

From Safety Equipment to Safety Hazard

Investigating a Life Raft Related LTI in Marine Operations



The American Waterways Operators

The Tugboat, Towboat & Barge Industry Association

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EXECUTIVE SUMMARY

- During a recent drydock period, a crewmember sustained a lost time injury while preparing a liferaft for its annual swap-out/servicing.
- •This incident highlighted the importance of a comprehensive risk assessment, the need for clear communication, and the value of supervision during complex tasks.

INJURY WHILE SERVICING LIFERAFT

- Liferaft slid off vessel unexpectedly while preparing for its removal.
- Crewmember attempted to stop it from sliding, resulting in a shoulder injury.



CONTEXT AND BACKGROUND

- Vessel was in drydock
- Liferaft was due for annual swap (service/inspection)
- Shoreside crane scheduled to move life rafts after lunch break



THE INCIDENT

- Crewmember tasked with preparing liferaft to be picked with crane.
- Crewmember to rig 2 slings on both ends of liferaft canister, connected to hook.
- While releasing the pelican hook, drop-down mechanism deployed.
- Liferaft released from cradle and slid off the vessel to the drydock floor.
- Crewmember attempted to stop liferaft from sliding resulting in a hurt shoulder.



A CLOSER LOOK

(Photos provided by an uninvolved company with similar equipment)





A CLOSER LOOK

(Video provided by an uninvolved company with similar equipment)





INITIAL RESPONSE AND CONTAINMENT

- Conduct risk assessments for all tasks, regardless of perceived routine nature.
- Provide adequate supervision to ensure safety standards are met.
- •Maintain a learning-focused culture to improve systems and prevent recurrence.

THE INVESTIGATION APPROACH

- •An investigation was completed by shoreside personnel using company's approved root cause analysis methodologies.
- Internal review identified gaps in risk assessment & supervision. No external parties were involved. Focus was on fact-finding and system improvement.

FINDINGS

- •The investigation revealed several contributing factors:
 - 1. Lack of a thorough risk assessment
 - 2. Unclear/ambiguous job description in preventive maintenance system
 - 3. Misunderstood procedures for performing task
 - Insufficient supervision/personnel for work

LESSONS LEARNED

Work Factors:

- Missing or unclear instructions
- Lack of preparation for task
- Divided attention due to drydock period

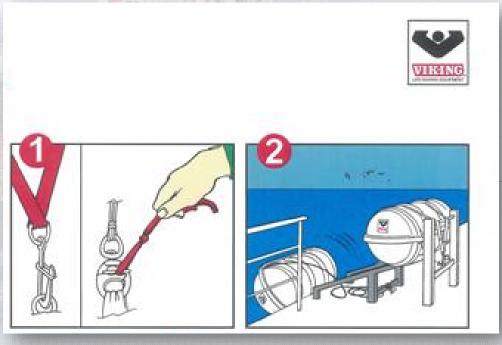
Organization Factors

 Issues with coordination and teamwork between crewmembers



CHANGES & IMPROVEMENTS IMPLEMENTED

- Created a task-specific Risk Assessment template
- PMS Job Description includes hazard warnings and Risk Analysis requirement.
- 3. Added Signage near the liferaft



BROADER INDUSTRY TAKEAWAYS

Routine tasks carry hidden risks

Planning and supervision needed for all

operations

Assigning Blame



Learning Culture





CONCLUSION

- •All incidents, no matter the size or severity, are opportunities to improve, grow, and learn.
- By promoting a culture rooting in learning and transparency, we can continue to commit to safety and resilience.



