

SAFETY RECOMMENDATION No: 13/2014

Text of Safety Recommendation:

Take appropriate measures through training in order to ensure that VDR data are saved and retrieved successfully, following a marine incident or casualty.

No of Safety Investigation Report:	02/2014: Grounding of B/C "INCE INEBOLU" (See the full Report <u>here</u> .)
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 02:00 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 process to download VDR data by crew was not successful and consequently the exact evolution of the events leading to the grounding were not electronically supported by Ince Inebolu's electronic navigation equipment that were interfacing the VDR.
- The actions taken to save and retrieve VDR were not effective enough.
- Navigational Officers were not aware on how to properly save and retrieve VDR data.
- The failure to effectively retrieve VDR data is related to the training requirements under Safety Management Code/Chapter 6 "Resources and Personnel".

The present document derives from a report published on the site of the Hellenic Bureau for Marine Casualties Investigation (HBMCI, <u>www.hbmci.gov.gr</u>). It consists a safety recommendation concluded following the safety investigation of issued marine casualty, according to the provisions of National Law 4033/2011, as applied with the only purpose to improve maritime safety.



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.

Marine casualty probable causes

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

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, and the main Navigational equipment were ineffectively being used.

Safety recommendation conclusion

The failure to effectively retrieve VDR data, is related to the training requirements under Safety Management Code.

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