



Report of investigation
into the falling overboard of the
Third Officer from the Hong Kong
Registered Container Ship
"BLUE OCEAN"
on 19 May 2008



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 At about 1429 on 19 May 2008, at the approximate position of lat. 15° 39.0'N, long. 110° 44.6'E, an accident happened onboard the Hong Kong registered container ship *BLUE OCEAN* while she was en-route from Hong Kong to Ho Chi Minh City, Vietnam.
- 1.2 During a drill on the No. 2 Lifeboat at sea, the Third Officer, who was accompanied by a seaman inside the lifeboat, pulled the remote control cable to lower the boat by the order of the Master. The lifeboat swung out from the lifeboat davit and stopped.
- 1.3 The Master ordered the Third Officer to lower the lifeboat further, but the cable was found jammed. The Third Officer asked the seaman to help him pull the cable together. Suddenly, the lifeboat descended rapidly and plunged into the water, rebounded, swung towards and hit the shipside and was damaged. Water ran into the lifeboat and flushed the Third Officer out to the sea.
- 1.4 The Master conducted a search and rescue operation for the Third Officer and the seaman. The seaman inside the No.2 Lifeboat was rescued but the Third Officer was missing. The SAR operation was continued until 1300 on 20 May 2008, but was in vain. After that, the Master recovered the No.2 Lifeboat and resumed the voyage to Ho Chi Minh City.
- 1.5 The investigation revealed that the main contributing factor to the accident was the improper maintenance and operation of the remote control mechanism for lowering of the No. 2 Lifeboat.

2. Description of the vessel

2.1 Particulars of M.V. *BLUE OCEAN*

| | | |
|-------------------|---|-------------------------|
| Port of Registry | : | Hong Kong, China |
| IMO No. | : | 8813611 |
| Call sign | : | VRYY6 |
| Type | : | Container ship |
| Year Built | : | 1989 |
| Gross Tonnage | : | 9949 |
| Net Tonnage | : | 5492 |
| Length Overall | : | 150.42 metres |
| Breadth | : | 22.6 metres |
| Moulded Depth | : | 11.1 metres |
| Summer Deadweight | : | 14900 tonnes |
| Main Engine | : | Mitsubishi 6UEC52LA |
| Engine Power | : | 6982.5 kW |
| Speed | : | 17 knots |
| Class | : | Germanischer Lloyd (GL) |



Fig 1 – Blue Ocean

3 Sources of evidence

- 3.1 Statements from the Master and crew of *BLUE OCEAN*; and
- 3.2 Management Company of Blue Ocean - Shanghai Hai Hua Shipping Co. Ltd.

4 Outline of events

- 4.1 At about 1400 on 19 May 2008, when the Hong Kong registered container ship *BLUE OCEAN* (the *Vessel*) was en route from Hong Kong to Ho Chi Minh City, Vietnam, the Master conducted a lifeboat drill.
- 4.2 At about 1420, the Master informed the deck crew, the Fourth Engineer and the Electrician to carry out a lifeboat drill for the port side No. 2 Lifeboat.
- 4.3 The lashing of the lifeboat was removed at about 1425 and the Fourth Engineer went inside to test the lifeboat engine.
- 4.4 After testing the lifeboat engine, the Fourth Engineer disembarked the lifeboat. Then the Third Officer and a seaman embarked and waited for the Master's instructions.
- 4.5 At about 1428, the Master ordered the Third Officer to pull the remote control cable to lower the lifeboat from inside.
- 4.6 At about 1429, the Third Officer pulled the control cable and the lifeboat swung out and stopped. The Master then asked the Third Officer to pull the cable again to lower the lifeboat further down. The Third Officer tried to pull the cable but it was jammed so he asked the seaman to help pull the cable together. When they pulled the cable, the lifeboat descended quickly and plunged into the water. As a result, the davit arm for hanging the lifeboat was bent by the extensive force of the rapidly descending lifeboat. At the time of the accident, the position of the *Vessel* was at lat. 15° 39.0'N long. 110° 44.6'E.
- 4.7 Water ran into the No. 2 Lifeboat through the starboard entrance door on the canopy and flushed the Third Officer out of the lifeboat to the sea. The lifeboat then banged against the shipside a few times before it became detached from the hooks of the davit falls and drifted away.
- 4.8 At about 1429^{1/2}, the Master ordered to stop the main engine and standby the main engine for immediate manoeuvre. At about 1430, a sailor threw out a lifebuoy to the Third Officer, but he could not grab it
- 4.9 At about 1435, the No. 1 Lifeboat was launched for the Search and Rescue operation. At about 1450, the No. 2 Lifeboat was located and the seaman inside the boat was rescued.

- 4.10 At about 1500, the *Vessel* commenced an expanding square search for the missing Third Officer while the No. 1 Lifeboat searched in the vicinity of where the accident happened. At about 1730, the No. 1 Lifeboat was recovered onboard but SAR operation conducted by *Vessel* was continued.
- 4.11 At 1300 on 20 May 2008, the Third Officer still could not be found and the Master ordered to stop the SAR operation and commenced to recover the damaged No. 2 Lifeboat drifting at sea. At about 1730, the No. 2 Lifeboat was recovered, placed and secured on the poop deck.
- 4.12 At about 1823, the *Vessel* resumed her voyage to Ho Chi Minh City, Vietnam.

5 Analysis of evidence

Certification and Experience

- 5.1 The Master held a valid Master's Certificate of Competency issued by Shanghai Maritime Safety Administration, the People's Republic of China and a Class 1 Licence (Deck Officer) issued by the Hong Kong Marine Department. He had two years experience as Master and signed on the *Vessel* on 1 April 2008.
- 5.2 The Third Officer held a valid Third Officer's Certificate of Competency issued by Shanghai Maritime Safety Administration, the People's Republic of China and a Class 3 Licence (Deck Officer) issued by Hong Kong Marine Department. He had a total experience as Third Officer for three months and had signed on the *Vessel* on 23 April 2008.
- 5.3 It is considered that the Master of the *Vessel* was properly certified with appropriate experience. However, the Third Officer, albeit certified, had accumulated only limited working experience as third officer onboard ship. He might need special guidance, supervision and assistance by the Master or other senior officers onboard while being assigned to execute some special tasks.

Lifeboat Condition

- 5.4 Both No.1 and No. 2 Lifeboat onboard the *Vessel* were entire enclosed type lifeboats, each had a capacity of 24 persons.
- 5.5 The condition of the No. 2 Lifeboat and its gravity launching type davit were reported to be in good condition before the accident and properly certificated.
- 5.6 The last drill for the No. 2 Lifeboat was conducted on 19 January 2008 and no abnormalities were reported in that drill.

Preparation for Lifeboat Drill

- 5.7 The lifeboats on board the *Vessel* could be launched by means of either lifting the brake-release directly at the winch located on the boat deck or by pulling the remote control cable for brake-release from inside the lifeboat. According to the previous records of lifeboat drills carried out on board before the accident, there

had been five times of lowering/launching of lifeboats since 10 December 2007 all performed by means of lifting the brake-release at the winch. It is therefore evident that both the Master and the Third Officer, who joined ship in April 2008, had no experience in the lowering of lifeboats by means of operating the remote control cable from inside the lifeboat.

- 5.8 In the boat drill carried out on 19 May 2008, the Master of the *Vessel* did not convey a clear message to his crewmembers prior to the drill, including the Bosun, Chief Officer and Third Officer, that the No.2 Lifeboat would be lowered by means of the remote control cable inside the lifeboat. As the Master and the Third Officer were not familiar with this operation onboard the *Vessel*, the Master should have organized properly prior to the drill, taken into account all necessary safety precautions and had the crew briefed, especially for the Third Officer who would have to operate the control for lowering of the boat. There is no evidence to prove that the Master had provided such advice to the crew.

Maintenance of Lifeboat Launching System

- 5.9 Lifeboat equipment and systems for launching should be maintained properly to ensure readily available for use at all times. During the drill on 19 May 2008, when the remote control cable was pulled, the lifeboat swung out and stopped. It was apparent that the remote control system was malfunction - probably due to improper maintenance of the remote control system. It was evident that the equipment and systems for lowering of No.2 Lifeboat had not been maintained properly and checked before the drill.

The Lifeboat Drill Conducted at Open Sea

- 5.10 The last drill for the No.2 Lifeboat was conducted on 19 January 2008. It should have been launched and manoeuvred in the water by its assigned operating crew at least once every three months (i.e. before 19 April 2008) during an abandon ship drill in accordance with SOLAS requirements. However, there was no record onboard giving reasons why the launching of the No.2 Lifeboat exceeding the mandatory three-month interval. It could be the reason why the Master arranged the boat drill at sea.
- 5.11 The drill for the No.2 Lifeboat was carried out in open sea on 19 May 2008 while the *Vessel* was cruising at full speed of 16 knots. There was no emergency muster

signal sounded prior to the drill. The crewmembers attended the drill did not don lifejackets. There was no proper communication established between crewmembers as the officers did not use the portable two-way VHF radio during the drill.

- 5.12 It is a dangerous practice to lower or launch lifeboat when the ship making headway. If such drill is to be conducted, special precautions should be taken which includes slowing down the vessel speed, lowering/launching the boat only in sheltered water, under supervision of an experienced officer, etc.
- 5.13 The Hong Kong Marine Department has issued the Hong Kong Merchant Shipping Information Notes No. 28/2006 on 23 June 2006, promulgating the “Guidelines on Safety during Abandon Ship Drills using Lifeboats”. The following is recommended in the guidelines:

“Before placing persons onboard a lifeboat, it is recommended that the boat first lowered and recovered without persons on board to ascertain that the arrangement functions correctly. The boat should then be lowered into the water with only the number of persons on board necessary to operate the boat”

The Master did not follow the recommendation in the guidelines. The No.2 Lifeboat should be tested without persons on board to ensure the gravity brake functioned properly and the lowering speed was normal.

Lifeboat Winch Brakes and Rapid Falling of the Lifeboat

- 5.14 There were two brakes fitted to the lifeboat winch: a manually activated gravity brake and an automatic centrifugal brake. The manual gravity brake would hold the lifeboat at any position and could be released by lifting the brake-release at the side of the winch. The gravity brake could also be released by the control cable from inside the lifeboat. The centrifugal brake would automatically limit the lowering speed of the boat. The brake system was inspected by the Classification Society on 8 September 2007.
- 5.15 According to the Operation Manual, the Lifeboat should be lowered by pulling the control cable steadily. However, when the control cable was jammed, the Third Officer and the seaman might have jerked the cable using excessive force. In this way, the brake was suddenly released. The lifeboat drill was carried out when the *Vessel* was cruising at 16 knots. When the gravity brake was released by the Third Officer inside the No. 2 Lifeboat, the lifeboat descended and at the same time

swung and hit on the hull severely. Therefore, excessive force could have been exerted on the centrifugal brake and rendered it malfunction. As a result, the No. 2 Lifeboat descended rapidly into the water on its own weight.

Fatigue at Work

- 5.16 The Vessel was en route from Hong Kong to Ho Chi Minh City. The officers were in normal watch. There is no evidence that the Third Officer had suffered from fatigue.

Reporting to MRCC

- 5.17 The Master reported that he had been sending man-overboard distress messages from 1600 to 1900 on 19 May 2008. After receiving the accident report from the Master, the ship management company also reported to the Nanhoi MRCC by telephone and fax. The ship did have received return of the man-overboard distress messages through the NAVTEX receiver from Nanhoi MRCC, but there was no assistance rendered.

6. Conclusions

- 6.1 At about 1429 on 19 May 2008, at the approximate position of lat. 15° 39.0'N, long. 110° 44.6'E, an accident happened onboard the Hong Kong registered container ship *BLUE OCEAN* while she was en-route from Hong Kong to Ho Chi Minh city, Vietnam.
- 6.2 During a drill on the No.2 Lifeboat at sea, the Third Officer, who was accompanied by a seaman inside the lifeboat, pulled the remote control cable to lower the Lifeboat by the order of the Master. The lifeboat swung out from the lifeboat davit and stopped.
- 6.3 The Master ordered the Third Officer to lower the lifeboat further, but the cable was found jammed. The Third Officer asked the seaman to help him pull the cable together. Suddenly, the lifeboat descended rapidly and plunged into the water, rebounded, swung towards and hit the shipside and was damaged. Water ran into the lifeboat and flushed the Third Officer out to the sea.
- 6.4 The Master conducted a search and rescue operation for the Third Officer and the seaman. The seaman inside the No.2 Lifeboat was rescued but the Third Officer was missing. The SAR operation was continued until 1300 on 20 May 2008, but was in vain. After that, the Master recovered the No.2 Lifeboat and resumed the voyage to Ho Chi Minh City.
- 6.5 The investigation revealed the main contributing factor to the accident was the improper maintenance and operation of the remote control mechanism for lowering the No.2 Lifeboat.
- 6.6 The other safety factors revealed in the investigation are:
 - the Master did not assess the risk and organize the drill of the No. 2 Lifeboat properly; and
 - the Third Officer was assigned to operate the remote control system for lowering of the lifeboat, a system of which he was not familiar and yet received no guidance by the Master of the *Vessel*.

7. Recommendations

- 7.1 A copy of the report should be sent to the Master and the ship management company of *BLUE OCEAN* advising the findings of the investigation into this accident.
- 7.2 The Company is required to issue circular and/or safety instructions to its fleet reminding the Masters and officers of their vessels to:-
- strictly follow the relevant safety procedural guidelines and instructions whenever lifeboat drills is to be conducted;
 - provide proper monitoring and guidance to newly-joined and/or inexperienced junior officers whenever they are assigned to work independently on lifeboat.
- 7.3 A Merchant Shipping Information Note (MSIN) should be issued to promulgate the lessons learnt from this accident.

8. Submission

- 8.1 In the event that the conduct of any person or organization is commented in an accident investigation report, it is the policy of the Marine Department to send a copy of the draft report or parts thereof to that person or organization for their comments.
- 8.2 The draft report was sent to the ship management company and the Master of *BLUE OCEAN* for comments.
- 8.3 The ship management company had submitted additional information relating to this incident. The final report has been amended accordingly.

