SAFETY RECOMMENDATION No: 15/2014

Text of Safety Recommendation:
Review Company’s recruiting policy targeting to the Competency, Proficiency and experience standards based on the levels of responsibilities of recruited personnel.

| No of Safety Investigation Report: | 02/2014: Grounding of B/C “INCE INEBOLU” |
| Safety Recommendation addressed to: | Managers/Owners |
| Date of publication: | 31/12/2015 |

INFORMATION OF ACCIDENT

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, the Bridge Navigational Watch Alarm System (BNWAS) had been deactivated, during the Suez Canal crossing on 03 September and since then it had not been reactivated. 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
By the time of the marine casualty, the 2nd Officer was running his fourth month of employment on board Ince Inebolu. He had started his seagoing career as a Deck Officer shortly after graduating from the Maritime Academy, in 2013. Based on his current service on board oceangoing cargo ships, by the time the marine accident occurred, his experience is considered limited, counting 11 months in total as a Deck Officer which is directly connected to his young age. Nevertheless, he was assigned to perform the 0000-0400 navigational night watch, despite the fact that the 3rd Officer already serving on Ince Inebolu and performing the 0800-1200/2000-2400 navigational watch had formerly served for almost two years on board tankers and could be reckoned that his professional profile had greater experience than the 2nd Officer’s.
The present document derives from a report published on the site of the Hellenic Bureau for Marine Casualties Investigation (HBMCI, [www.hbmci.gov.gr](http://www.hbmci.gov.gr)).

It consists of 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.

### 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.

### 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, and the main Navigational equipment were ineffectively being used.

### Safety recommendation conclusions

1. The evaluation system for the new recruiting Officers implemented by the Company was rather generic and was not effective in full.
2. The 2nd Officer’s credentials provided limited experience for undertaking the 00:00-04:00 night watch for satisfying the competency and proficiency standards, as deemed appropriate through STCW Code/Functions in Table A-II/1.
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