SAFETY RECOMMENDATION No: 12/2014

Text of Safety Recommendation:	
Revise the Safety Management System under the requirements for an effective Bridge Resource Management in relation to technical and human resources, including watch keeping procedures.	
No of Safety Investigation Report:	02/2014: Grounding of B/C "INCE INEBOLU" *(See the full Report here.)*
Safety Recommendation addressed to:	Managers/Owners
Date of publication:	31/12/2015
Comments-Remarks:	

INFORMATION OF ACCIDENT

Type of vessel: Bulk Carrier
Year of built:11/2002

Grounding of B/C "INCE INEBOLU"

Course of events

On 30 August 2014, Ince Inebolu had sailed from Hodeidah/Yemen, located in the Red Sea, with 22 crew members on board, in ballast condition heading to Novorossiysk/Russia for loading. Following her passage plan, she exited Suez Canal and continued her passage at open sea towards Canakkale Strait. By that time cargo cleaning operations had been deployed, engaging almost all deck ratings, including the ABs forming part of the navigational watch.

On 05 September 2014, at approximately 0000, the Second Officer took over the navigational watch (0000 – 0400). The watch handover was carried out without any particular navigational remarks, steering was in autopilot heading to 318° while Ince Inebolu was running at about 13 knots and no look out watch was posted. However slight changes to Ince Inebolu course were recorded due to drifting.

The investigation process showed that probably from 0130 or shortly after, the Second Officer was not monitoring her passage as the vessel's positions were not plotted on the navigational chart and at approximately 0200 and he fell asleep. According to AIS information, the last selected course that was set by autopilot, was maintained throughout the 2nd Officer's navigational watch.

According to crew reports, on 03 September, during the Suez Canal crossing, the Bridge Navigational Watch Alarm System (BNWAS) had been deactivated, and it had not been reactivated since then. At approximately 0405 Ince Inebolu while running at approximately 13 knots, grounded on the south east rocky coastline of Astypalaia Island-Greece. At the time of the marine casualty the relieving Navigational Officer had not been called for duty. Weather conditions were reported to be very good (wind force 2-3 bfrs, sea state calm with very good visibility) and it was still dark.

Relevant comments on the safety recommendation

- The technical advantages of the bridge navigational equipment, such as Radar guard zones, GPS off course alarms, were not utilized by the Navigational Officers.
- The bridge navigational watch alarm system (BNWAS) non operation, as alleged by the Navigational Officers, was not communicated between the bridge teams.
- The effective management and integration of all resources, human and technical, available to the bridge team, to navigate the vessel in a safe and efficient manner were not practiced.

Grounding point of Ince Inebolu at Astypalaia Island.


Ince Inebolu anchored at Astypalaia.

Extent of damage

Due to the heavy impact on the rocky coastline, several compartments of her bow section were damaged to an extent of about 21 m of length longitudinally. More specific the damages reported to be cracks and hull plating deformation at forepeak tank, collision bulkhead, No. 1 cargo Hold, No 1 port and starboard ballast tanks. No injuries and no pollution was reported.


Deformed starboard bottom fore section.


The crack at inner bottom plate of No 1 cargo hold.

Marine casualty probable causes

The safety Investigation and analysis highlighted the following main contributing and underlined factors that led to the marine casualty as presented in random order:

- absence of posted look out at the night watch;
- the OOW fell asleep due to fatigue;
- the Bridge Watch Navigation Alarm (BNWAS) was switched off;
- the main navigational equipment was ineffectively being used without alarm utilities settings.

Safety recommendation conclusions

1. Bridge resource management in relation to technical resources was poor, as appropriate instructions and procedures were not in place.
2. The guard zone alarm utility on the operating Radar and GPS “off course alarms were not set by the Navigational Officers.
3. The “changing over the watch procedure” was rather generic, indicating a lack of incorporating explicit instructions to the Navigational Officers related to the Bridge Resource Management.
4. The Navigational Officer´s self-situational awareness was seriously reduced leading to his incapacitation.
5. The Navigational Officer had showed a “can-do” attitude, refraining from reporting his foreseeable physical incapacitation, although under lack of sleep and not fit for duty.
6. Prevailing weather conditions affected the Navigational Officer’s performance by reducing his watchfulness and by causing a sense of security and complacency that eventually led to his drowsiness and incapacitation.