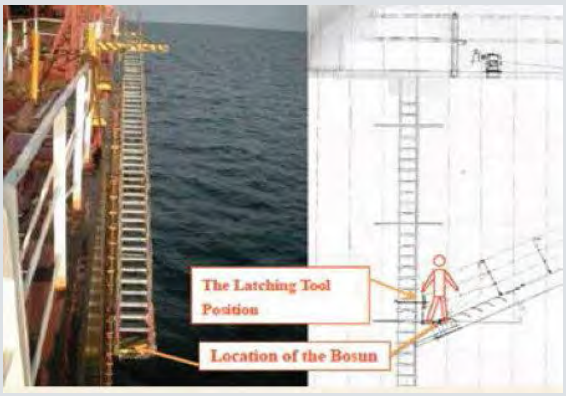
KISH P&I CLUB

KISH P & I LOSS PREVENTION CIRCULAR KPI-LP-168-2014
(Not Wearing Lifejacket nor A Lifeline; Ending Up Dead)

►The Incident:
A vessel was underway in darkness having just disembarked the pilot. Winds were modest at Beaufort scale 6 and there was a swell of about three metres. Air temperature was a cool 8 degrees C. The bosun, assisted by three other crews, was bringing on board and securing the pilot boarding arrangements. The bosun descended to the lower platform of the accommodation ladder to disconnect the latching mechanism which secured the pilot ladder to the accommodation ladder.

After the bosun had pulled up the lower section of the pilot ladder and placed it on the accommodation ladder, he asked one of the assisting crew to heave up the accommodation ladder. Each time the crew tried to hoist the ladder; it descended rather than moving up. After a few attempts, the crewman stopped the operation, but at this time a noise was heard and the crew realized the accommodation ladder was now hanging vertically down. The bosun could not be seen; he had not been wearing a lifejacket nor a lifeline.
A life ring and light were thrown into the water and the bridge informed.

Despite many hours of searching using their rescue boat, the vessel itself, the pilot boat and other boats in the area, the bosun could not be located. His body washed ashore three weeks later.



►The Findings:

1- The investigation found it probable that when the ladder was mistakenly lowered (instead of being raised), the weight of the ladder transferred from the hoisting wire to the latching mechanism. The mechanism failed under a load that it was not designed to hold, and the resulting shock load on the wire caused failure and free fall of the lower end of the accommodation ladder, leaving it in the vertical position.

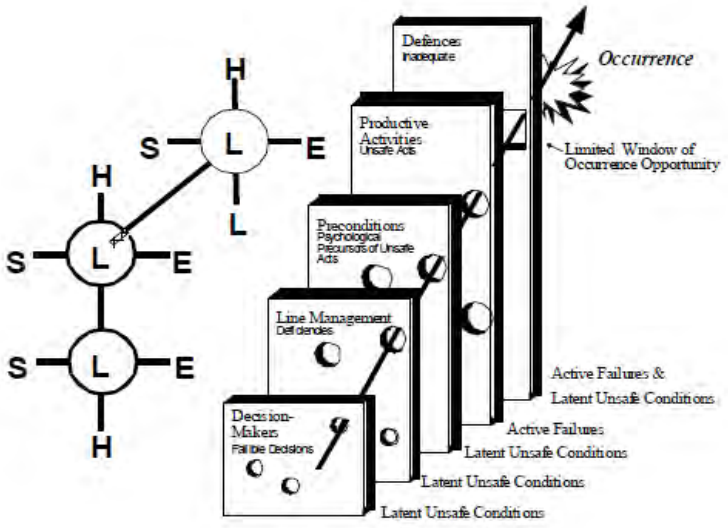
2- The investigation also found it probable that the non-permanent air hose connections for powering the hoist/lower function of the accommodation ladder, which were unmarked, were mistakenly inversed when connected initially, hence the lowering action achieved when the crew wanted to hoist.

3- Additionally, it was found that the wire on the failed accommodation ladder was in fact

only 55 metres long instead of the manufacturer's recommended 67 metres. This probably caused undue stress and further undermined the wire's integrity, especially considering that at least two wraps were needed on the drum at maximum payout.

4- The investigation further found that the bosun was working in contradiction to the company procedure for this operation, having no lifejacket nor safety line. None of the other crew working with the bosun had interjected to advise him of these shortcuts.

As with almost every accident, a series of unsafe acts and unsafe conditions conspired to bring about a very serious consequence. Had any one of these been absent from the sequence of events, the accident may very well not have happened. But first and foremost I see an absence of safety culture here. Had safety been a true value of the crew, the bosun would never have gone over the side without a lifejacket and safety line. But also, had he wanted to do so nonetheless just to get the job done quickly, the other crew would have called him out on those dangerous shortcuts. See **SHEL and Reason Hybrid Model** below**:**



There are four components to the SHEL model:
Liveware - L
Hardware - H
Software - S
Environment - E.