National Transportation Safety Board

Marine Accident Brief

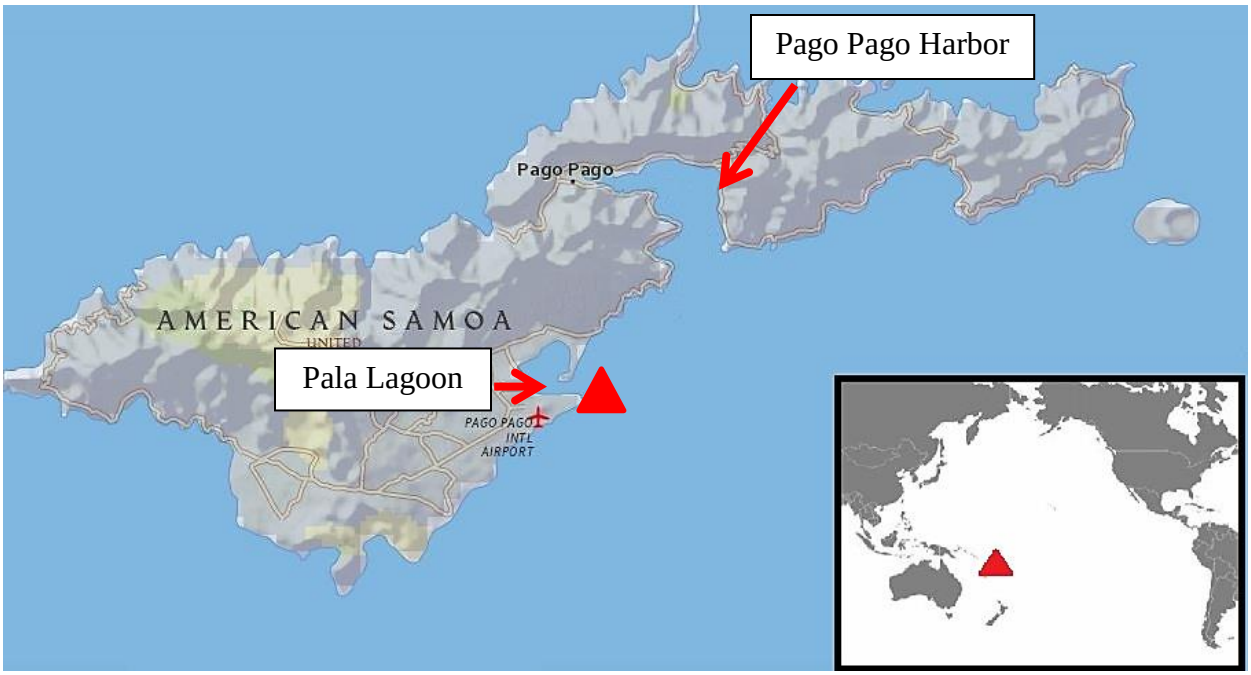
Grounding of Commercial Fishing Vessel *SeaHawk No. 68*

Accident no.	DCA15LM022
Vessel name	*SeaHawk No. 68*
Accident type	Grounding
Location	Pala Lagoon, Pago Pago, American Samoa (14˚19.46' S, 170˚42.02' W)
Date	May 22, 2015
Time	0530 Samoa standard time (coordinated universal time − 11 hours)
Injuries	Some crewmembers received minor injuries
Property damage	Total loss of vessel and cargo, valued at more than $500,000
Environmental damage	None reported
Weather	Seas about 10 feet, winds from the east about 15 to 25 knots, rain showers, and visibility about 10 miles.* Small craft and high surf advisories were in effect.
Waterway information	Pacific Ocean, southeast coast of Tutuila Island, American Samoa

About 0530 local time on May 22, 2015, the Taiwan-flagged commercial fishing vessel *SeaHawk No. 68* ran aground on a reef at the entrance to Pala Lagoon, Tutuila Island, American Samoa. All 22 crewmembers abandoned the vessel after the grounding and boarded the vessel's liferaft, which then floated to the shore. Some crewmembers sustained minor injuries during their egress from the vessel. No pollution was reported. The vessel was declared a constructive total loss.

***SeaHawk No. 68* before the grounding. (Photo by Mattlb from www.shipspotting.com)**

* Unless otherwise noted, all miles in this report are nautical miles (1.15 statute miles).



Map of Tutuila Island, American Samoa, with the accident location shown by a red triangle. The insert shows the location of American Samoa in the Pacific Ocean. (Background by National Geographic Mapmaker)

The *SeaHawk No. 68* had been on a fishing trip in the waters near Tahiti, French Polynesia, that began about 1 month before the grounding. The vessel was carrying nearly 75 tons of tuna as it transited from the fishing grounds to Pago Pago Harbor, located along the coastline of Tutuila Island, to disembark the vessel's engineer, who reported experiencing a minor medical condition.

There were 22 crewmembers aboard the vessel, including the captain and the engineer, both of whom were from the People's Republic of China. The rest of the crewmembers were from Indonesia. The captain, engineer, and crewmembers spoke only their native language. As a result, the captain and the engineer were able to communicate with each other but not with the other crewmembers (and vice versa).

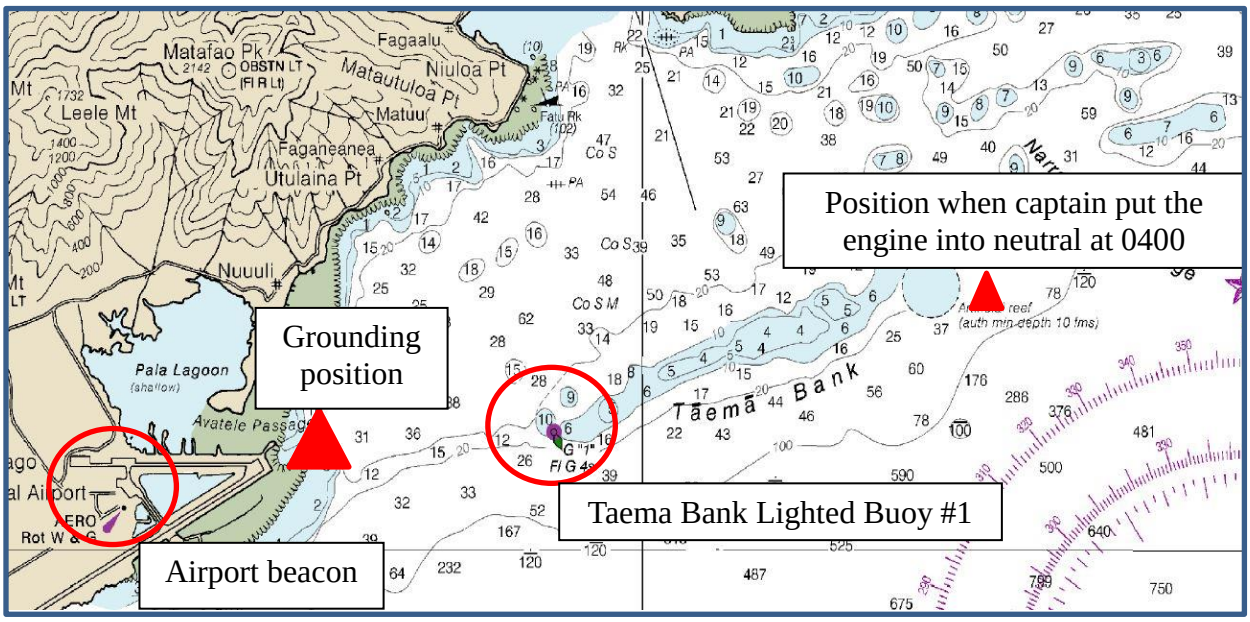
The wheelhouse of the *SeaHawk No. 68* was outfitted with an autopilot system, a global positioning system, and an electronic chart display and information system (ECDIS). The captain had not updated the navigational charts stored in the vessel's ECDIS computer during the 11 months that he had been aboard the vessel. The vessel was not equipped with a fathometer.

Safety/lookout crewmembers stood watch in 1-hour shifts. In good weather conditions, they stood watch outside of the wheelhouse; in poor weather conditions, they stood watch outside under the shelter of the exterior wheelhouse doors. The watchstanders indicated that they did not monitor the navigational equipment in the wheelhouse and in the chart room or use binoculars or searchlights while on watch. They also stated that the radar was typically shut down at night, as was the case during the hours preceding the accident. The safety/lookout crewmembers were not provided with written instructions or checklists for watchstanding, lifesaving, or emergency procedures. Consequently, they were also not provided with training in these areas. Also, no weather forecasts were received by the *SeaHawk No. 68* crew for the navigational period before the grounding.

Grounding of Commercial Fishing Vessel *SeaHawk No. 68*

About 2300 on May 21, 2015, the *SeaHawk No. 68* was about 27 miles to the east of Pago Pago Harbor. The captain was planning to have the vessel arrive in port at 0830 on May 22 because commercial fishing vessels do not typically arrive at Pago Pago Harbor at night (after normal business hours). To delay the *SeaHawk No. 68*'s arrival in port until 0830, the captain shut down the vessel's engine at an approximate position of 14˚21' S 170˚13' W. He did not provide the crew with any written or oral instructions regarding his plans. Also, the captain had not submitted an Advance Notice of Arrival form, as required by Title 33 *Code of Federal Regulations* 160.203 for vessels arriving in US ports.

About 0100 on May 22, the captain started the engine again, without advising the safety/lookout crewmembers, and then set the autopilot control (in the combined chart room/cabin area behind the wheelhouse) so that the vessel would travel in a westerly direction at a speed of about 8 knots to arrive at the harbor entrance about sunrise. The captain reported that the winds at the time were from the west, but he did not recall the wind speed. About 0400, the captain shifted the engine to idle so that the vessel would drift (likely because the vessel was closer to the harbor than anticipated) and then left the wheelhouse to attend to personal matters. The watchstanders reported that they saw lights along the shoreline and the beacon from Pago Pago International Airport but did not notify the captain that the vessel was approaching the shore. The watchstanders stated that they did not notice the Taema Bank Lighted Buoy #1 when the vessel passed it while traveling toward Pago Pago Harbor. (The US Coast Guard checked the buoy after the grounding and verified that it was properly illuminated and in its proper position.)



National Oceanic and Atmospheric Administration chart 83484 showing Tutuila Island, American Samoa. The position of the *SeaHawk No. 68*'s grounding near the entrance to Pala Lagoon, the vessel's position before the grounding, the lighted buoy, and the airport beacon are overlaid.

At 0520, a crewmember noted that there was "panic" in the wheelhouse because a large wave came from behind, pushing the vessel forward toward a reef. The captain returned to the wheelhouse and attempted to put the engine astern, but the vessel grounded on the reef. The engineer and some crewmembers then lowered the anchor from the bow, which was ineffective due to the shallow water depth. The *SeaHawk No. 68* rolled to its port side, and the crew decided to abandon the vessel onto an inflatable liferaft. The crewmembers had to first locate a knife to

cut away the lines securing the liferaft to its cradle. The liferaft, with all of the crewmembers inside, then floated safely to shore.

The *SeaHawk No. 68* grounded on its port side. The liferaft cradle and lines are circled. (Photo by the Coast Guard)

The captain had about 7 years of experience as a vessel captain and had worked aboard the *SeaHawk No. 68* for about 11 months. He had reportedly slept well from 0500 to 1100 on the day preceding the grounding (May 21, 2015) but stated that he did not sleep during the night before the grounding. The captain was taking an antibiotic for a toothache and over-the-counter cold medicine during the accident trip.

The engineer had about 18 years of experience at sea and had been aboard the *SeaHawk No. 68* for 11 months as well. He had reportedly slept from 0200 to 0800 each day during the fishing trip. On the morning of the accident, he watched television with the captain in the cabin aft of the wheelhouse until 0200 and then went to bed. The engineer stated that he was awakened by disturbances associated with the grounding.

Work/rest histories for the two safety/lookout watch personnel for the 0400 to 0500 and 0500 to 0600 periods (one watchstander per time period) indicated regular sleep periods interrupted by meals and watch periods. The captain, the engineer, and the watchstanders who were on duty before and at the time of the accident underwent postaccident drug and alcohol testing. The results were negative.

During the investigation of this accident, Coast Guard investigators discovered safety equipment discrepancies from the accident vessel. The investigators found that, according to the label on the *SeaHawk No. 68*'s emergency position indicating radio beacon (EPIRB), the

EPIRB's battery had expired in July 2011. The battery enables the EPIRB to transmit a coded message via satellite to facilitate search and rescue services in an emergency. The investigators also found that the captain was the only crewmember who knew how to operate the EPIRB.

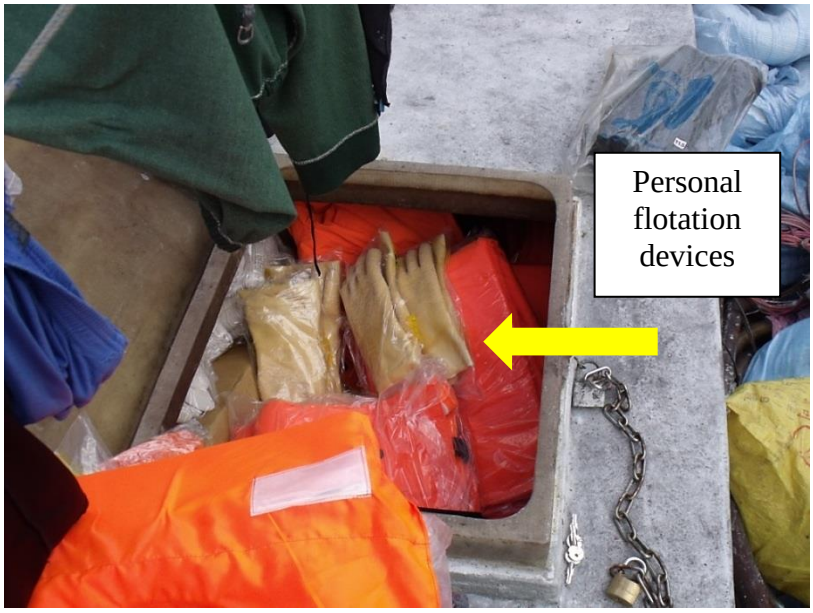
EPIRB from the *SeaHawk No. 68* showing the expiration date of the battery. (Photo by the Coast Guard)

In addition, the *SeaHawk No. 68*'s Ship Inspection Certificate, issued in February 2015, indicated that the vessel was equipped with safety equipment for 21 persons. However, the vessel was carrying 22 persons at the time of the accident and was therefore not in compliance with the certificate.

Due to the vessel's position grounded on the reef, Coast Guard investigators were not able to conduct a full inspection aboard the *SeaHawk No. 68*. Consequently, as part of the accident investigation, the investigators, accompanied by the captain and the engineer of the *SeaHawk No. 68*, examined the grounded vessel's sister vessel, the *SeaHawk No. 18*, which was docked in Pago Pago Harbor. The investigators discovered safety equipment discrepancies aboard the *SeaHawk No. 18* that could affect that crew's ability to access and use the equipment effectively. The *SeaHawk No. 68* captain and engineer told investigators that the condition of the safety equipment as found during the *SeaHawk No. 18* vessel examination was similar to that aboard the *SeaHawk No. 68*.

The personal flotation devices (PFD) aboard the *SeaHawk No. 18* were stored in a locked (chain and padlock) fiberglass box above the wheelhouse. The only key to access the PFDs was located away from the storage box. After the crew located the key below deck and opened the box, Coast Guard investigators found the PFDs stowed in clear plastic bags under fishing gear. The investigators randomly selected two crewmembers and asked them to don a PFD. Both of the crewmembers struggled to properly don and fasten the PFDs and needed assistance from the

SeaHawk No. 18 captain. The captain of the *SeaHawk No. 68* stated that the PFDs aboard his vessel were typically kept in the crew's chambers while at sea. However, the *SeaHawk No. 68* captain also stated that, 2 days before the accident, he had the PFDs moved to a locked box above the wheelhouse to prevent them from being stolen while the vessel would be in port.



PFDs stored in a locked fiberglass box aboard the *SeaHawk No. 18.* (Photo by the Coast Guard)

Another finding that concerned investigators while aboard the *SeaHawk No. 18* was that several lines secured the liferaft to its cradle on the starboard side of the vessel. The captain and the engineer of the *SeaHawk No. 68* stated that the liferaft aboard their vessel was secured in the same manner, which is why crewmembers had to use a knife to release the liferaft after the grounding. Neither vessel's liferaft was equipped with a hydrostatic-release device, which is designed to automatically release a liferaft once it becomes submerged.

Liferaft aboard the *SeaHawk No. 18* secured to its cradle with lines. (Photo by the Coast Guard)

Coast Guard investigators also found that the liferings aboard the *SeaHawk No. 18* were in poor condition as a result of their frequent exposure to sunlight. Specifically, the liferings had faded orange paint, cracked outer casings, missing reflective tape, and deteriorated lines. The captain and the engineer of the *SeaHawk No. 68* indicated that the liferings aboard their vessel were similarly degraded.

Faded and deteriorated liferings aboard the *SeaHawk No. 18*. (Photo by the Coast Guard)

Although not a factor in this accident, the issues with the lifesaving equipment aboard the *SeaHawk No. 68* demonstrated the owner/operator's lack of emphasis on safety, which could have compromised the welfare of the crew. The method of securing the liferaft to its cradle with lines caused a delay in launching the liferaft. Also, at the time of the accident, the PFDs would not have been readily available because they were locked in a storage box. Further, because the number of crewmembers exceeded that allowed by the vessel's inspection certificate, there might not have been enough safety equipment for each crewmember. In addition, the EPIRB's label indicated that the battery had been expired for almost 4 years at the time of the accident. If the vessel had experienced an emergency farther out at sea, rescue efforts could have been delayed or rendered ineffective due to the lack of position information.

The condition of the safety equipment aboard the *SeaHawk No. 18* (sister vessel) further demonstrated the owner/operator's lack of emphasis on safety. The deteriorated condition of the liferings could decrease the effectiveness of their flotation capabilities, and the faded orange color could reduce their visibility if a search and rescue effort were necessary. Also, the time required for crewmembers to access and properly don PFDs along with the lack of a hydrostatic-release device on the liferaft could put the crewmembers' survival at risk in an abandon ship scenario.

The lack of communication also played a role in the accident involving the *SeaHawk No. 68*. The captain had provided no information to the watchstanders about his navigation plans for the vessel's arrival in port after sunrise. The captain had also not provided written or oral instructions to the watchstanders when he shut down and restarted the engine during the hours preceding the accident. The language barrier between the captain and engineer and the other

crewmembers had exacerbated this situation because information could not be shared, which further compromised the safety of the vessel and crew.

While the *SeaHawk No. 68* was under way during the early morning hours before the accident, the watchstanders saw lights along the shoreline and the airport beacon. The watchstanders understood that the vessel was approaching the shore but were not trained or instructed to notify the captain in such a situation.

Probable Cause

The National Transportation Safety Board determines that the probable cause of the grounding of the commercial fishing vessel *SeaHawk No. 68* was the captain's failure to effectively monitor the vessel's position and progress as well as provide specific watchstanding instructions. Contributing to this accident was the owner/operator's lack of policies and procedures for navigation and training of vessel crewmembers.

Safety Equipment

The investigation into the *SeaHawk No. 68* accident found numerous deficiencies regarding the safety equipment on board the accident and sister vessels, including the following:

- PFDs stored in a locked storage box without the key nearby,
- liferafts secured to their cradles with several lines instead of a hydrostatic-release device,
- liferings that were faded, cracked, and deteriorated, and
- an EPIRB battery that had expired almost 4 years before the accident.

Owner/operators and vessel crewmembers should maintain safety equipment so that the equipment would function as designed in an emergency and provide crewmembers with the best chance for survival. Owner/operators should ensure that their vessels carry enough safety equipment for each crewmember.

Vessel Particulars

Vessel	*SeaHawk No. 68*
Owner/operator	Hung Sheng-Feng
Port of registry	Kaohsiung, Taiwan
Flag	Taiwan
Type	Commercial fishing vessel
Year built	2007
Official number (US)	014794
IMO number	N/A
Construction	Fiberglass
Length	85 ft (25.9 m)
Draft	7.2 ft (2.2 m)
Beam/width	18 ft (5.5 m)
Gross and/or ITC tonnage	99 gross tons
Engine power; manufacturer	1,000 hp (745 kW); Yanmar six-cylinder diesel
Persons on board	22

For more details about this accident, visit www.ntsb.gov and search for NTSB accident ID DCA15LM022.

Issued: February 11, 2016

NTSB investigators worked closely with our counterparts from the Coast Guard Investigations National Center of Expertise throughout this investigation. NTSB investigators did not travel to American Samoa.

The NTSB has authority to investigate and establish the probable cause of any major marine casualty or any marine casualty involving both public and nonpublic vessels under Title 49 *United States Code* 1131. This report is based on factual information either gathered by NTSB investigators or provided by the Coast Guard from its informal investigation of the accident.

The NTSB does not assign fault or blame for a marine casualty; rather, as specified by NTSB regulation, "[NTSB] investigations are fact-finding proceedings with no formal issues and no adverse parties . . . and are not conducted for the purpose of determining the rights or liabilities of any person." Title 49 *Code of Federal Regulations*, Section 831.4.

Assignment of fault or legal liability is not relevant to the NTSB's statutory mission to improve transportation safety by conducting investigations and issuing safety recommendations. In addition, statutory language prohibits the admission into evidence or use of any part of an NTSB report related to an accident in a civil action for damages resulting from a matter mentioned in the report. Title 49 *United States Code*, Section 1154(b).