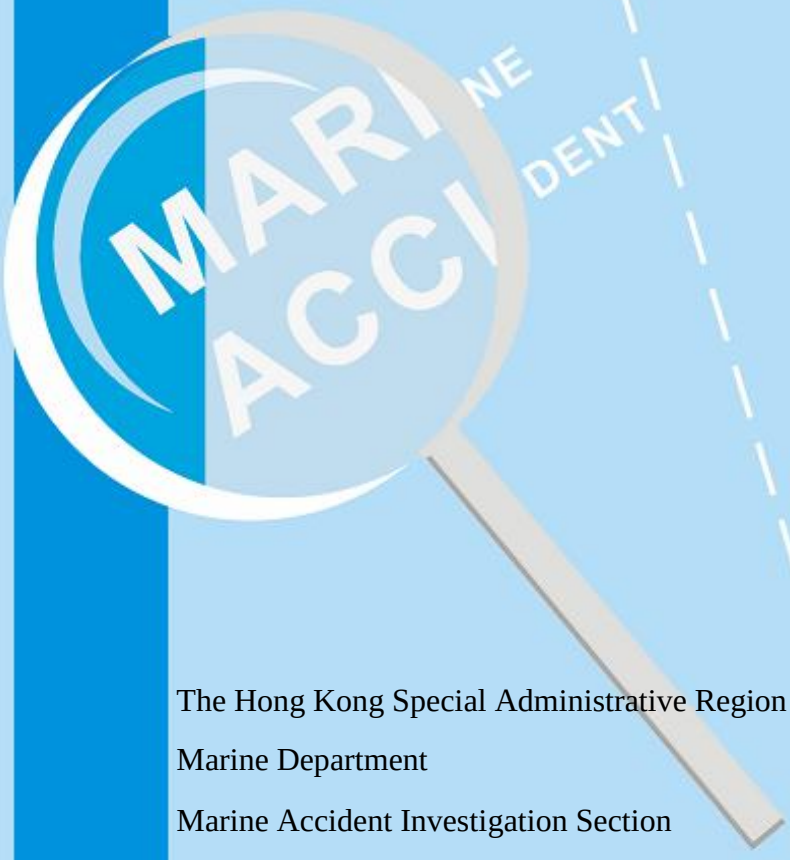
Report of investigation into the man overboard accident on board the Republic of Sierra Leone registered dry cargo vessel " *Lin Fung 16*" at Yau Ma Tei Anchorage, Hong Kong on 26 May 2018



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

16 April 2020

Purpose of Investigation

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 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 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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Summary

At 2155 hours on 26 May 2018, a fatal man overboard accident happened to an oiler of the Republic of Sierra Leone registered general cargo vessel "*Lin Fung 16*" (*the vessel*) anchored at Yau Ma Tei Anchorage, Hong Kong.

At the time of the accident, some of the crew of *the vessel* were having dinner in the mess room on the poop deck. After hearing someone shouting from the aft of *the vessel*, they rushed to the poop deck aft and found a person in the water screaming for help. They threw lifebuoys with lifelines to him, but he caught none of them and was soon drifted away. The Hong Kong Maritime Rescue Co-ordination Centre (HKMRCC) coordinated the search and rescue (SAR) operation after receiving the report of the accident. Three days later, a dead body was found and identified to be the oiler.

The investigation revealed that certain shipside guardrails for the protection of crew from falling overboard were not fitted in way of the deck fittings (e.g. bollards, fairleads, and mooring chocks) on the poop deck aft of *the vessel*. These missing shipside guardrails formed openings to sea (*the shipside openings*) and were not in compliance with the protection of crew requirements of the International Convention on Load Lines, 1966. The oiler joined *the vessel* on the date of the accident. Since there was no witness to the accident, it might deduce that the oiler was not aware of the inherent hazard of *the shipside openings* on the poop deck aft, and inadvertently fell into the sea.

1. Description of the vessel

Ship name		***Lin Fung 16*** (Figure 1)
Flag	:	Republic of Sierra Leone
Port of registry	:	Freetown
IMO number	:	8955043
Type	:	General Cargo Ship
Year built, shipyard	:	1998, Chong Qing Shipyard
Gross tonnage	:	1,861
Net tonnage	:	913
Summer deadweight	:	2,243 tonnes
Length overall	:	82.34 metres
Breadth	:	13.6 metres
Engine output, type	:	735 kW, Guangzhou Diesel Engine 6320ZCD
Classification society	:	Asia Shipping Certification Services (ASCS)
Registered owner		Lin Fung Shipping (HK) Ltd.
Management company	:	Lin Fung Shipping (HK) Ltd.

Figure 1: *Lin Fung 16*

2. Sources of evidence

2.1 The crew of *the vessel*.

2.2 The weather report from the Hong Kong Observatory.

2.3 The autopsy report from the Department of Health, Hong Kong.

2.4 The Sierra Leone Maritime Administration (SLMA).

3. Outline of events

(All times were local time UTC + 8 hours)

3.1 On 25 May 2018, eight crew including the oiler arrived in Hong Kong and joined *the vessel* at Yau Ma Tei Anchorage. They were tasked to rectify the detainable deficiencies found during the Port State Control inspection in Hong Kong on 11 May 2018.

3.2 After the first day of work on 26 May 2018, the oiler was seen by the chief engineer at the poop deck corridor at around 2000 hours. At 2155 hours, when six crew (the chief engineer, the second engineer, the chief officer, the bosun, an able-bodied seaman and the cook) were having dinner in the mess room on the poop deck, they heard someone shouting from the aft of *the vessel*. They immediately rushed to the poop deck aft and found a person in the sea screaming for help. They threw lifebuoys with lifelines overboard to him. However, the person failed to catch the lifebuoys and was soon drifted away by waves generated by passing launches. He was out of sight and went missing. The crew were not recognize the person missing in the sea.

3.3 The chief officer reported the man overboard accident to the master who was on duty on the bridge. The master mustered all crew to carry out visual searching. However, the person missing in the sea could not be located again. The master ordered to carry out headcount and found that the oiler was missing. He immediately reported to the Hong Kong Marine Department and asked for help by VHF[1] radio.

3.4 HKMRCC coordinated the SAR operation for the oiler but in vain. Three days later, a dead body was found in the sea near the anchorage and identified to be the oiler.

[1] Very high frequency (VHF) radio is used for a wide variety of purposes, including summoning rescue services and communicating with other vessels.

4. Analysis

Ship's manning and crew certification

4.1 *The vessel* was manned by a total of ten crew and met the minimum safe manning requirement. They possessed valid certificates of competency or certificates of proficiency in accordance with the manning requirements of the flag administration.

Fatigue, alcohol and drug abuse

4.2 There was no evidence to show that any crew including the oiler had suffered from fatigue at work or alcohol and drug abuse.

Weather and sea conditions

4.3 At the time of the accident, the weather was fair with wind of Beaufort force 2. The state of sea was calm with slight swell. Visibility was good.

The autopsy report and health condition of the oiler

4.4 The oiler suffered from hypertension and fatty liver, but there was no evidence to show whether he had taken any medicine before he fell overboard.

4.5 As the oiler's body was submerged in water for three days and decayed, the autopsy could not ascertain his cause of death.

Protection of crew under the International Convention on Load Lines, 1966 and the analysis of oiler's falling overboard

4.6 Shipside guardrails were fitted around the poop deck aft to prevent crew from falling overboard. As shown in Figure 2, however, there were certain places where *shipside openings* were found around the periphery of the poop deck aft.

4.7 Paragraph 2 of Regulation 25 "*Protection of the Crew*" of Annex I of the International Convention on Load Lines, 1966 (the Load Lines Convention) stipulates that "*Efficient guardrails or bulwarks shall be fitted on all exposed parts of the freeboard and superstructure decks. The height of the bulwarks or guardrails shall be at least 1 metre (39½ inches) from the deck, provided that where this height would interfere with the normal operation of the ship, a lesser height may be approved if*

the Administration is satisfied that adequate protection is provided." As such, *the shipside openings* in way of the mooring fittings on the poop deck aft of *the vessel* did not comply with the above-mentioned requirement.

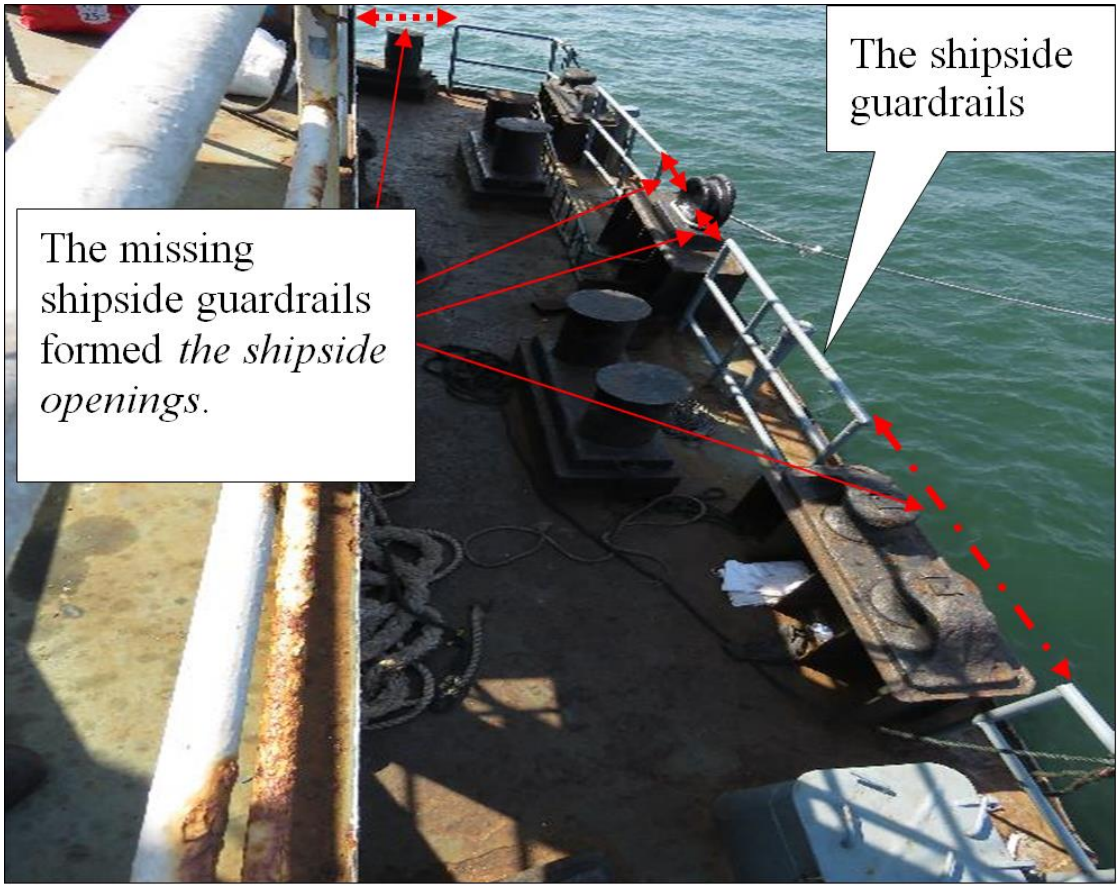

Figure 2: Poop deck aft

4.8 At the material time of the accident, there was no witness to the oiler's fall into the sea. It could only be deduced that he might have taken a walk on the poop deck aft after work. As the oiler was not aware of the inherent hazard of *the shipside openings*, he inadvertently fell into the sea.

4.9 The chance of the oiler's fall from either the port or starboard embarkation ladder on the poop deck could be ruled out since both of these ladders were properly secured in their stowed positions and provided proper protection of preventing crew from falling overboard (Figure 3).

Figure 3: Embarkation ladder

5. Conclusions

5.1 At 2155 hours on 26 May 2018, the oiler of *the vessel* fell overboard and went missing when *the vessel* was anchored at Yau Ma Tei Anchorage. Three days later, the dead body of the oiler was found in the sea nearby.

5.2 The investigation revealed that certain shipside guardrails in way of deck fittings (e.g. bollards, fairleads, and mooring chocks) on the poop deck aft of *the vessel* were not fitted. These missing shipside guardrails forming openings to sea were not in compliance with the protection of crew requirements of the International Convention on Load Lines, 1966. There was no witness to the accident. However, it might deduce that the oiler was not aware of the inherent hazard of *the shipside openings* on the poop deck aft and inadvertently fell into the sea.

6. Recommendations

6.1 A copy of the investigation report should be sent to SLMA, the master and the management company[2] of *the vessel* advising them of the findings of the investigation.

6.2 The management company should:

(a) arrange to provide efficient guardrails for *the shipside openings* to prevent crew from falling overboard in order to comply with the Load Lines Convention; and

(b) strengthen the crew safety awareness of falling overboard from exposed parts of the freeboard and superstructure decks.

[2] The company is required to provide objective evidence, to the satisfaction of the Marine Accident Investigation Section, as a proof of the implementation of the recommendations in this report within a time-frame mutually agreed. Failing that, *the vessel* in question will be subject to port State control inspection when she returns to Hong Kong waters.

7. Submission

7.1 The draft investigation report had been sent to the following parties for their comments:

(a) the ship management company and master of *the vessel*; and

(b) SLMA.

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