SYNOPSIS

On 1 December 2000, the Marine Accident Investigation Branch was notified that four people had been injured after a lifeboat had fallen from the ro-ro passenger/cargo ferry, *European Highway*. An investigation began that day.

The ro-ro passenger/cargo ferry, *European Highway,* was berthed in Zeebrugge harbour during the morning of 1 December 2000. Her port lifeboat had been swung out and lowered slightly with three men on board. The weight of the lifeboat was being taken on hanging-off pendants, a pair of wires from which the lifeboat can be slung for maintenance or recovery purposes.

The operating lever of the suspension hook release mechanism was activated, and resulted in the lifeboat falling into the water shortly before 0933. It initially struck part of a support column for an adjacent walkway, and then fell into the water, inverted. Two men were trapped underneath the lifeboat, but the third fell into the water alongside.

Authorities ashore were alerted. The vessel's recently installed fast rescue craft (FRC) was launched to assist. During this operation, the hand-winding lever of the davit, which rotated as the FRC was lowered, injured the second officer. Once in the water the FRC was able to tow the lifeboat towards a nearby pilot boat.

With the aid of a quayside crane, the inverted lifeboat was lifted, and the two men beneath recovered on to the pilot boat. All three men had been recovered from the water by 0950. These three and the second officer were taken to hospital with a range of injuries, some serious.

While the FRC was being recovered, lack of vertical clearance prevented it from being swung over some adjacent liferaft canisters. While using the hand-winding lever to raise the FRC slightly, it involuntarily lowered on to a canister, and tipped towards the unguarded side of the vessel. However, the FRC's three crewmen were able to hold on until assisted from the craft on to the vessel's deck.

The lifeboat fell because the hanging-off pendants had been attached incorrectly. The second officer's injury was caused by the rotation of the FRC davit's hand-winding lever. A lack of headroom on the davit caused the FRC to tip during its recovery.

The owners have corrected the headroom problem on the FRC davit by increasing the height of its support column. Similarly, they have also changed the lifeboats' hanging-off pendant arrangement so that it is impossible to make the incorrect connections that occurred in this incident.

The owners of *European Highway* are recommended to supplement training and instruction material, and to modify procedures, with the aim of preventing a repetition of this incident. A recommendation is also made to the MCA to consider whether the standards required of FRC davits are sufficient to ensure the safety of all personnel involved with their operation.