident was because of "human error" (which really means operator error). But reaching this conclusion can be dangerous because further analysis can be neglected.

What about the person who designed or constructed the boat? Did they design it with a realistic view of how difficult it could be to connect a lifeboat hook? Were the



Many seafarers are familiar with the hazards of launching lifeboats

focused on trying to avoid being seriously injured by the fall block while operating in such cramped conditions.

Too often there has been resistance to the use of FPDs or SSDs for reasons that are unclear, as their use only brings lifeboat hoisting into line with other personnel lifting procedures by duplicating the load path or locking the hook mechanism and thus eliminating a single point of failure. These devices should reassure the master that he or she is taking appropriate measures to protect his or her crew from harm.

Not all lifeboats are conventionally launched, of course. Some freefall boats may have features that cause concern. For example:

- Do some of the interior fittings leave seafarers exposed to impact injuries during launching?
- Is the rudder centred amidships to prevent sudden turns on launching and is there any internal indication of this?
- Do some instructions leave seafarers confused rather than knowledgeable?
- Are safeguarding fittings between the boat and the ship, such as safety strops – sometimes called simulation strops – and attachments, of suitable strength and able to absorb shock loads?

It could be argued that seafarers have the most to lose if lifeboat drills go wrong. A fatality or serious injury is a very real prospect in the circumstances. To get this message back to where it needs to be heard – in the regulatory debating chamber at the International Maritime Organization and by the manufacturers, who should be able to make improvements – hazardous incidents need to be reported. Operating companies as well as seafarers can report such occurrences. Indeed they should, in the spirit of ISM, be prepared to review any malfunction and learn and promulgate lessons in the process. ◀

procedures in use unnecessarily exposing seafarers to danger? In even the smallest harbour chop, for example, reconnecting can be extremely dangerous.

In modern, fully enclosed boats, crew are perceived to be better protected. In terms of exposure to weather that may be true but during recovery exercises crew members usually work through confined hatches or on small decks with a heavy block swinging near their heads.

If, for example, a crew member misses a vitally important indicator of the connection being correctly made or if the fall preventer device (FPD) or secondary safety device (SSD) is also missed, there may be no protection against an inadvertent opening of an incorrectly connected hook. The crew member could be forgiven for being more

### Contact

It is generally accepted that for every accident there are numerous near misses. Using a centralised and respected scheme such as CHIRP ([www.chirp.co.uk](http://www.chirp.co.uk)), observations can be sent to [reports@chirp.co.uk](mailto:reports@chirp.co.uk). These confidential reports are released to a wider audience, with anonymity retained throughout. Through this process, seafarers can initiate change and improve safety standards and design.