

Lifeboat accident on board M.V. "Tiara Ocean" 18.7.2005

1. The Incident

- 1.1 On 18 July 2005, a lifeboat drill was conducted on board m.v. "Tiara Ocean" (*the Vessel*) which was moored alongside the Port Phoades, Jamaica. The No.2 lifeboat at the ship's port side was launched at 0815. The lifeboat manoeuvred in the water for about 15 minutes
- 1.2 After the manoeuvring, the crew prepared to recover the lifeboat back to the ship's davit. At 0832, the Third Officer (3/O) and the Able Seaman (A/B) stationed at the forward and aft lifting hook positions for recovering the lifeboat.
- 1.3 While the A/B was connecting the floating block onto the hook at the aft deck, the lifeboat drifted by the water current and a gust of wind into the curvature area of the aft side shell. During the impact, the A/B was crushed between the canopy of the lifeboat and the side shell of *the Vessel*. He fell into the water after the incident. (See attached sketch)

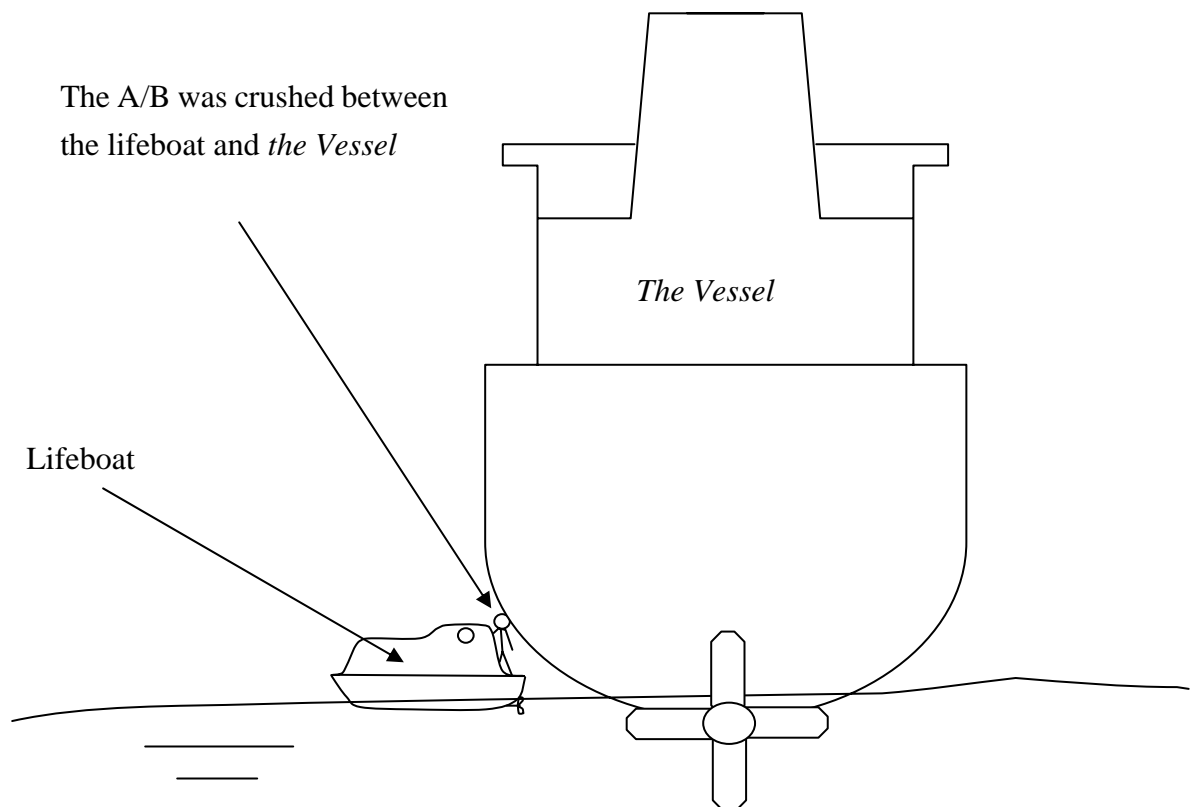
2 Findings

- 2.1. *The Vessel* was berthed with starboard side alongside. The sea was slight with light breeze and the weather condition was considered suitable for conducting the lifeboat drill.
- 2.2. The lifeboat was under the command of the Chief Officer (C/O) and he was acting as the helmsman to maneuver the lifeboat.
- 2.3. The lifeboat were constructed of glass reinforced plastic and was normally stowed in gravity davit on port side at the boat deck level. The steering position was fitted with four windows around the helmsman to enable the helmsman to have an all-round view. However, the windows were small in sizes and they did not provide a good view to the outside environment. In order to maintain a vigilant lookout, the top hatch was to be used to ensure the helmsman to have a clear view. Alternatively, a crew could be assigned to maintain an all-round and unobstructed view for any irregularity. However, neither the hatch was opened nor a crew was assigned during the recovery of the lifeboat.
- 2.4. The stowage position of the lifeboats was closed to the aft of *the Vessel*. Due to

construction of *the Vessel* the side shell at the aft quarter was in large curvature. If not controlled properly, the canopy of the lifeboat would be easily wedged under the curvature of the aft shell plating of *the Vessel* during recovering of the lifeboat.

3 Lessons

3.1 The helmsman of the lifeboat did not maintain an all-round lookout during the recovering process. Neither the top hatch of the canopy was used, nor a designated crew was assigned to keep a proper lookout while the C/O was manoeuvring the lifeboat. As a result he was not able to assess the situation and react promptly to manoeuvre the lifeboat.



Sketch showing the scene of the accident