

## SYNOPSIS

On the afternoon of 26 September 2006, the passenger vessel *Thomson Celebration* prepared to depart from St Peter Port, Guernsey. All passengers had been confirmed on board and the passenger tenders were recalled for recovery. When *Tender 15* was being positioned under its falls, close to the side of the ship, the 1.5 knot tide affected the manoeuvre and the coxswain lost full control of the boat. The tender was carried astern and against the ship's side. A crew member had left his station at *Tender 15*'s stern to try to prevent the davit hook from damaging the tender. He moved between the coach house and the ship's side and became trapped. He received fatal crush injuries to his upper chest.

The onboard training given to *Thomson Celebration*'s passenger tender crews only covered the approach to the ship's side in fine conditions; it did not include handling the tenders in tidal stream conditions. Additionally, there had been problems with hydraulic oil loss from the steering system of *Tender 15*, which might have adversely affected the efficiency of the steering.

*Thomson Celebration* carried 16 lifeboats, 4 of which were designated as lifeboat/passenger tenders. These craft complied with international lifeboat regulations; they also met further requirements issued by the vessel's classification society on behalf of the Flag State. The passenger tenders on *Thomson Celebration* were larger, faster and more manoeuvrable than the vessel's other lifeboats and, when being operated as passenger tenders, could each carry a maximum of 80 passengers, at speeds of up to 12 knots.

The coxswain of *Tender 15* was an AB/quartermaster and was qualified to command it by virtue of his lifeboatman's certificate. A passenger tender coxswain is not required to meet further international competency standards, and no training criteria exist on which companies can base in-house tender drivers' courses. Nevertheless, the company had procedures in place for on board training and certification of coxswains, but these were not well implemented, monitored or verified. There is no evidence that the coxswain of *Tender 15* at the time of the accident had completed the company's in-house course, and he did not hold a company tender drivers' certificate.

The safety officer usually supervised the launching and recovery of the tenders. However, at the time of the accident, there was no safety officer on board the vessel; his duties had been re-assigned to the chief officer who, at the time of the accident, was on the forecastle preparing to heave up the anchor. This effectively left supervision of the recovery of the tenders to the bosun, who had been promoted to that rank only 6 days previously, although he had been bosun on other vessels, including vessels under Columbia Ship Management control.

There are no international standards for the operation of lifeboats as passenger tenders. However, classification societies provide and administer guidelines on an 'ad hoc' basis.

The MAIB investigation into the accident identified safety issues relating to *Thomson Celebration*'s safety management system. These include:

- Inadequate shipboard supervision of the tender operations;
- Manning levels on passenger tenders not in accordance with levels specified in the ship's SMS;
- Inconsistent application of the in-house passenger tender training scheme.

Recommendations have been made to:

Lloyd's Register of Shipping to:

- Develop within IACS agreed standards for the issuing of lifeboat/passenger tender certificates.

The Maritime and Coastguard Agency to:

- Take forward to IMO, through the most appropriate channels, competency requirements for passenger ship lifeboat/tender coxswains and crew for inclusion in a revision of STCW.

Columbia Ship Management:

- Concerning unauthorised maintenance being carried out on passenger tenders.