



Report of Investigation  
into the Lifeboat Accident  
on Board M.V. "Tiara Ocean"  
on 18 July 2005



The Hong Kong Special Administrative Region  
Marine Department  
Marine Accident Investigation Section

## **Purpose of Investigation**

This incident is investigated, and published in accordance with the IMO Code for the Investigation of Marine Casualties and Incidents promulgated under IMO Assembly Resolution A.849(20). The purpose of this investigation conducted by the Marine Accident Investigation and Shipping Security Policy Branch (MAISSPB) of Marine Department is to determine the circumstances and the causes of the incident with the aim of improving the safety of life at sea and avoiding similar incident in future.

The conclusions drawn in this report aim to identify the different factors contributing to the incident. They are not intended to apportion blame or liability towards any particular organization or individual except so far as necessary to achieve the said purpose.

The MAISSPB has no involvement in any prosecution or disciplinary action that may be taken by the Marine Department resulting from this incident.

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## **1. Summary**

- 1.1 On 18 July 2005, a lifeboat accident happened on the Hong Kong registered vessel m.v. "Tiara Ocean" at Port Rhoades, Jamaica. While the crew were recovering the No.2 lifeboat back to the davit, the lifeboat bumped against the port quarter of the vessel. An Able Seaman was crushed to death between the canopy of the lifeboat and the aft side shell of the vessel in the accident.
- 1.2 The investigation revealed that all-round lookout was not maintained during the recovery of the lifeboat. As a result, he was not able to assess the situation and react promptly to manoeuvre the lifeboat when it drifted towards *the Vessel*.

## 2. Descriptions of *the Vessel*

### 2.1 Particulars of m.v. "*Tiara Ocean*"

Port of Registry:	Hong Kong
IMO No.:	9278868
Official No.:	HK-1237
Call Sign:	VRZP8
Type of Ship:	Bulk Carrier
Year Built:	2003
Name of Builder:	Tsuneishi Heavy Industries (Cebu), Inc.
Ship Manager:	Sandigan Ship Services, Inc.
Classification Society:	Nippon Kaiji Kyokai
Length:	182.87 metres
Breadth:	32.26metres
Moulded Depth:	17.00 metres
Gross Tonnage:	30,053
Main Engine:	Mitsui M.A.N. -B&W 6S50MC x 1Set

"*Tiara Ocean*" (hereinafter referred as *the Vessel*), is a 5-hold bulk carrier built in 2003 by Tsuneishi Heavy Industries (Cebu), Inc in Japan. *The Vessel* was owned by Stony Brook Maritime S.A. and managed by Sandigan Ship Services Inc. At the time of the accident, a lifeboat drill was being conducted while *the Vessel* was alongside the berth at Port Rhoades, Jamaica.



Fig. 1: Photo of m.v. "*Tiara Ocean*"

### 3 Sources of Evidences

#### 3.1 Witness statements of the following persons:

- a) The Master;
- b) Chief Officer;
- c) Second Officer;
- d) Third Officer;
- e) Bosun;
- f) Ordinary Seaman A
- g) Ordinary Seaman B
- h) Chief Engineer;
- i) Fourth Engineer;
- j) Wiper;
- k) Chief Cook; and
- l) Messboy.

#### 3.2 Ship's records, drawings and plans provided by the Master and the Sandigan Ship Services, Inc.

#### 4. Outline of Events

- 4.1 In the morning of 18 July 2005, the *Vessel* was moored alongside the Port Rhoades, Jamaica. The Master of *the Vessel* decided to conduct a lifeboat drill with the launching and manoeuvring of the port lifeboat (No. 2 lifeboat) in the water.
- 4.2 After receiving approval from the Port Authority, the lifeboat drill commenced at 0800. The Master and nine crewmembers were participating in the drill. The No.2 lifeboat at the ship's port side was successfully launched at 0815.
- 4.3 There were five crewmembers inside the lifeboat. The Chief Officer (C/O) was in charge and the helmsman, the Fourth Engineer monitored the lifeboat engine whilst the Third Officer (3/O), the Wiper and the Able Seaman (A/B) carried out other supporting duties. The lifeboat manoeuvred in the water for about 15 minutes.
- 4.4 After the manoeuvring, the crew prepared to recover the lifeboat back to the ship's davit. At 0832, the 3/O and the A/B stationed at the forward and aft lifting hook positions for recovering the lifeboat.
- 4.5 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 accident. (See fig. 2)
- 4.6 The 3/O fetched a lifebuoy and jumped into the water to rescue the A/B. After the rescue, the A/B was sent ashore to St. Ann's Bay Hospital by ambulance. However, he died before arriving the hospital.

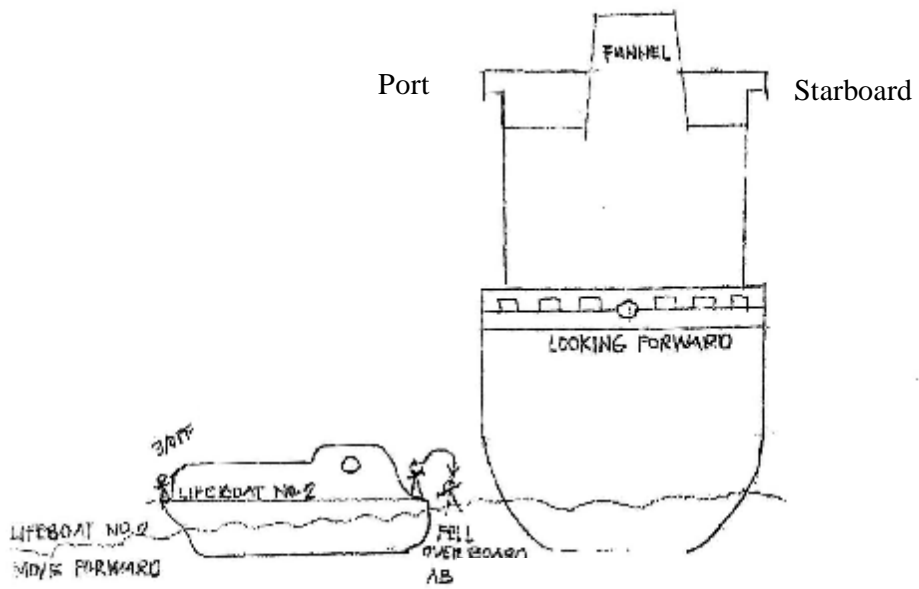
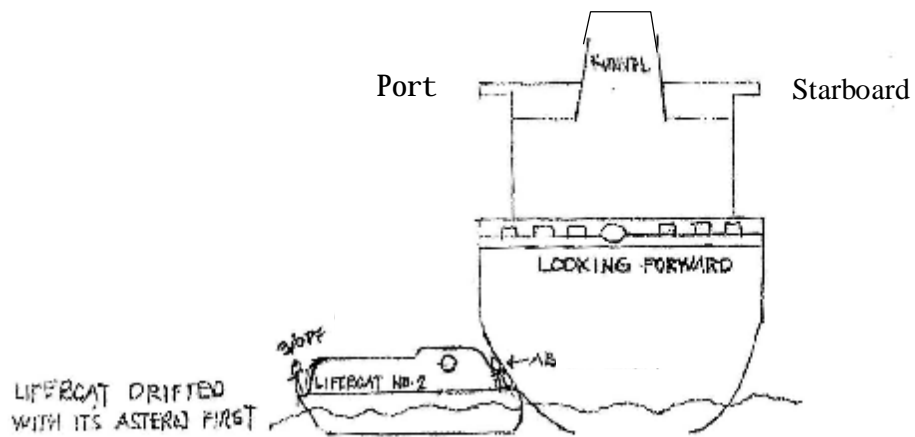


Fig.2: Sketch showing the sequence of the accident  
(Provided by the Master of the Vessel)

## 5. Findings and Analysis

### The environment

5.1 The accident occurred early in the morning, with partly cloudy condition. *The Vessel* was berthed with starboard side alongside. The sea was slight with light breeze from north easterly at force 3, waves at height of 0.6 metre were reported. Apparently, the weather condition was considered suitable for conducting the lifeboat drill.

### The lifeboats

5.2 *The Vessel* was equipped with two identical 25-person totally enclosed lifeboats. They were manufactured by "Dalian Mingzhu F.R.P. Boat Co., Ltd." in China. Two lifeboats were stowed in a gravity davit on either side at the boat deck level. The lifeboats were constructed of glass reinforced plastic with dimensions of 5.7 m in length, 2.2 m in breadth and 1.0 m in depth. The weight of each fully equipped lifeboat was 2,425kg. Each lifeboat was propelled by a 22kW Yanmer diesel engine with a speed of 6.3 knots. Two hooks were fitted on the lifeboat at the forward and aft end for engaging the floating blocks from the gravity davit. Access hatches were fitted at the aft and the amidships on starboard side of the lifeboat.

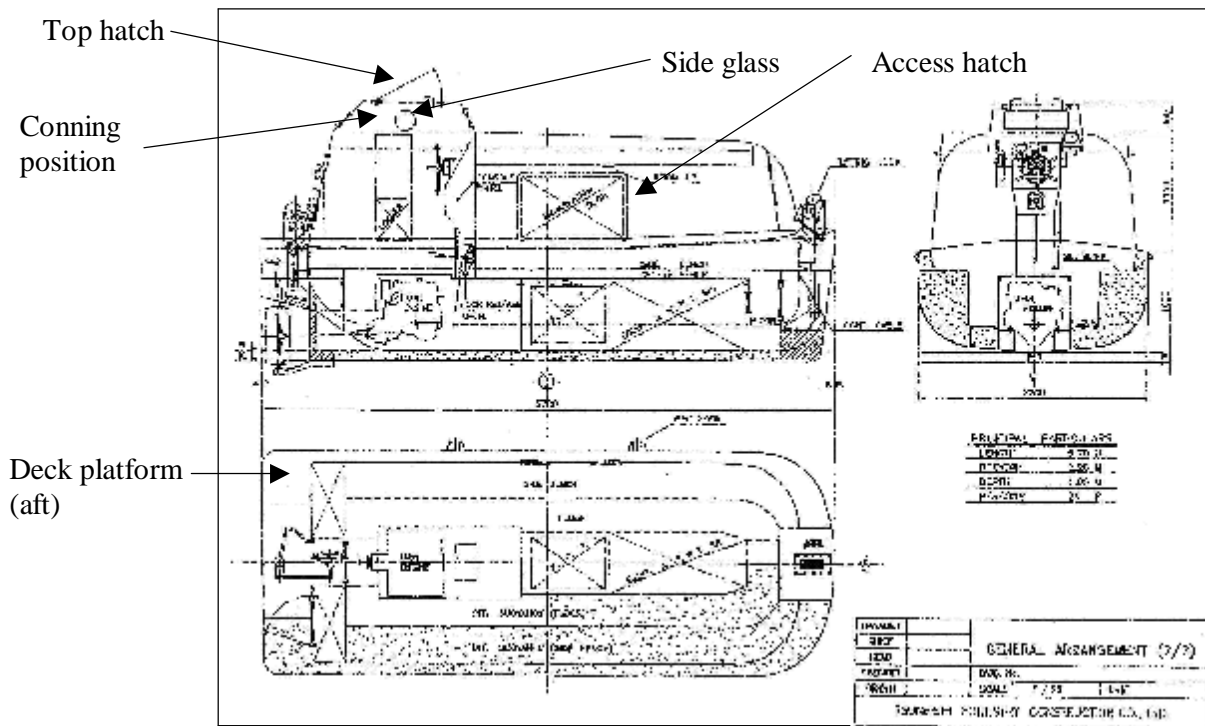


Fig.3: General arrangement of the lifeboat

- 5.3 A deck platform of about 0.5 m width was provided at the aft for facilitating the crew to engage the floating block to the hook of the lifeboat. Griprails were fitted around the canopy of the lifeboat. At the time of the accident, the deceased stationed at the aft deck platform and concentrated on the connection of the floating block onto the hook of the lifeboat. The aft deck platform provided limited space for the A/B to move about when the lifeboat made contact to the side shell of *the Vessel*.
- 5.4 The lifeboat was under the command of the C/O and he was acting as the helmsman to maneuver the lifeboat. The steering position was fitted with four windows around the helmsman to enable the helmsman to have an all-round view. A hatch was also fitted at top of the helmsman to allow him to stand up to obtain an unobstructed view.
- 5.5 However as the windows were small in sizes (at about 0.25 m in diameter) they did not provide a good view to the outside environment. The top hatch was to be used to ensure the helmsman to have a clear view but it was not opened during the maneuver. To maintain a vigilant lookout, alternatively, a crew could be assigned to maintain an all-round and unobstructed view for any irregularity.
- 5.6 Throughout the lifeboat drill, the top hatch was not opened and there was no designated crew assigned to keep a lookout. The steering position inside the lifeboat did not given an unobstructed view to the helmsman. As a result, the Chief Officer was not able to assess the situation outside the lifeboat and react promptly with the manoeuvring when the lifeboat was drifted to the side shell of *the Vessel*.

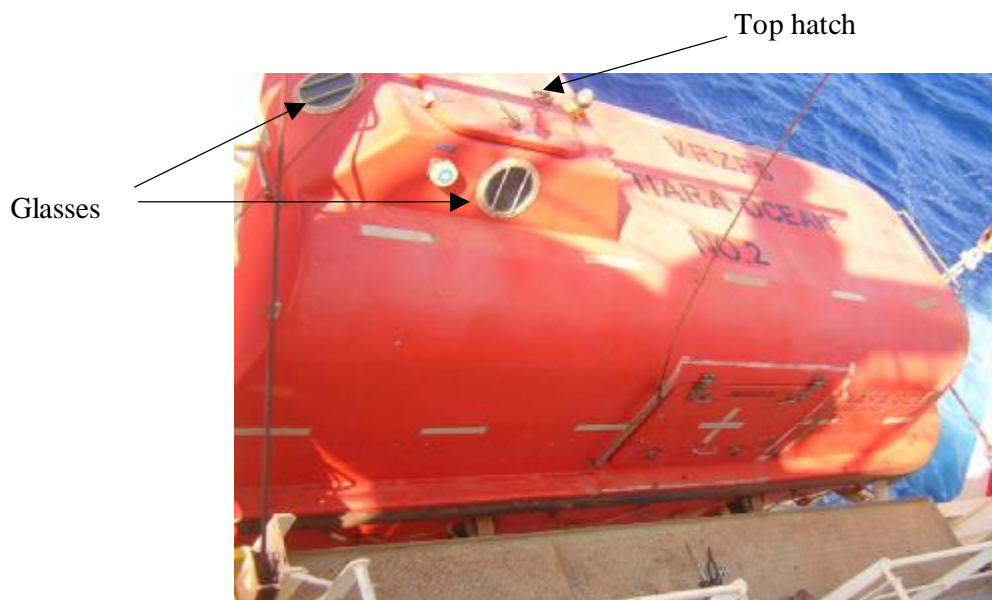


Fig.4: Photo of the lifeboat

The certification and training of the crew

- 5.7 All the ship's officers and crew were of Filipino nationality. They held valid and appropriate certificates to work on board *the Vessel* and had received familiarization training upon joining.

Stowage position of the lifeboats

- 5.8 The stowage position of the lifeboats was closed to the aft of *the Vessel* (at frame No. 30). 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.

The personal protective equipment

- 5.9 The deceased as well as all the crew participating in the drill had worn a lifejacket and proper safety clothing.

Post Mortem Examination

- 5.10 According to the post mortem report, multiple bruises were found over the chest of the deceased. Haemorrhagic shock due to contusion injury to both lungs, liver, brainstem and cerebellar were identified. A number of ribs were found fractured. The cause of the death was due to multiple injuries over the body of the deceased.

## **6. Conclusions**

- 6.1 On 18 July 2005, a lifeboat accident happened on the Hong Kong registered bulk carrier at Port Rhoades, Jamaica. While the crew were recovering the No.2 lifeboat back to *the Vessel*, the lifeboat was drifted by the water current and a gust of wind into the port quarter of *the Vessel*. The A/B standing in the vicinity was crushed between the canopy of the lifeboat and the side shell of *the Vessel*. He died after the accident.
- 6.2 The investigation revealed that 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.

## **7. Recommendations**

- 7.1 A copy of this report should be sent to the concerned parties such as the Master, Chief Officer and the Operator of *the Vessel*, advising them the findings of the of this incident.
- 7.2 A Merchant Shipping Information Note is to be promulgated to alert the crew of the Hong Kong registered ships the potential hazards in carrying out lifeboat drill. A proper lookout should always be kept to ensure safe handling of the lifeboat.

## 8. Submissions

- 8.1 In the event that the conduct of any person or organization is criticized in the investigation report, it is the policy of the Hong Kong Marine Department that a copy of the draft report is given to that person or organization so that they have the opportunity to rebut the criticism or offer evidence not previously available to the investigating officer.
- 8.2 The draft report was forwarded to the followings:
  - a) Sandigan Ship Services, Inc.
  - b) The Master of *the Vessel*.
  - c) The Chief Officer of *the Vessel*.
- 8.3 Submissions was received from the Master and the Chief Officer of *the Vessel*, amendments were made as appropriate.