Report of investigation into the man overboard accident on board Hong Kong registered bulk carrier "*Lara Venture*" on 13 March 2018

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

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Purpose of Investigation

The purpose of this investigation, conducted by the Marine Accident Investigation Branch (MAIB) of Marine Department, is to determine the circumstances and the causes of the incident with the aim of enhancing the safety of life at sea and avoiding similar incidents in future.

It is not intended to apportion blame or liability towards any particular organization or individual except so far as necessary to achieve the said purpose.

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

Table of Contents **Page**

Summary

On 13 March 2018 at about 0210 hours, a man overboard accident happened on board the Hong Kong registered bulk carrier "*Lara Venture*" (*the vessel*) at Cape Charles Anchorage, USA.

The vessel completed some of the cargo loading at Newport News, Virginia, USA at 2200 hours on 12 March 2018. She left the berth under pilotage and anchored at Cape Charles Anchorage at 0138 hours on 13 March 2018 waiting for the next berthing at Norfolk. The weather was poor with gale wind and high waves, and there was snowfall a few hours ago. At 0201 hours on 13 March 2018, *the working crew* including the bosun and an able-bodied seaman (the AB) prepared to recover the starboard combination arrangement of ladders[1] (the SCL) after the pilot disembarked *the vessel*. At about 0210 hours, when the AB went down the SCL and stayed on the lower platform to release the accommodation ladder, a high wave suddenly struck at the lower platform causing the AB to fall overboard. The AB was not found after a thorough search and rescue (SAR) operation.

The investigation revealed that the poor weather and sea conditions caused the AB working on the slippery lower platform to be carried away by high waves and missing. The investigation identified that the AB failed to wear lifejacket and was not properly monitored by the bosun when the AB worked over the shipside to recover the accommodation ladder. Moreover, there was a communication breakdown between the master, the chief officer and *the working crew*.

[1] "combination arrangement of ladders" is an arrangement that the pilot ladder is rigged beside the lower platform of the accommodation ladder to the shipside to facilitate accessing ship in accordance with the International Convention for the Safety of Life at Sea, Chapter V "Safety of navigation" Regulation 23 "Pilot transfer arrangements".

1. Description of the vessel

Ship name	: Lara Venture (Figure 1)
Flag	: Hong Kong, China
Port of registry	: Hong Kong
IMO No.	: 9512575
Type	: Bulk carrier
Year built	: 2011
Shipyard	: Shanhaiguan New Shipbuilding Industry Co., Ltd.
Gross tonnage	: 52,718
Net tonnage	: 29,666
Length overall	: 235.00 metres
Breadth	: 38.00 metres
Engine output, type	: 12240 kW, DMD MAN B&W6S60MC-C
Classification society	: Bureau Veritas
Registered owner	: Ocean Sunshine Shipping Limited
Management company	: Wah Kwong Ship Management (Hong Kong) Ltd.

Figure 1 *The vessel*

2. Sources of evidence

2.1 The statements of the crew and officers of *the vessel*.

2.2 The information provided by the management company of *the vessel*.

3. Outline of events

(All times were local time UTC - 4 hours)

3.1 On 12 March 2018 at 2200 hours, *the vessel* completed some of the cargo loading at Newport News, Virginia, USA and departed from the berth under pilotage. *The vessel* proceeded and anchored at Cape Charles Anchorage (37º15'N, 076º07'W) at 0138 hours on 13 March 2018 to wait for the next berthing at Norfolk.

3.2 After the pilot disembarked from the SCL at 0201 hours (Figures 2 and 3), the chief officer instructed the bosun and the AB to recover the accommodation ladder of the SCL. He then went to the bow to check the anchor chain condition.

3.3 The bosun instructed the AB to release the lashing of a magnetic pad at the end of the accommodation ladder. When the AB reached the lower platform of the accommodation ladder, a high wave suddenly struck at the platform causing him to fall overboard. The bosun on the main deck threw the nearest lifebuoy to the AB and reported man overboard to the bridge using his portable radio. The bosun saw the AB floating in the water with face downwards.

3.4 At 0210 hours, after knowing the accident from his portable radio, the chief officer rushed to the SCL station. On the way to the station, he threw a lifebuoy to the water. When he arrived, he also saw the AB with his face downwards in the water.

3.5 At the same time, the master reported the accident to the United States Coast Guard (USCG) and contacted the pilot boat which left *the vessel* shortly before the accident for assisting in SAR operation.

3.6 At 0212 hours, the master raised emergency signals and announced the man overboard accident via the public address system. He also mustered all crew at the rescue boat station.

3.7 At 0219 hours, the master reported the accident to the management company's Designated Person (DPA) and at 0239 hours, he reported the accident to the local agent.

3.8 At 0315 hours, the USCG called *the vessel* to gather the personal information of the AB including his name, height and weight.

3.9 At 0335 hours, a vessel named "Jing Jin Hai" at the anchorage called *the vessel* via very high frequency radio station informing that she found a reflective object at sea. The master requested her assistance to keep track of the object.

3.10 At 0337 hours, the master related the message of "Jing Jin Hai" to the pilot boat and the pilot boat sailed directly to "Jing Jin Hai".

3.11 At 0345 hours, the pilot boat reported to *the vessel* that the reflective object was *the vessel*'s lifebuoy.

3.12 At 0400 hours, the pilot boat ceased the SAR operation.

3.13 At 1200 hours, the USCG ceased the SAR operation, and the AB was not found.

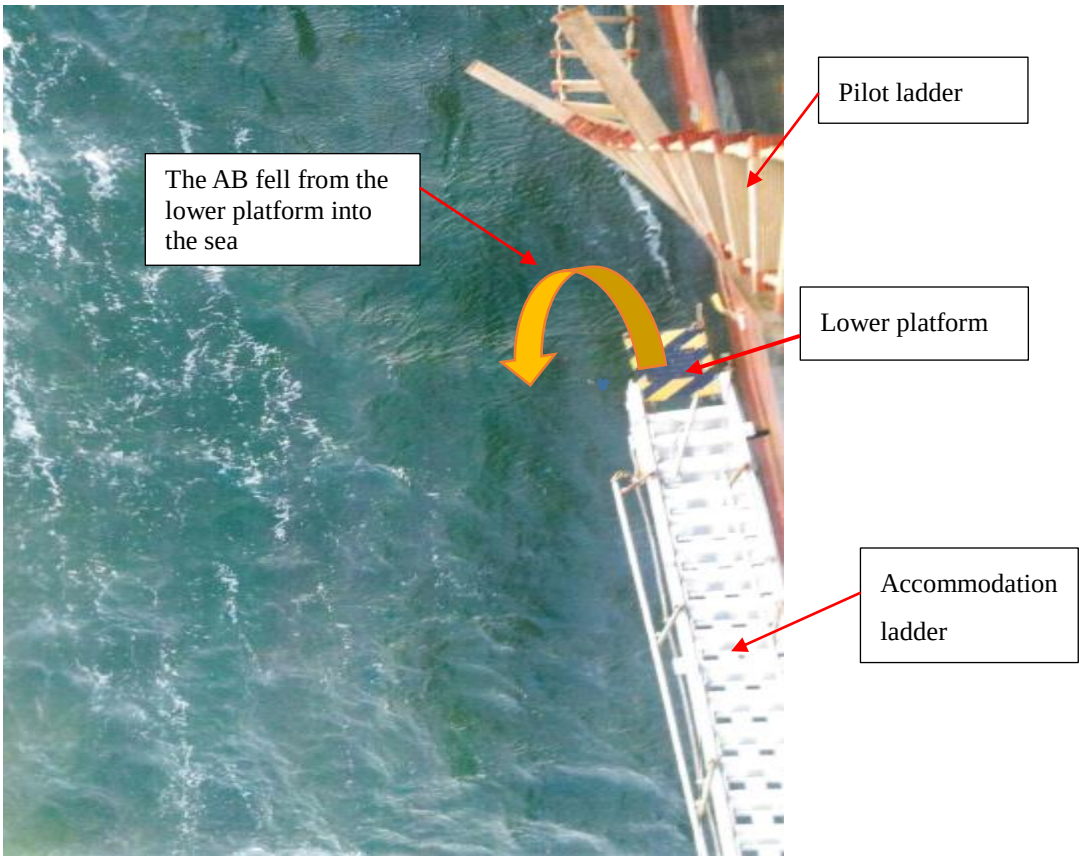

Figure 2 The SCL

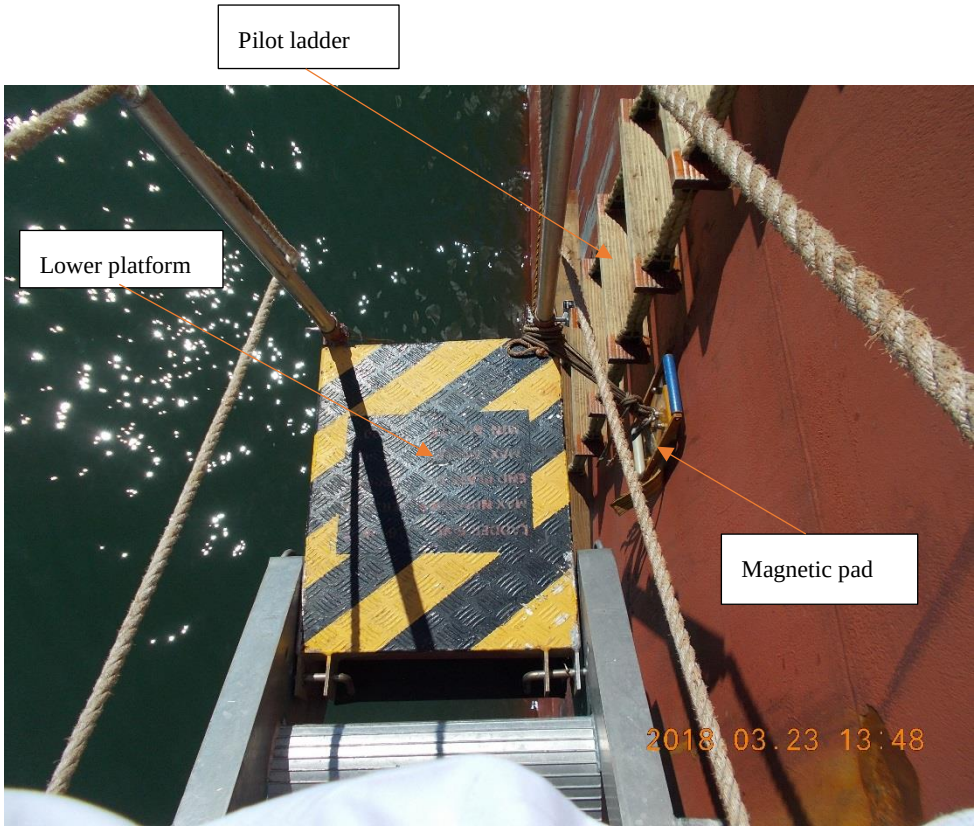

Figure 3 The SCL with a magnetic pad to secure the accommodation ladder to shipside

4. Analysis

Certification and experience

4.1 *The vessel* was manned by a total of 18 Chinese crew, including the master. The master held a valid Class 1 Licence of the Deck Officer issued by the Hong Kong Marine Department (HKMD). He had about 8 years of experience in the capacity of master. He had served the management company (the company) for about 3 years and joined *the vessel* on 9 May 2017.

4.2 The chief officer held a valid Class 1 Licence of the Deck Officer issued by HKMD. He had about 4 years of experience in the capacity of chief officer. *The vessel* was his first vessel with the company and he joined *the vessel* on 18 February 2018.

4.3 The bosun had about 5 years of experience in the capacity of bosun. *The vessel* was his first vessel with the company and he joined *the vessel* on 18 February 2018.

4.4 The AB had a total sea time of about 9 months as able-bodied seaman. *The vessel* was his first vessel with the company and he joined *the vessel* on 18 February 2018.

Fatigue, alcohol and drug abuse

4.5 There was no evidence to show that any crew including the missing AB suffered from either fatigue at work or abuse of alcohol and drug.

Weather and sea conditions

4.6 The weather was overcast with northwesterly strong gale and long swell. There was snowfall a few hours before the accident which made the accommodation ladder steps and the platform slippery. At the time of the accident, the lower platform of the accommodation ladder was suddenly struck by a high wave. Poor weather and sea conditions were contributory factors of the accident.

Safety Management System

4.7 In the company's Health, Safety and Environment Manual, the safety procedures relating to safe working of accommodation ladder were stipulated as follows:

(i) life vests/jackets to be worn when working over shipside or with gangways; and

(ii) when work has to be carried out over shipside, buoyancy garments should be worn and a lifebuoy with sufficient line attached should be kept ready for immediate use.

4.8 In this accident, the AB and the bosun were *the working crew* to recover to the accommodation ladder of the SCL. The AB was lack of safety awareness and did not observe the company's procedures to put on a lifejacket when working over the shipside on the accommodation ladder.

4.9 The bosun was an experienced petty officer leading the AB to recover the accommodation ladder. As a team leader, the bosun should pay special attention to the safety of his team member, in particular the AB who was young with less than a year relevant experience. The bosun failed to ensure the safety of the AB before asking him to go over shipside and walk down the ladder.

Communication breakdown

4.10 All crew including the master were Chinese, their working language was Chinese and they did not have language barrier.

4.11 After the pilot left *the vessel*, the master claimed that he had instructed the chief officer and the bosun via the portable radio not to recover the SCL because of the poor weather and rough sea conditions. However, both the chief officer and *the working crew* failed to receive such instruction probably due to radio interference by gale wind.

4.12 Apparently, there was a communication breakdown between the master on the bridge and the chief officer as well as *the working crew* on deck in this accident. The master should ensure that his instruction was received properly by repeating his instruction until confirmation feedback could be heard through the portable radio.

Cause of the accident

4.13 According to the chief officer's statement, he instructed the bosun and the AB to recover the accommodation ladder of the SCL. The bosun then asked the AB to go to the lower platform to release the lashing of the magnetic pad at the end of the accommodation ladder. The AB went down the accommodation ladder to the lower platform without wearing a lifejacket. While the AB was releasing the magnetic pad, a high wave suddenly struck the lower platform causing the AB to fall overboard.

4.14 Since both the chief officer and the bosun saw the AB floating in the water with face downwards, it was probable that the AB had already lost his consciousness when falling into the water.

5. Conclusions

5.1 *The vessel* completed some of the cargo loading at Newport News, USA at 2200 hours on 12 March 2018. She anchored at Cape Charles Anchorage at 0138 hours on 13 March 2018 and waited for next berthing at Norfolk. After pilot disembarked *the vessel*, the AB went down to the lower platform of the starboard accommodation ladder to prepare for the ladder recovery. A high wave struck at the platform causing him falling overboard at about 0210 hours. The pilot boat and the USCG respectively assisted in searching the AB until 0400 hours and noon, but in vain. The AB was finally missing.

5.2 The investigation identified the following contributory factors:

a) the poor weather with snowfall, gale wind and high waves were the environmental causes. The snowfall made the accommodation ladder slippery, and the high wave caused the AB falling overboard;

b) the AB failed to wear lifejacket and was not properly monitored by the bosun when the AB worked over the shipside to recover the accommodation ladder in poor weather and rough sea conditions; and

c) there was a communication breakdown between the master, the chief officer and *the working crew*. The master did not confirm his instruction of not requiring to recover the SCL after the pilot left *the vessel* was well received by the chief officer and *the working crew.*

6. Recommendations

6.1 A copy of the investigation report is to be provided to the company and the master of *the vessel*. The company should issue circulars informing all masters, officers and crew of the findings and the lessons learnt from this investigation and instructing them to:

a) follow the company's procedure of wearing lifejacket when working over the shipside; and

b) arrange relevant safety training to enhance the crew's safety awareness on effect of the poor weather and sea conditions and familiarize themselves with the company's safety procedures. The crew should also be strengthened on the use of proper personal protective equipment.

6.2 The company should review the case and establish guidelines/safety procedures on effective communication amongst the teams of the crew.

6.3 A Hong Kong Merchant Shipping Information Notes is to be issued to promulgate the lessons learnt from this accident.

7. Submission

7.1 The draft investigation report, in its entirety, was sent to the company and the master of *the vessel* as well as the Ship Safety Branch of the Marine Department for their comments.

7.2 By the end of the consultation, no comment was received from the abovementioned parties.