

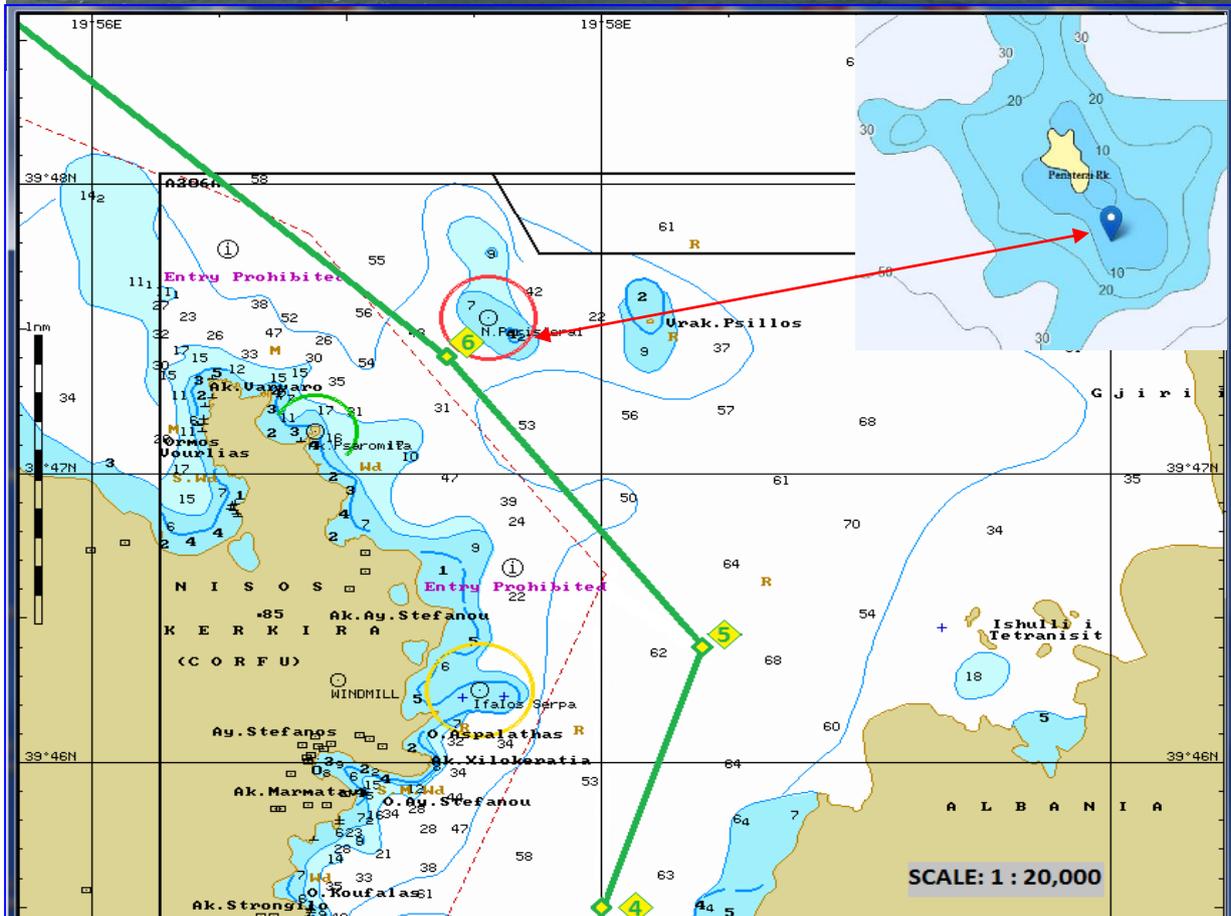


HELLENIC REPUBLIC
HELLENIC BUREAU FOR MARINE CASUALTIES INVESTIGATION

MARINE CASUALTY SAFETY INVESTIGATION REPORT
04/2014



Impact of
RoPax Europalink on Peristerai Islet shoal reef



September 2016

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Foreword

The Hellenic Bureau for Marine Casualties Investigations was established by Law 4033/2011 (Government Gazette 264/12.22.2011), in the context of implementing EU Directive 2009/18/EC.

HBMRI conducts technical investigations into marine casualties or marine incidents with the sole objective to identify and ascertain the circumstances and contributing factors that caused it through analysis and to draw useful conclusions and lessons learned that may lead, if necessary, to safety recommendations addressed to parties involved or stakeholders interested in the marine casualty, aiming to prevent or avoid similar future marine accidents.

The conduct of Safety Investigations into marine casualties or incidents is independent from criminal, discipline, administrative or civil proceedings whose purpose is to apportion blame or determine liability.

This investigation report has been produced without taking under consideration any administrative, disciplinary, judicial (civil or criminal) proceedings and with no litigation in mind. It does not constitute legal advice in any way and should not be construed as such. It seeks to apprehend the sequence of events occurred on the 21 September 2014 that resulted in the examined serious marine casualty.

Fragmentary or partial disposal of the contents of this report, for other purposes than those produced may lead to misleading conclusions.

The investigation report has been prepared in accordance with the format of Annex I of respective Law (Directive 2009/18/EC) and all times quoted refer to local time (UTC +3) unless otherwise stated.

Considering the above, an investigation has been conducted, regarding the grounding of Ro-Ro Passenger Ship EUROPALINK, Flag of Italy, IMO no 9319454 on islet "Peristerai" at Corfu, Greece on 21 September 2014, which resulted in major hull damage, water ingress and flooding of void spaces and machinery compartments, the vessel's recourse at Corfu port and the evacuation of the passengers at the pier, upon arrival.

This report is based on data acquired by interviews and collection of evidence by the parties engaged in the marine incident.

Glossary of Abbreviations and Acronyms

1.	AB	Able seaman
2.	AIS	Automatic Identification System
3.	Bf	Beaufort (measurement unit of wind force)
4.	CCTV system	Closed Circuit Television system
5.	COC	Certificate of Competency
6.	COLREGS	International Regulations for preventing Collisions at Sea, 1972
7.	CPA	Closest Point of Approach
8.	ECDIS	Electronic Chart Display and Information System
9.	EMSA	European Maritime Safety Agency
10.	DOC	Document of compliance
11.	gt	gross tonnage
12.	HCG	Hellenic Coast Guard
13.	IMO	International Maritime Organization
14.	ISM	International Management Code for the safe operation of ships and for pollution prevention
15.	kts	knots (nautical miles per hour)
16.	Lat, Long	Latitude, Longitude
17.	LT	local time
18.	m	meters
19.	nm	nautical mile (1852 m)
20.	OOW	Officer of the Watch
21.	RO	Recognized Organization or Classification Society. An organization which meets the relevant conditions set forth by respective international legislation and has been authorized by the flag State Administration to provide the necessary statutory services and certification to ships entitled to fly its flag
22.	RINA	“Registro Italiano Navale” recognized organization
23.	ROPAX	(roll-on/roll-off passenger ship) a RORO vessel built for freight vehicle transport along with passenger accommodation. Technically this encompasses all ferries with both a roll-on/roll-off car deck and passenger-carrying capacities
24.	ROT	Rate of Turn (degrees per minute)
25.	RPM	Revolutions per Minute
26.	SMC	Safety management certificate
27.	SMM	Safety Management Manual
28.	SMS	Safety management system
29.	SOLAS	Convention for the Safety of Life at Sea 1974, as applied
30.	UTC	Universal Coordinated Time
31.	VDR	Voyage Data Recorder
32.	WPT	Way Point (on Voyage Plan)

1. Executive Summary

Ro-Pax “Europalink”, under Italian Flag, was operating between the ports of Trieste, Italy and Patra, Greece. Her voyage schedule also included the port of Igoumenitsa, Greece and Ancona, Italy, as intermediate ports of call (figure 1/1).



Figure 1/1: Depiction of Europalink itinerary

On 21 September 2014 Ro-Ro Passenger Europalink was en route to Ancona, Italy having departed from the port of Igoumenitsa, Greece with 693 passengers, 70 crew members and loaded with 366 vehicles. At about 0220 she was running at approximately 24 knots keeping a course of 360° while helm was in autopilot mode. Actual weather conditions were reported to be good with moderate sea and variable winds 2-3 bfts and good visibility. At 02:33:09", while under turn to port by continuously setting the autopilot, she hit on the rocky shoal reef South of Peristerai Islet, located 0.6 nm off the Northeast coast of the island of Corfu, Greece. The Master seconds before the grounding, at 02:32:11" counteracted by ordering the setting of rudder in manual mode however the impact

could not be avoided. The heavy impact generated a noisy, shuddering vibration that alerted the Master and the crew. No injuries to crew or passengers were reported and no pollution occurred. Although her voyage plan provided passage through the narrow channel between Corfu and Peristerai islet however it was not exactly followed as planned, due to a sailing boat navigating on Europalink's port bow which partially obstructed her timely turn to port, post to the preplanned waypoint. During the marine accident the 2nd Officer was on Duty, however the Master being also on the bridge had the con. Following the heavy impact she continued on the same course with her speed having slightly decreased (figure 1/2).

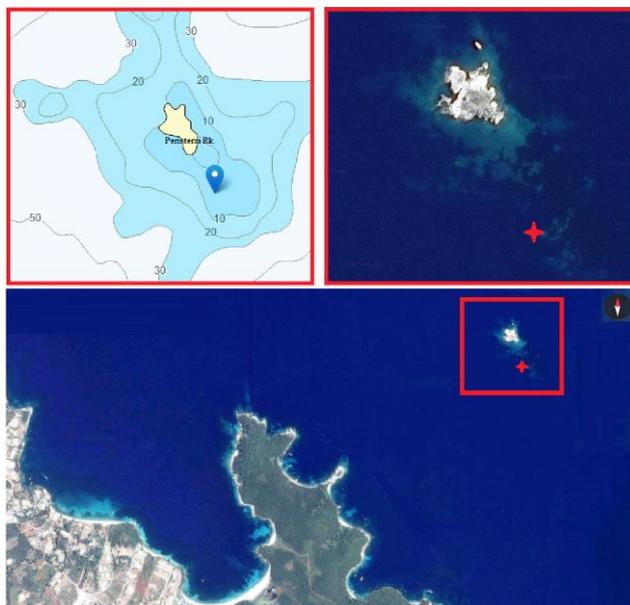


Figure 1/2: The grounding position (Lat 39° 47.47 N Long 19° 57.61 E).

(Map Source: Google Maps & EMSA)

As reported she had sustained breaches to several void and engine compartments and sea water was flooding in the void spaces, however neither her rudders nor her propellers were affected by the impact.

The Master contacted the Coast Guard Authority of Corfu and reported that he intended to proceed to Corfu's passenger port and crew mustered the passengers for precautionary reasons.

At approximately 0341 Europolink managed to reach the port by her own means running at 20 knots. Due to the water ingress at critical engine compartments, her main Engines were stopped as she was approaching the berthing dock, meters away from the mooring position whereas a failure of the electrical generating system occurred almost simultaneously, causing a black-out.

She finally berthed with her starboard side and her stem post facing the dock while her stern was pointing towards the port entrance. A list to starboard close to 1° was reported by Europolink's crew.

At approximately 04:40 the evacuation of the passengers started through the Bunker Station starboard door using a portable ladder, provided by the Port Authorities and lasted for almost 50 minutes.

At about 0700 a diving team, called by the Coast Guard Authority, came on scene and two divers inspected Europolink's hull with a camera so as to estimate the extent of the damage.

It was decided to shift her on the same dock and moor her alongside with her port side so as to unload trucks and vehicles through the stern ramp. The shifting operation was completed at approximately 1238. Following, the stern ramp was opened and the discharging operation of the garage spaces commenced while the team of two divers started chocking wooden wedges and other materials inside the breached bottom platings.

Europolink was inspected by the local Port State Control Office of the Hellenic Coast Guard and was detained. She underwent temporary repairs and following an inspection by her Class, on 31 October 2014 she sailed under towage to Yalova shipyard in Turkey for drydocking.

Concisely, the investigation carried out has highlighted the following:

- the navigation by the Officers on the Bridge of Europolink was poorly scheduled and executed prior to the occurrence, despite the monitoring and plotting navigational aids available.
- The decision of her Master to try to reach to the nearest port by vessel's own means after the impact, despite the water ingress in many compartments was considered to be appropriate although to some degree delayed.

Recommendations have been made to Europolink Owners/Managers:

- To supplement its Safety Management System in specific sections related to safety investigation reports findings and address key contribution factors fleet-wide.

A Recommendation has also been addressed to Corfu Coast Guard Authority:

- to reactivate PORAX speed limitation order when transiting Corfu Channel and Peristerai Passage that had implicitly become inactive for safe navigation purposes.

A Recommendation has been addressed to competent Authorities of Greece:

- To consider of introducing a "shore-based" transportable Passengers emergency

evacuation arrangement” capable for facilitating passengers’ disembarkation-
evacuation from ROPAX or passenger ships’ upper decks in emergency situations
that regularly call at major Ports or may project them as a “safe return port”.

2. Factual Information

2.1 Particulars of RoPax Europolink

Name of Vessel	Europolink
Call Sign	ICUO
Company (ISM Code A 1.1.2)	Industria Armamento Meridionale S.p.A. - Inarme
Ownership	Atlantica S.p.A. di Navigazione
Flag State	Italy
Port of Registry	Palermo
IMO Number	9319454
Type of Vessel	Ro/Ro Passenger
Classification Society	RINA
Year built	2007
Shipyard	Fincatieri Cantieri Navali Italiani S.p.a - Ancona
Construction	Steel - Ice Class IA
LOA (Length over all)	218,8 m
Breadth (extreme)	30.52 m
Depth	16.15 m
Draught (summer)	7.05 m
Gross tonnage	46119
Net Tonnage	24006
Engine /Speed	4 x Wartsila 9L 46 D (4 x 10539 kW) / 25 kts service speed
Propulsion	Twin CPP propellers and Two bow thrusters
Document of Compliance	RO RINA
Safety Management Cert.	RO RINA
Last Port State Control inspection	30-11-2013

2.2 Voyage Particulars

Vessel's name	Europolink
Port of departure	Igoumenitsa – Greece
Port of arrival	Ancona - Italy
Type of voyage	International
Cargo information	Loaded with 366 vehicles and 693 passengers
Manning	70 crew members
Minimum safe manning	44 (for up to 730 passengers)

2.3 Marine casualty information

Vessel's name	Europolink
Type of casualty	Serious
Date and time	21 September 2014 at approximately 0233
Position	lat: 39° 47.47 N / Long 19° 57.61 E
Location	Peristerai Islet NE Corfu
External environment	variable winds force 2-3 Bfs - sea state moderate visibility very good - scattered clouds - night time
Ship operation	Navigation
Voyage segment	Underway to Italy
Consequences (to individuals, environment, property)	No injuries No pollution Extended severe hull damages (deformations and cracks and intends) <ul style="list-style-type: none"> port side from fr. 115 to fr. 204 (62,3 m)

	<ul style="list-style-type: none"> • stbd side from fr. 82 to fr. 154 (50,4 m). • bottom plating's adjacent strengthening components <p>Water ingress to Void Spaces and engine room, damages to critical equipment</p> <ul style="list-style-type: none"> • Main Engines, • boilers, • motors, • pumps, electronic components, etc
Passengers	693

2.4 Emergency response

Authorities – Services involved	
Corfu Coastguard Authority	→ Coast Guard Officers
Corfu Port Authority	→ Officials and equipment → Cruise ships passengers' terminal facilities
Port Services	→ two (02) port Tugs → two divers
Fire Brigade Service	→ two fire brigade vehicles
Mega Dive Services	→ 7 Divers & 2 technicians (fitters-welders) → Technical & diving equipment
Tsavliris Salvage services	→ One salvage Tug (Megas Alexandros) – pumping equipment → One anti-pollution-oil recovery vessel (Aegis) with equipment → One anti-pollution oil separator boat (Aktea 15)

3. Narrative

The evolution of the events is based on the VDR extracts and crew’s interviews. The progress of the flooding is mainly based on interviews as video files from the ship’s CCTV system could not be recorded, as stated.

3.1 Ro-Pax Europolink

Ro-Pax Europolink was an Iced Class modernized roll-on/roll-off passenger ferry that was built at the Fincatieri Cantieri Navali Italiani S.p.a in Ancona.

She was one of the five “Star Class” ROPAX that were built by Fincatieri for Finnlines. She was ordered as Finn lady but she was renamed to Europolink prior entering into service. She was delivered in March 2007 and initially operated between the routes of Malmö and Travemünde, in Baltic Sea.

In September 2013, Europolink was bought by Grimaldi Group and became one of the three Roll on - Roll off Passenger ferries operated by Industria Armamento Meridionale S.p.A. - Inarme.

Europolink was engaged on a regular round itinerary from the port of Trieste to the port of Patras with intermediate calls at the ports of Ancona and Igoumenitsa. Each round voyage lasted for about twenty-four hours and she was actually serving the Adriatic Routes, three times on a weekly basis.

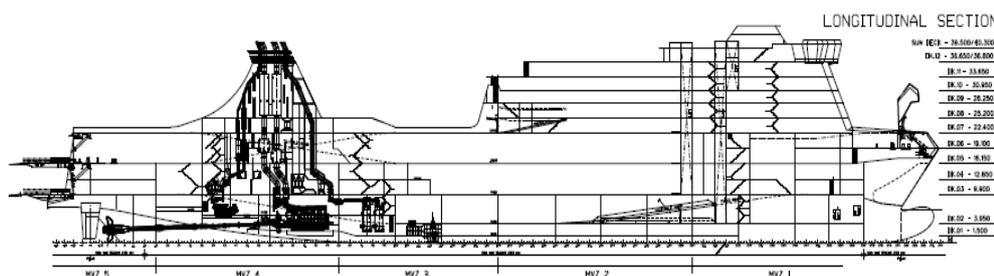
She could accommodate 730 passengers cruising at 25 knots (figure 3.1/1).

Her structural design included five vehicle decks with a carrying capacity of close to 380 vehicles (cars, trailers and refrigerated trucks).

Europolink was fitted with a single-section main stern ramp offering a driveway into the threshold deck no 3 and with a similar two-section upper stern ramp providing a driveway into car deck no 5 while a bow visor was available, all hydraulically operated (figure 3.1/1).



Fig. 3.1/ 1 & 2:
RoRo/Passenger
Europolink



3.2 The voyage plan

The voyage plan had been prepared by the 3rd Mate based on Europolink Safety Management System and was approved by the Master.

The voyage segment from Igoumenitsa to Ancona included 9 WPT in total and according to it the passage from Igoumenitsa up to Corfu north coast would be practiced through the strait formed between said part of Corfu and Peristerai Islet (figure 3.2/1).

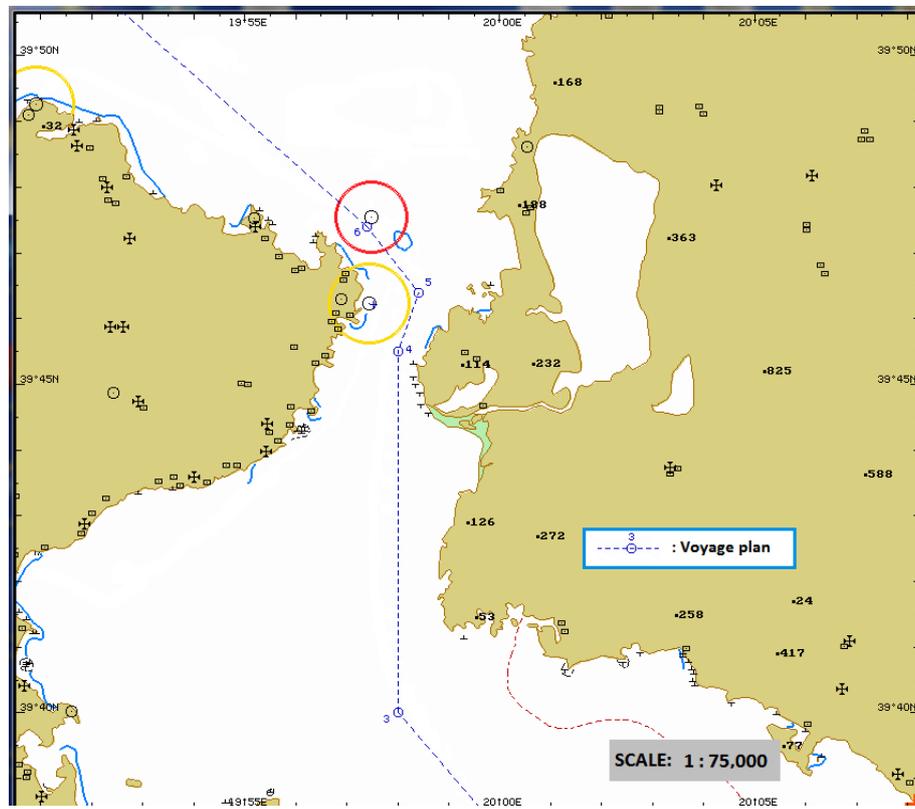


Figure 3.2/1: Europolink voyage plan segments from WPT 3 to WPT 6 and open sea (map HBMC I).

Having regard to the formulated geography of Corfu northeast sea areas, the narrow sea passage (channel) between Corfu northeastern coast and Peristerai Islet is practically called “inner passage” while the option to navigate a vessel east of Peristerai Islet is called “outer passage” (see par. 3.3 for further information).

In order to decide whether the passage would be conducted through the “inner passage” or the “outer passage”, the factors which had been taken into consideration were actual time of departure, actual weather conditions and visibility and other factors as described in the respective sections of this report.

The voyage plan included waypoints and data as presented in following table 3.2/1.

The passage at Peristerai Islet was planned to be executed at a speed not exceeding twenty (20) kts, (table’s item 5 in bold), while following its exit boundaries, speed was planned to be raised at 24 knots (table’s item 6 in bold).

WPT number	Latitude (N)	Longitude (E)	Course (°)	Distance between Waypoints (nm)	Safe speed (kts)
1	39° 30.10	20° 11.50	270	1.94	12
2	39° 30.10	20° 09.00	319	13.00	15
3	39° 40.00	19° 58.00	358	4.96	24
4	39° 46.60	19° 58.00	13	1.47	24
5	39° 46.40	19° 58.40	322	1.25	20
6	39° 47.40	19° 57.40	308	2.16	24
7	42° 01.30	16° 37.48	313	151.80	24
8	43° 44.50	13° 42.00	238	10.30	24
9	43° 39.00	13° 30.00	-	-	-

Table 3.2/1: Passage segment’s waypoints from Igoumenitsa to Ancona.

Based on ECDIS data, Europolink last voyages had been executed through the inner passage of Peristerai, an option that was usually practiced, as also stated by crew during the investigation process.

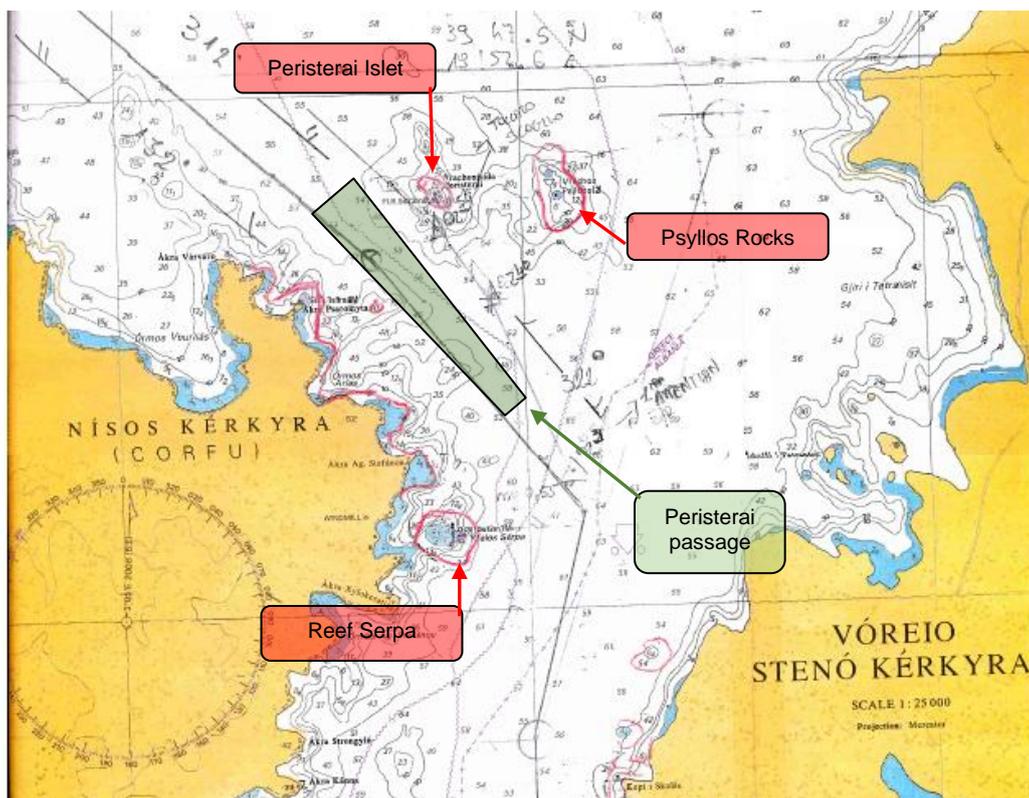


Fig. 3.2/2: Depiction of Corfu Channel in Europolink’ paper chart. The voyage plan as charted, for the passages in Corfu Channel is also showed. Danger sea areas to avoid were circled in red.

3.3 The Corfu Strait to Peristerai Islet

The Corfu Strait is formed by the ENE coastline of Corfu and the W coast of Albania. The Channel has a width of approximately 1.3 nm and at its narrowest part there are a number of dangers to navigation (figure 3.2/2 above).

Almost at the end of the narrows, the reef “Serpa” extends about 0.25nm ENE from the coast of Corfu with shelves and reefs formulated around it of approximately 0.1nm of range.

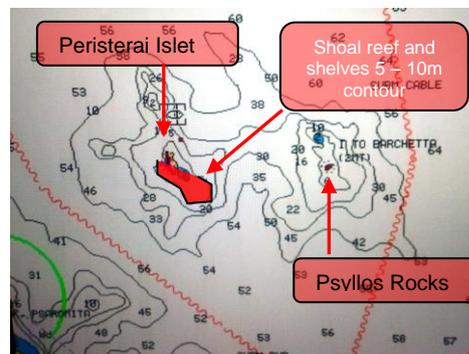
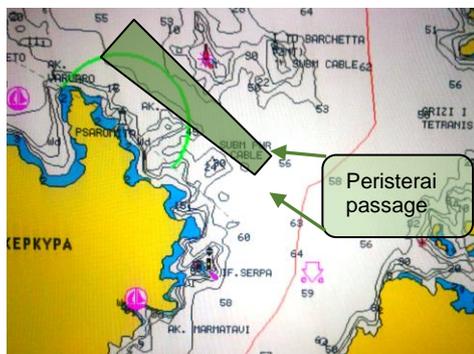
Following Corfu Channel exit and further to NW Peristerai Islet lies almost 0.5 nm from the NE coastline of Corfu and more specifically from Cape Psaromyta. Peristerai is a small whitish islet exhibiting a main light from a prominent structure, 5m high, surmounting the islet (figures 3.2/2 above and 3.3 / 1 & 2).

The south seafront of Peristerai is formulated with a shoal reef that extends southeastwards with depth contours ranging from 5 m to 10 m for almost 0.18nm of distance (figures 3.3 / 3 & 4).

Peristerai Islet and the opposite coastline of Psaromyta Cape physical geography outlines a sea passage of approximately 0.65nm of width. The passage entrance is signaled by the Islet and its exhibited light and leads to the South Adriatic Sea.



Figures 3.3/1 & 2: Photos of Peristerai islet.



Figures 3.3/3 & 4: Peristerai passage and Peristerai Islet and Psvllos Rocks formulation.

Phyllos, a rock nearly awash, lies on a shoal bank about 0.5mile E of Nisis Peristerai that is 6 m long. A shoal, with less than 2m depth lies about 0.1nm north of the N extremity of the bank on with the rock stands.

Peristerai Islet and Phyllos Rock formulate a sea passage of approximately 0.5nm of length that is considered navigable by vessels, however voyage segments are usually plotted east of the Rock.

3.4 Voyage segment from Igoumenitsa to the approaches of Corfu Channel

On 20 September 2014, at 1808 Europolink’s stern ramp was closed and she departed from Patras Port, heading towards to Igoumenitsa where she arrived almost ten minutes after midnight.

At approximately 0117, she sailed from Igoumenitsa port and commenced her voyage to Ancona with 693 passengers on board and loaded with 366 vehicles (motorcycles, cars, trailers, refrigerated trucks).

Following her departure, the navigational watch was performed by the 2nd Officer and an AB was posted as Look Out watch. After the departure and the exit of Igoumenitsa Channel, the Master had remained on the bridge and according to the interview process information he had the con.

Based on information from the interviews, the Master was positioned in starboard wheelhouse side, as regularly, observing and utilizing the starboard ARPA Radar, fitted on the navigation console while the 2nd Officer was mostly standing at the wheelhouse port side, operating the port ARPA radar. The Chief Officer although out of duty was also on the bridge engaged in preparing administrative paper work for the destination port.

As soon as Europolink exited Igoumenitsa Channel at approximately 0130 steering was set in autopilot, operated under two out of the four hydraulic steering pumps.

Shortly after, at about 0135, the Master called the Chief Engineer in the Engine Control Room and informed him that they had exited Igoumenitsa Channel and gave the "Full Away" standard order for the specific part of the voyage until entering the NE passage of Corfu Strait.

At about 0150, having cleared Prasoudi Islet (WPT 2), the 2nd Officer altered Europolink's course to starboard by adjusting the autopilot. By that time Europolink started keeping the course of 319° while sailing at 24 knots, in line with the prepared voyage plan and plotted routes on the navigational chart and ECDIS.

ROPAX Superfast II, having departed from Igoumenitsa port, six minutes prior to Europolink's unmooring, that is at approximately 0111, was almost 1.5 nm ahead of her, running at approximately 22 knots. Europolink, making 24 knots, was progressively overtaking Superfast II.

Superfast II was also a liner ROPAX, with similar characteristics and size as to those of Europolink that was likewise operating in the same itinerary from Patras to Ancona. Superfast II had departed from Patras at 1800 on the same day as Europolink and had arrived in Igoumenitsa at about 0050 on 20 September 2014.

At approximately 0213, Europolink reached the next waypoint No 3 and the 2nd Officer altered her course further north by setting the autopilot to 358° and headed towards the narrow strait between Corfu Island and the Albanian coast.

Europolink continued heading North, however her followed course over ground was close to 003° and she was navigating 0.3nm off to port from her plotted course under the voyage plan, as she was gradually overtaking Superfast II from her port quarter and both vessels were practically navigating under parallel courses (figure 3.4/1).



Figure 3.4/1: Snapshot from EUROPALINK radar display at the time SUPERFAST II OOW contacted her through VHF.

At approximately 0221, and while the remaining distance to the next WP 4 was approximately 4.5nm, that is close to 10 minutes in sailing time (figure 5), Superfast II OOW contacted Europalink through VHF in order to clarify his intentions to navigate via the “inner” or the “outer” passage of Peristerai Islet. Superfast II OOW reported that he would proceed following the “outer” passage while the Master of Europalink notified that he would navigate through the “inner” passage.

3.5 The occurrence

At approximately 0225, Europalink had entered the narrow channel of Corfu, that as already reported, is formulated between the ENE coastline of Corfu Island and the opposite Seafront of the Albanian mainland.

The 2nd Officer having reached WPT no 4, set Europalink’s course to 008° following the Master’s respective order while the running speed at approximately 24 knots was maintained.

Superfast II, as mentioned above, was also navigating on the starboard side of Europalink, keeping almost a parallel course and speed close to 22 knots. By that time Europalink had to run approximately 1.6 nm to exit the restricted waters of the channel that is about 4 remaining minutes in navigating time (figure 3.5/1).

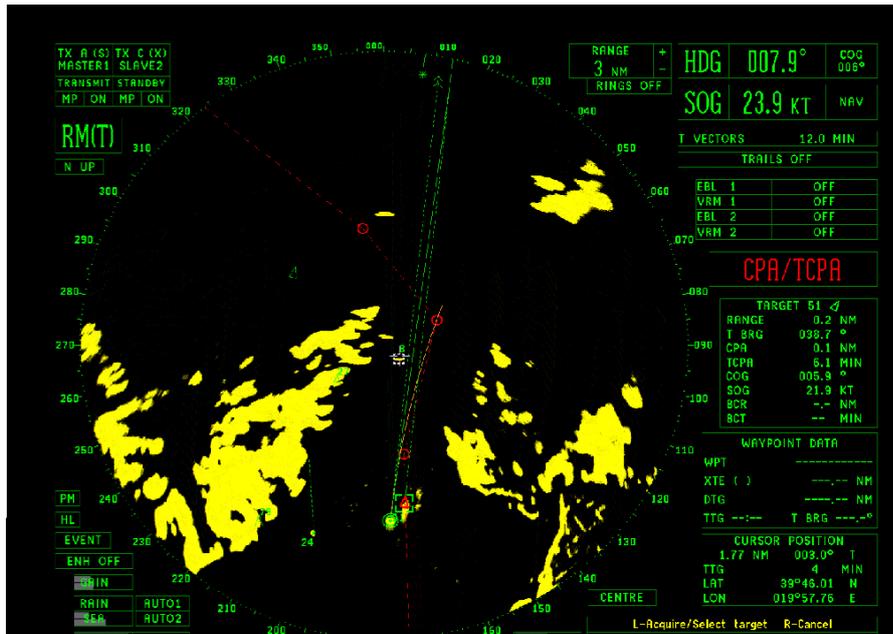


Figure 3.5/1: ARPA display snapshot from VDR extract just post to alternation of Europolink’s course.

Shortly after Europolink’s course alternation, at approximately 0224, a target was displayed on both port and starboard ARPA radars that were being utilized by the 2nd Officer and the Master, respectively. The target was spotted ahead and roughly to port off Europolink’s bow, close to Corfu NE coastline, sailing slightly southerly from Sepra Reef. At about 0225, the 2nd Officer acquired the target that appeared as “target 8” on the ARPA display. The processed data indicated that it was bearing about 5° off Europolink port bow, heading to 22.5° at a speed of about 4 knots (figure 3.5/2). Considering the target’s data as well as its visual observation by both the Master and the OOW, showing a white masthead light, it was identified as a sailing boat.



Figure 3.5/2: ARPA display snapshot from VDR extract by the time the sailing boat was plotted.

The Master continued the passage towards the exit of Corfu Channel while Europolink course was slightly altered to port at 006° maintaining the same speed of 24 knots and navigating almost abeam of Superfast II.

Nevertheless, seconds after, the Master having reassessed the situation, ordered the 2nd Officer to slightly alter the course to starboard by adjusting the autopilot, to approximately 010°, in order to avoid a possible dangerous and alarming close quarter or crossing situation with the sailing yacht.

However, no actions to establish communication with the plotted target were taken.

Furthermore, as stated during the interview process, the Master had ordered the 2nd Officer to swiftly turn to port, as soon as the sailing boat would be observed abeam of Europolink’s port bridge wing.

In parallel, the Master called the Engine Control Room and instructed the Chief Engineer to set the “Attention in Engine Room”, which was the standard order and procedure for navigating Peristerai passage, however said order was not recorded in VDR.

The “Attention to the engine” order called for the setting of the engines to “maneuvering mode”, by which only the two Main Engines were servicing Europolink’s propulsion via the propeller shaft clutch and the two other Main Engines were used for the bow thrusters operation while two diesel generators were in operation out of the three fitted on board. The maneuvering mode configuration is shown in below figure 3.5/3.

At that time the 2nd Engineer and a Motorman were forming part of the engine watch while the Chief Engineer was also in the engine room as Europolink was transiting Corfu Channel and the “attention to the engine” was ordered.

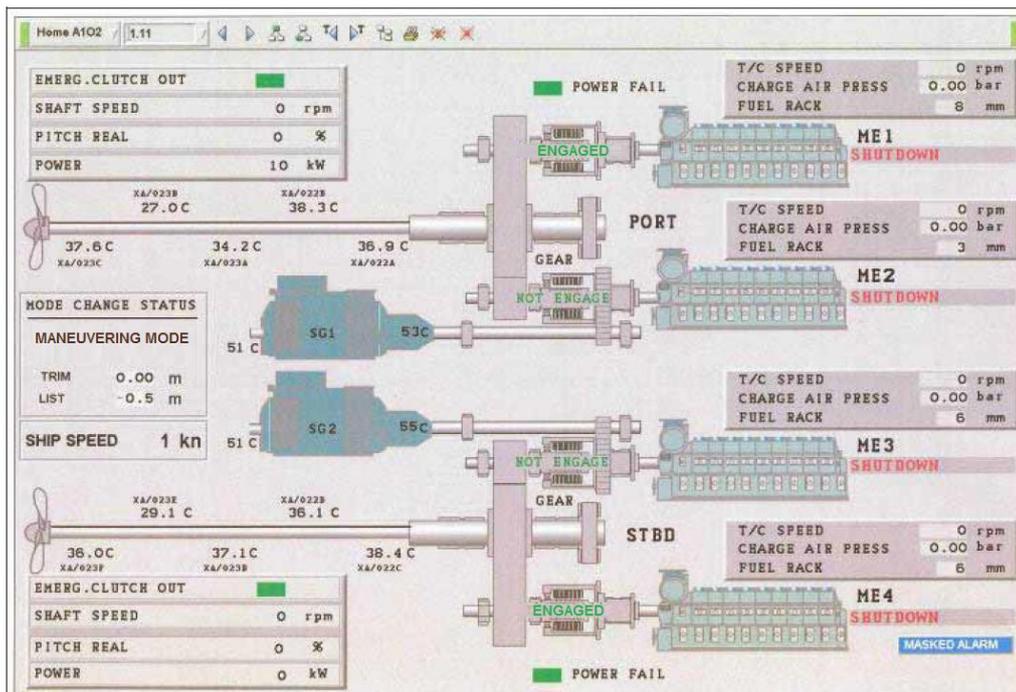


Figure 3.5/3: Schematic diagram of the four Main Engines and the two Shaft Generators in “Maneuvering mode”.

At approximately 0229, almost 20 seconds after the target was displayed on ARPA, sailing abeam of Europolink port bow and showing a CPA of 0.2nm, the 2nd Officer started altering Europolink’s course to port, as stated during the interview process, by setting the autopilot, 5° to port (figure 3.5/4).

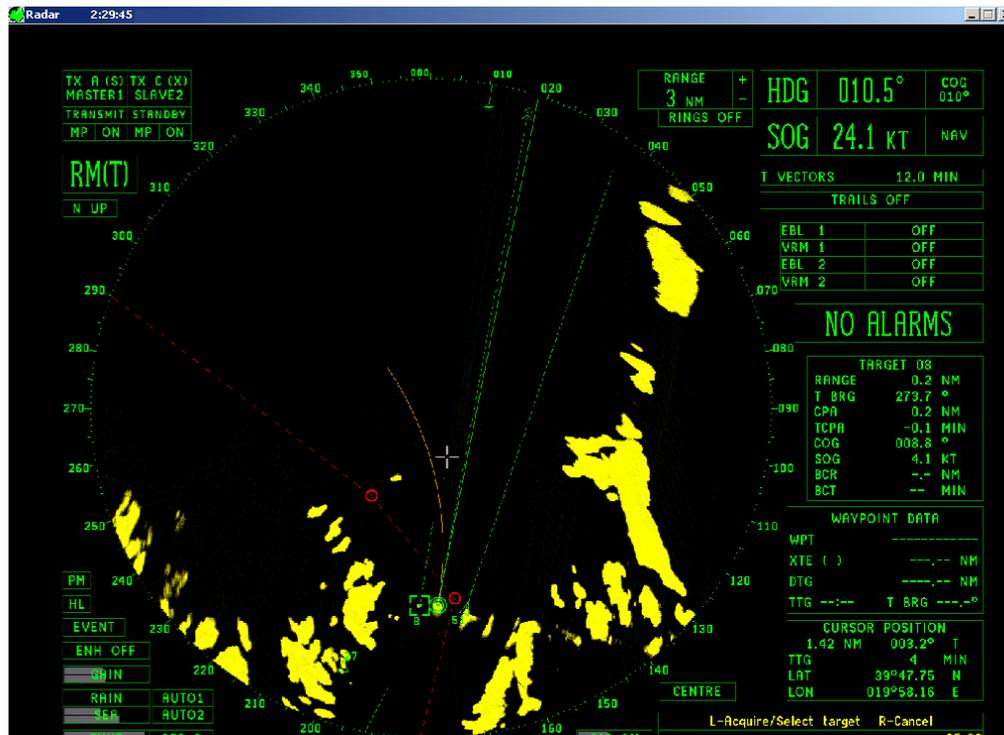


Figure 3.5/4: Snapshot of the radar display of Europalink at the time the sailing boat (“target 08”) appeared abeam of her bridge wing (captured at 02:29:45”).

By that time Europalink course was recorded to be 10.5° running at 24 knots while she had overtaken Superfast II that then headed towards the outer passage of Peristerai Islet and eastwards of Psyllos Rock, maintaining a course close to 035°.

As stated during the interview process, Peristerai Islet that was exhibiting its Red flashing light (8nm nominal range), could be clearly seen from Europalink’s bridge and also observed in radar display, close to 20° bearing, off her port bow.

The light during night time could be visually used as leading light for a safe passage when heading NW while together with the Green flashing light located at Cape Psaromyta at Corfu NE coast were indicating the safe passage towards NW to open sea. Based on the available electronic data extracted from Europalink’s VDR, by the time the 2nd Officer started altering her course, she was about 0.3 nm NW off the plotted No 5 WPT and 0.2 nm off to port from her plotted course under the voyage plan. Seeing that, the execution of her turn to port was delayed for approximately 45 seconds.

The relative courses of Europalink and sailing boat are presented in figure 3.5/5.

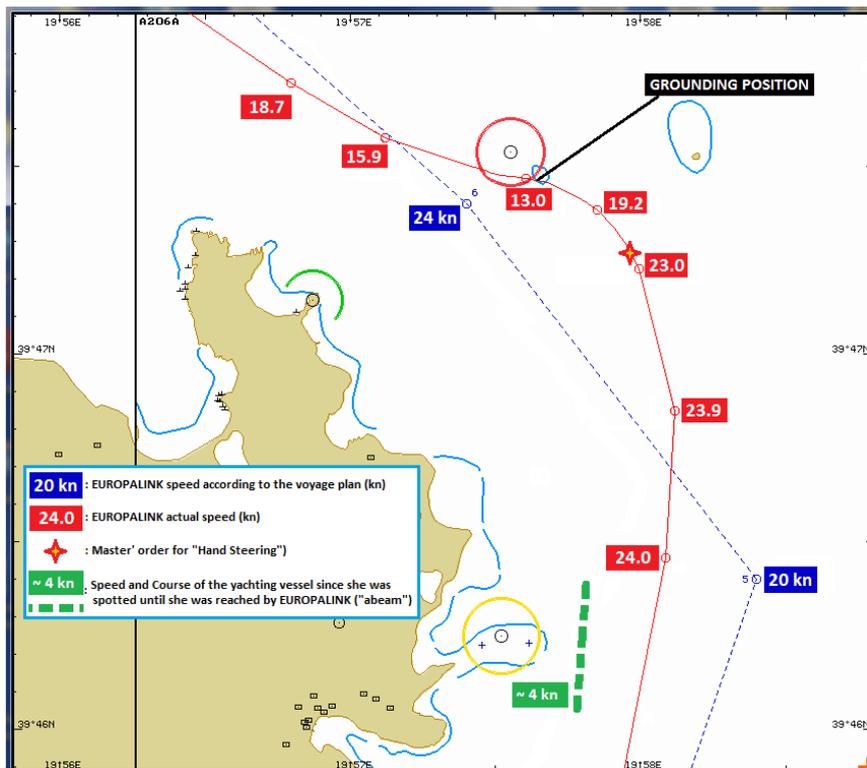


Fig. 3.5/5: *Europalink actual course and speed compared to her voyage plan and to the course of the sailing boat. Plotted course and speed also show the grounding position and following moments when picking up speed. (Plotted by HBMCI).*

Moments after, at approximately 0230, notwithstanding Europalink was gradually turning to port, the Master realized that the Rate of Turn was not effective enough to lead her to safe navigable waters, off the south seafront of Peristerai Islet and the shoal reef extended southwards.

Having appraised the evolving situation and the imminent danger of a possible unsafe passage, according to information received during the interview process, he counteracted immediately and set the autopilot R.O.T. selector at 35°. By that time Europalink heading was increasingly changing to port while her speed was recorded at 23.6 knots (figure 3.5/6).



Fig. 3.5/6: *Snapshot from Europalink VDR at the time autopilot selector was increasing the rate of turn.*

Despite the Master’s counteraction, Europolink was still turning poorly and the sea room ahead of her was not sufficient enough for a clear passage.

By that time, at 02:32:11”, that is almost 01 minute before Europolink’s bottom hit the shoal reef, the Master, sensing the existing risk of grounding, in his last-ditch effort to avoid the forthcoming casualty, ordered the 2nd Officer to set the rudder in manual mode whilst the Chief Officer, still on the bridge, switched on the other two rudders’ hydraulic pumps (figure 3.5/7).



Fig. 3.5/7: Europolink VDR ARPA data showing her speed and course approximately when steering mode was changed to manual. The R.O.T indicator indicated that she would pass over Peristerai shelves.

Immediately after, at 02:32:14”, the Master trying to avoid the forthcoming impact on the shoal reef, ordered the helmsman 20° to port and hard to port (40° to port), then 60° to port and at 02:32:28”, midships (see table 3.5/1).

Local Time	Master’s orders	Local Time	Master’s orders
02:32:11”	Hand steering	02:32:34”	Midship
02:32:14”	Port 20°	02:32:37”	Starboard 10°
02:32:15”	Hard to Port	02:32:42”	Midship
02:32:17”	40°	02:32:46”	Port 10°
02:32:20”	60° to Port	02:32:53”	Midship
02:32:25”	40°	02:32:57”	Starboard 10°
02:32:28”	Midship	02:33:03”	Midship
02:32:31”	-Vibration noise-	02:33:09”	-Grounding noise-

Table 3.5/1: Timeline of Master’s steering orders

At 02:32':31", the 218.80 m of length ROPAX while running at 20.5 knots with her draught close to 6.70m and air draught at 49.30m listed significantly, generating a noisy shuddering vibration that lasted for about 20 seconds whilst her speed was dropped to 18 knots. No actions to decrease her speed were taken.

The Master kept giving a row of continual orders to the helmsman to put the rudder 10° to starboard and then midships in order to counteract to the ship's violent reaction.

Following, at 02:33':09", almost 40 seconds later, a shuddering vibration was experienced, due to the heavy raking impact on the rocky seabed that was encountered for about 10 seconds while the speed was recorded at 8.6 knots, as Europolink was dragging on the rocky shoal reef.

The Master, continued struggling to pull Europolink from the shelves in order to avoid damages to her rudders and propellers (*Figure 3.5/8*).



Fig. 3.5/8: Europolink VDR ARPA data showing her speed and course at the time she was raking on Peristerai shelves.

By the time Europolink had ridden the shelves, she started almost instantaneously picking up speed, reaching 18 knots.

As a result of the heavy hit and dragging Europolink sustained severe longitudinal breaches on her hull onto several void compartments of her port and starboard side, however she was still steerable.

In less than one minute post to the occurrence, at 02:33':57", several void spaces' alarms were activated on the bridge watertight integrity monitoring system, indicating the seawater ingress into the double bottom spaces that based on crew reports, soon after the casualty had caused a slight trim by fore.

3.6 Emergency response actions

3.6.1 The flooding

As soon as Europolink passed into safe waters and the water ingress was detected through the watertight integrity monitoring system, the Chief Officer ensured that all nine (09) watertight doors were closed by turning their status selector from “sea mode” to “general close”.

Immediately after, the Engine Room Watch was alerted due to Europolink’s heavy impact and dragging on the shelves and the activation of the alarms. The 2nd Engineer together with the motorman on duty were immediately deployed to the damaged spaces and reported to the Chief Engineer the emergency and the evolving situation of huge quantities of seawater flooding the boiler room and also flowing into the Purifier Room.

At approximately 0235, the Master contacted the Chief Engineer in the Engine Control Room who briefed him for the situation that he had already experienced from the engine control room.

Based on crew interviews, the 2nd Engineer forthwith, activated the Rule Bilge Pump and the Alternative Bilge Pump and additionally the Water Ballast Pump, operating as bilge pump, from their remote controlling panel in the Engine Control Room to counter flooding. He also started the Diesel Generator No 3 to assist the operating by then No 1 and 2 Diesel Generators.

Nevertheless, both the Rule Bilge Pump and the Alternative Bilge Pump, mounted in the Boiler Room, became inoperable after a few minutes as they got submerged into the inflowing seawater. After that, the 2nd Engineer went to open the Emergency Suction Valve fitted in the Boiler Room, however it was not achievable due the quick rising level of the inflowing seawater.

In result, the flooding seawater entering into the Boiler Room could not be dealt with.

The Master continued navigating following the route to Ancona, as preplanned with course 306°, steering in manual mode, while Europolink was picking up speed up to 22 knots. He also ordered the ship’s Chief Steward to have the Accommodation crew standing by.

At 0238, approximately five minutes post to the grounding and while Europolink had proceeded about 2nm NW off Peristerai Islet, heading towards Ancona, the Chief Engineer called the Bridge and reported to Master that uncontrollable quantities of sea water were flooding the Boiler Room compartment. Furthermore, he reported that the Purifier Room, located inside the Boiler Room was also flooding with water that was taking on through its fire door, which was not watertight. He additionally reported that the flooding was not feasible to be constrained as the Rule Bilge Pump and the Alternative Bilge Pump had become inoperable.

Both flooding compartments were fitted with critical machinery equipment and more specifically the Boiler Room was fitted with the High and Low Temperature Water Circulating Pumps for the cooling of the Diesel Generators whereas in the Purifier Room the two Booster Pumps for the Main Engines’ fuel supply were installed.

By that time, the Chief Engineer additionally reported to the Master that the progressive increase of the seawater inflow into the Boiler and Purifier Room would result to loss of power and propulsion and suggested to attempt to reach the nearest port.

Following a Master’s question whether Europolink would manage to maintain her propulsion for the next fifty minutes, the Chief Engineer replied that she could make it based on estimations of the rate of water level increase in the engine room compartments. By that time the inflowing seawater level could be monitored and estimated through the engine room CCTV system which however went off later on due to electrical malfunctions (short-circuits) caused by the flooding sea water.

Both the Master and the Chief Engineer decided that the vessel’s damage necessitated Europolink’s return to the nearest port of refuge.

According to the data collected through the interview process, their decision was based on the situation evaluation under the Master’s and the Chief Engineer’s experience, as neither the “damage stability booklet”¹ data nor the “NAPA” computer-based system² for calculating damage stability condition were appropriately considered and processed due to the rapidly evolving situation.

At 02:41’34”, the Master having decided to return to the departure port of Igoumenitsa, ordered the helmsman to turn to starboard. His decision was taken more than 8 minutes post to the occurrence and while Europolink was underway heading for Ancona at 22 knots, almost 2.5nm NW of Peristerai Islet (figure 3.6.1/1).

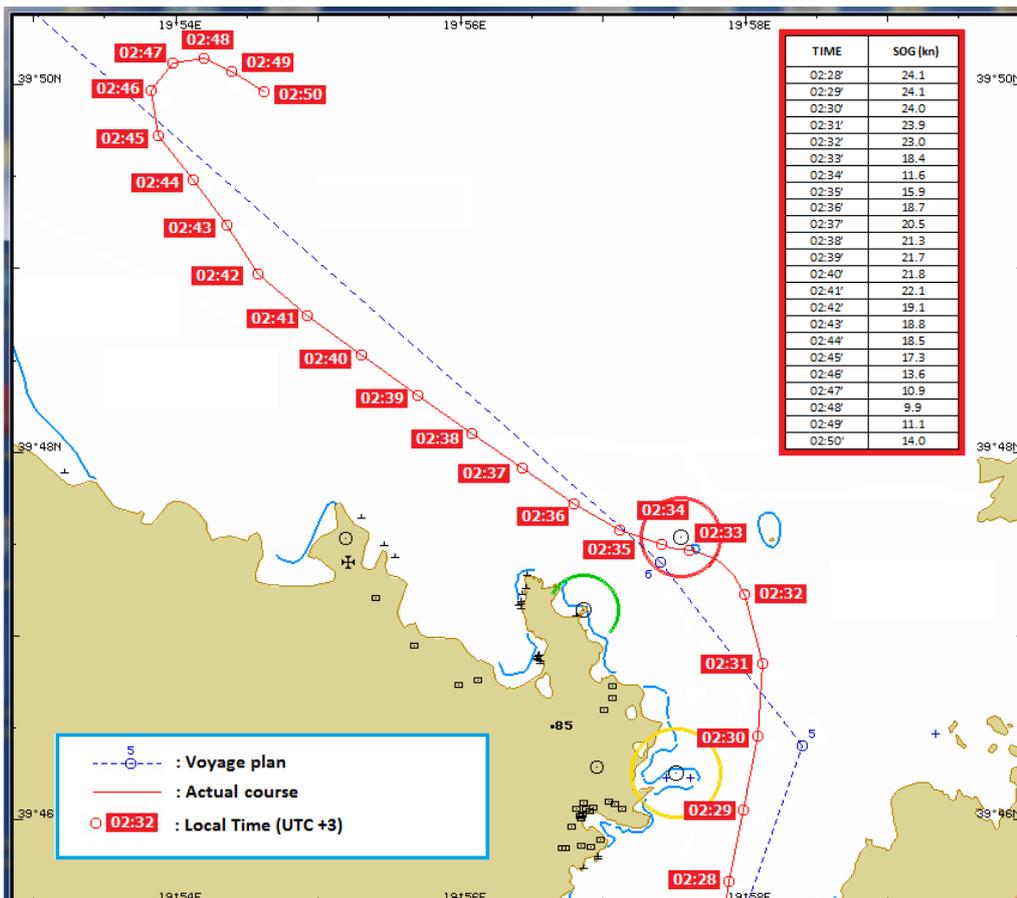


Fig. 3.6.1/1:
 Europolink time depiction and speed as plotted by HBMCI.

¹ The damage control plan and damage control booklet, which are required by SOLAS regulation II 1/19, are intended to provide ships’ officers with clear information on the ship’s watertight subdivision and equipment related to maintaining the boundaries and effectiveness of the subdivision so that, in the event of damage to the ship causing flooding, proper precautions can be taken to prevent progressive flooding through openings therein and effective action can be taken quickly to mitigate and, where possible, recover the ship’s loss of stability.

² Computer-based system with damage stability condition software calculating and integrating loading data and real time flooded compartment characteristics from sensor supplied inputs.

3.6.2 The passengers Mustering

At approximately 0243, that is almost 2 minutes after Europolink's course alteration towards the port of refuge, the Master ordered the Chief Officer and the Chief Purser to inform the passengers regarding Europolink's return to Igoumenitsa, through the Public Address System, without sounding the emergency signal. He furthermore instructed them not to refer to the reasons of returning to the port of departure but rather to announce that an engine problem has been encountering, so as to avoid or minimize the possibility and risk of panicking the passengers.

At 0245, the Master reported the casualty to the Managing Company and his decision to return to Igoumenitsa port.

Shortly after, at 0248, he ordered the Chief Officer and the Chief Purser to muster the passengers at the Assembly Stations, with their life jackets on, in preparation for a potential order for evacuation and prepare the life saving appliances and equipment.

By that time Europolink was navigating at 22 knots and no listing to either port or starboard was observed.

Following Master's orders the mustering procedure was launched based on Europolink Evacuation Plan. The designated teams, Alfa and Bravo were activated for the preparation of the life boats and the life saving equipment as well as the Delta team for mustering the passengers.

Based on the investigation data, the passengers' assembly at the Muster Stations lasted for almost 20 minutes and was completed by 0315. The total number of the passengers was verified by the designated Delta Team. One disabled individual that was amongst the passenger list was also transferred to the respective Assembly station. In general and according to the crew the passengers mustering procedure was completed in order and no remarkable cases of panic were reported. It is noted that apart from statements, the state of passengers during the emergency and the preparation for abandonment was also evident by videos and photos.

At 0250, the Master informed the Company's Agent at Igoumenitsa port about the situation and his decision to return to Igoumenitsa.

At 0251, the Chief Engineer called the Master and reported the ongoing flooding emergency, stressing that the seawater level in the Boiler Room was rapidly rising and any counter-flooding measures and actions were not effective.

Taking into consideration the Chief Engineer's updated report, the Master decided to proceed to Corfu port that was closer than Igoumenitsa, in order to save time and instructed the 3rd Officer to make an announcement through the public address System that was carried out shortly after.

At 0255, almost 22 minutes after the casualty, the 3rd Officer, following Master's orders, contacted the Corfu Coast Guard Authority via VHF radio and reported the casualty and the emergency evolving situation. Additionally, he notified that Europolink was heading to Corfu Port and the time of approach was estimated in approximately 30 minutes, running at an average speed of 20 knots. He also requested the assistance of the Port Pilot and 02 Tugs.

The Duty Officer of Corfu Coast Guard Authority confirmed the acknowledgement of the emergency situation and informed the 2nd Officer to proceed, assuring him regarding the availability of a berthing dock.

3.6.3 Emergency response plan by the Hellenic Coast Guard

At approximately 0310, the Corfu Coast Guard Authority, following the marine accident report by the Master of Europolink, reported the occurrence to the Hellenic Coastguard Search & Rescue Coordination Center, in Piraeus while in parallel launched the Emergency Local Contingency Plan and relevant Authorities were notified accordingly.

In particular, the Civil Protection Authority and the Port Authority of Corfu were alerted in order to make the necessary arrangements for the facilitation of passengers while the Local Fire Department was also informed. The two port tugs Skippers and the port pilot were also called and informed for the emergency situation and the assistance requested by Europolink's Master.

At 0320, the Search & Rescue Operational Center Duty Officer directly contacted the Master of Europolink by calling him on vessel's mobile phone. The Master reported the casualty and the situation and position of Europolink at the time, running at 20 knots by her own power and being almost 8 nm away from the port of Corfu, that is close to 25 minutes before entering the port.

The coordination and management of the emergency was undertaken by the Local Coast Guard Authority, as at that time, a Search & Rescue Operation was not necessitated to be launched by the Search & Rescue Operational Centre, which closely monitored the emergency situation's development.

3.6.4 Arrival in Corfu port

At 0320, Europolink was heading towards the port of Corfu at approximately 20 knots. The remaining distance was close to 4 nm and the Master had gradually started to reduce her speed while the engine crew, commanded by the Chief Engineer was on a continuous effort to counter flooding.

At 03:40:40", while Europolink was dozens of meters away off Corfu port entrance with a speed close to 09 knots, no 1 Diesel Generator's overheating alarm was activated and seconds after the same alarm sounded for no 2 Diesel Generator.

At 0341, as she was approaching the Corfu port entrance with a speed close to 09 knots, Europolink's mooring teams were already deployed to the fore and aft mooring stations and anchors were prepared for dropping, if required.

The requested port tugs were not available yet as their crews had been "on call" and not standing-by onboard. They finally approached her later on, shortly after berthing. The Pilot was not available either as he had not arrived at the port yet. The Master decided to proceed with the berthing maneuverings, as the water level in the engine compartments was radically rising and a black out was foreseeable. A Coast Guard vehicle with its beacon flashing had parked at the head of the port's north dock to signal the docking position, while port Authority's moorings gangs had been deployed and standing by for the mooring operation.

The Master carried on with the docking procedures at a speed of close to 04 knots. However, while he was aligning Europolink's stem post with the berthing dock, almost 300 m away off the mooring position, her Main Engines sequentially stopped, as the two

Booster Pumps servicing the fuel supply to the Main Engines were covered and submerged under the rising sea water level in the Purifier Room, resulting to their shutting down.

Consequently, at 0344 Main Engine No 4 firstly stopped and then Main Engine No 3, shortly later Main Engine No 1 and lastly Main Engine No 2.

By that time, while Europolink was approaching the dock under a course of 279° and speed close to 3.0 knots, all three diesel generators were shut down, as the water cooling circulating pumps, that had activated the high temperature alarm shortly before, were flooded and stopped operating due to the rising seawater in the Boiler Room. Consequently, the electrical power plant went off causing a blackout leading to total loss of propulsion and bow thrusters.

The emergency diesel generator was automatically started however it could not service the operation of all the required equipment for the vessel's mooring.

The Master, having assessed: the propulsion and maneuverability loss situation; Europolink's position with her starboard bow heading towards the dock; her speed close to 2.5 knots as well as the imminent danger of crashing on the pier, counteracted and ordered the Bosun, positioned at fore mooring station, to drop both anchors by the emergency gravity release mode.

Firstly, he ordered him to drop the port anchor in order to turn Europolink slightly to port and correct her alignment with the dock and seconds after to drop the starboard anchor. The Bosun released two anchor shackles and Europolink's headway speed was stopped almost before contacting with the dock. Her bulbous bow slightly touched the pier however without any damage.

At 03:49:37", Europolink was alongside the north dock of Corfu Port with her starboard side and her stern pointing towards the port entrance. Mooring crew proceeded quickly with the mooring operation and sent ashore three bow lines and three stern lines (*figure 3.6.4/1*).

By that time it was reported by her crew that she was listing to starboard by almost 1°.

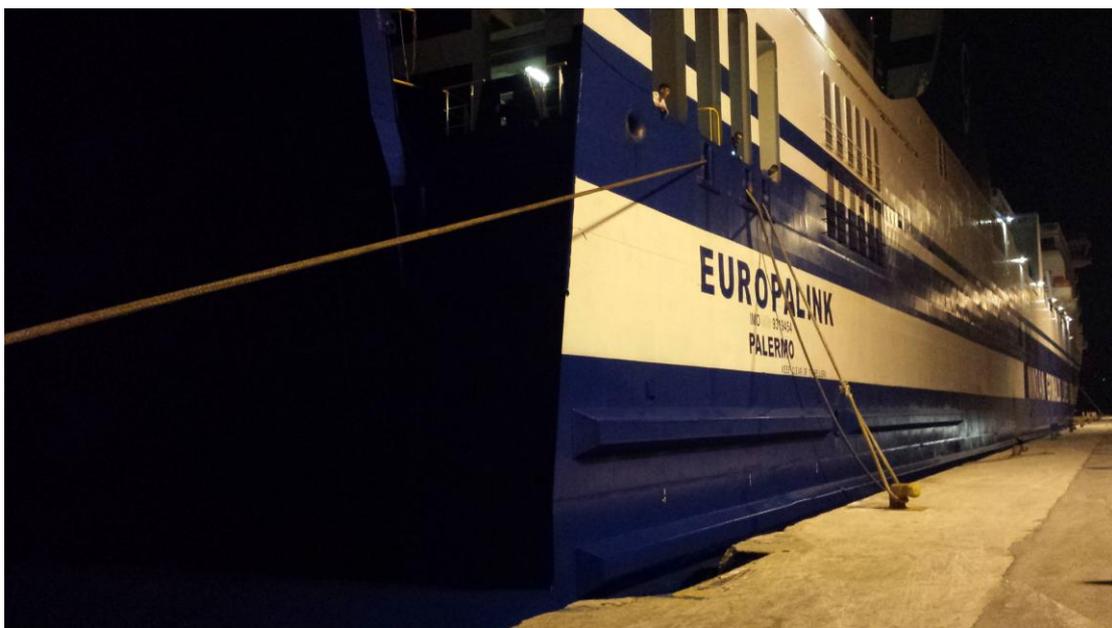


Fig. 3.6.4/1: Europolink berthed with her starboard side alongside Corfu port north docking arrangement before the passengers evacuation operation.

Based on Europolink's VDR extract, at 0351, almost 02 minutes after her berthing, the two port tugs approached her (tugs Dias & Doxa) and following Master's request started pushing her port side towards the dock (figure 3.6.4/2).



Figure 3.6.4/2: Snapshot of the radar display of Europolink after her berthing, showing the tracks of the Port Tugs, Dias & Doxa moving towards her position (03:51:45”).

3.6.5 The evacuation of passengers

As soon as Europolink was fastened and secured at the docking position with her bow facing the dock, the Master ordered the Chief Engineer to open the bow visor, in order to disembark the passengers and start the unloading of the vehicles. The 1st Engineer together with 03 engine crew went forward to main garage deck to do so, nevertheless it was not possible, due to the lack of sufficient electrical power as the Emergency Diesel Generator was the only mean of power supply.

Following, the Master and the Chief Engineer considered the alternative option of using the starboard Bunker Station watertight door, located at the main garage deck, to evacuate the passengers and reported their intention to the Coast Guard Officer in Charge of the Emergency.

The Port Authority of Corfu was informed and supplied a small boarding ladder, close to 08m of length that was actually fit in the width of the disembarkation door. The ramp was transferred by a crane truck and was positioned and secured at Europolink's bunker station side door and practically provided a safe and effortless straight to the dock disembarkation exit for the passengers (figure 3.6.5/1).



Fig. 3.6.5/1:
 The disembarkation ladder supplied by Corfu port Authorities, positioned and secured at Europolink’s bunker station starboard side door.

The 693 passengers had already been mustered at the accommodation assembly station on deck no 7 under the Chief Purser’s supervision and Team Bravo attendance. The Master had ordered the Chief Officer to prepare an evacuation route to minimize the disembarkation time.

The evacuation route prepared by the Chief Officer planned to direct the passengers from deck no 7 to main deck no 3 through the accommodation interior ladder ways, leading to the stairways exit door, located at the fore main deck (deck no 3) section amidships, as depicted in the following diagram (Figure 3.6.5/2).



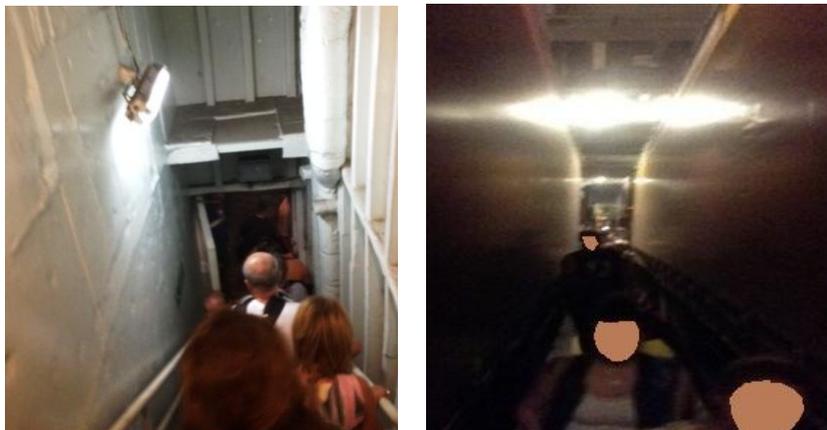
Figure 3.6.5/2: The evacuation route followed by passengers from Muster station at deck 7 to bunker’s station side door as shown on EUROPALINK General Arrangement plan

The inner exit door leading to deck no 3 was about 135m far from the side evacuation door of the bunker station and members of the crew were strung out showing the way to the exit. The evacuation route on car main deck no 3 was leading to the starboard side's yellow emergency line towards the bunker's station side door that was used for the emergency disembarkation exit (Figure 3.6.5/3).



Figure 3.6.5/3: Eurolink's inner exit door to car main deck no 3 and the evacuation route leading to be followed by passengers.

At approximately 0450, the controlled passengers' evacuation started, that is almost an hour post to Eurolink's berthing and lasted for almost 50 minutes. The 3rd Officer was positioned at the exit door and counted the passengers during the evacuation. The number of the evacuating passengers was controlled and verified in cooperation with the Chief Steward, positioned at the Muster Station (deck 7). Bottles of water and blankets were supplied to the passengers by the Port Authorities once they were getting out of Eurolink. Coast Guard Officers were managing their controlled transportation by buses to Corfu Port Authority's passengers' Terminal.



Figures 3.6.5/ 4 & 5: Photos from the evacuation procedure



Figures 3.6.5/ 6 & 7: Photos from the mustering and the emergency evacuation of the passengers.

Nevertheless, it was reported that both the passengers and the crew encountered breathing difficulties when reaching and walking through the main car deck space, due to the fact that some reefers' drivers had already started the trucks's engines to operate their refrigerators' units in order to preserve the transferred goods without being observed by the crew. Consequently, the main garage space was filled with exhaust gas emissions such as carbon monoxide and grey smoke (exhaust fumes), due to the fact that the ventilation system could not be operated with only the emergency generator's power supply. During the passengers' evacuation, Europolink was reported to have a list of 1° to starboard and a slight trim by stern.

At 0545, that is almost five minutes post to the passengers' evacuation, Europolink was reported to have listed to starboard by approximately 2.4° and trimmed further by stern, probably due to the water ingress in the Main Engines Room, which had started after the Boilers Room were completely flooded.

3.6.6 Events after the evacuation of the passengers.

At 0550, Coast Guard Officers and Port Authority representatives boarded Europolink and met the Master on the bridge. A short briefing meeting took place and the situation was assessed and reevaluated. The vessel's damaged stability was underlined as a major concern, whilst the unloading of vehicles and trucks was also prioritized. The aim was to lighten her displacement and resultantly reduce or eradicate the rate and amount of flooding sea water together with the temporary patching and sealing repairs which were to be undertaken as soon as possible.

Moreover, taking into account that the emergency diesel generator power supply was not sufficient to open the bow visor, it was acknowledged to use a shore power connection for the shore to ship power supply. Nevertheless the proposed option was not materialized due to several technical issues that came up in relation to the shore power supply installation, the onboard Receiving Switchboard and the cooperation between Europolink's and Port Authority electricians.

At approximately 0700, a diving team that was called by the Coast Guard Authority, came on scene and two divers conducted an underwater inspection recorded by video camera to assess the extent of the damages. The initial damage report and briefing by the divers

showed the extent of damages and especially the hull critical breached sections through which amounts of seawater were flooding the compartments of Europolink.

At 0731, port tug Doxa was released by the Master, as he assessed that one port tug was efficient to assist Europolink remain secured at the mooring position.

At 0745, the Master and the crew perceived that Europolink started listing further to starboard. At the same time, the Chief Engineer reported to Master via portable VHF radio that the level of the flooding water in the Engine Room compartment had been significantly increased and had reached the height of the crankshaft of Main Engine no 4 (starboard).

The Master, as reported, having evaluated the stability condition of the vessel which seemed to deteriorate due to the continuous water ingress, decided to precautionary order the abandonment of the vessel.

At 0746, the Chief Officer ordered the evacuation of Europolink through the public address system in Italian and English while the Chief Purser communicated it in Greek and the divers were also called off by the Coast Guard Officer in charge. The crew hurried to the bunker station door and gradually abandoned Europolink while the 3rd Officer was verifying names and capacities based on the crew list. The Chief Engineer was the last engine crew member to evacuate the engine room while the Master was the last one to abandon Europolink, at approximately 0810 after he was informed by the 3rd Officer that all crew members had evacuated the ship and no problems were reported.

The 1st Engineer reported that he had attempted to open one of the two Emergency Suction Valves mounted in the Main Engine Room, while the seawater level at No 4 Main Engine (starboard side) was reaching the height of the crankshaft, yet at that time the evacuation order was announced and he hurried his way out.

Until that time the main ballast pump was the only equipment still operating for the discharge of the flooding seawater.

3.6.7 The discharging of the vehicles.

Shortly after the evacuation, the vessel's stability appeared to be steady. The Master estimated the resulting stability of Europolink and advised accordingly the Company's Crisis Management Team by phone.

Following, at approximately 0930, the Master together with the Coast Guard Officer in Charge of the Emergency, the Port Authority's representatives and the Classification Society's Surveyor who had arrived in the meantime, discussed the actions to be taken. Considering the fact that Europolink was observed to have been stabilized with no trimming and listing variations, it was decided to proceed to her shifting (figure 3.6.7/1).



Figures 3.6.7/ 1:
*Europolink
condition prior to
shifting operation.*

The operation and berthing alongside with her portside was planned to be executed with the assistance of the two port tugs and the port Pilot, aiming to lower the stern ramp in order to discharge the loaded vehicles and subsequently reduce Europolink’s displacement.



Fig. 3.6.7/2: The ship’s position prior to her rotation and the direction she was rotated to by T/B “DIAS” and T/B “DOXA” in order her stern ramp to be lowered against the dock (Map Source: Google Maps)

The Master having decided to allow only the necessary crew members for the mooring operation to get on Europolink, boarded her at about 1000 and went on the bridge together with the Deck and Engine Officers while the fore and aft mooring teams were positioned accordingly.

At approximately 1030, the pilot came on board and at about 1100, the port tugs were made fast. At 1118, the shifting operation started and lasted for almost 1h and 20 min, that is until 1238.



Fig. 3.6.7 / 3, 4 & 5: Photos from the shifting operation.

The new berthing position of Eurolink, alongside with her port bow, could facilitate the opening of the stern ramp and the unloading of the vehicles. The Chief Engineer together with the Chief Electrician and engine crew connected the Emergency Diesel Generator Switchboard to the Main Electrical Switchboard and proceeded with the lowering of the stern ramp that lasted for approximately 20 min.

At that time, the diving team, assigned to carry out underwater the temporary counter flooding operation, commenced chocking and wedging blankets, mattresses and wooden wedges into the breached bottom hull and continued for the next 4-5 hours so as to restrain and control the water ingress.

In parallel, the Fire Brigade Department of Corfu provided 03 submersible pumps for pumping out the flooding seawater in the Diesel Generators compartment. The pumping equipment remained on board Eurolink for the next 05 days.

At about 1310, truck drivers started boarding Eurolink under the deck crew supervision and instructions and the discharge of cars and vehicles from the garage decks begun at approximately 1320 (figures 3.6.7 /6 & 7).



Figures 3.6.7 /6 & 7. Photos from the discharging operation of vehicles.

The discharging operation was planned to be carried out by firstly discharging the articulated tracks and reefers, marshaled at the starboard side of no 3 main car deck and afterwards continue with the discharging of the vehicles from the upper decks, no 5, 7, 8. Port Tugs Doxa and Dias were keeping pushing Eurolink from her starboard side in order to counterbalance her list to starboard and secure her at the berthing position (figure 3.6.7/8).



Figure 3.6.7/8:
Port tugs pushing Eurolink post to the completion of the shifting operation

At approximately 1600, as the discharging operation was underway, Europolink was observed to have listed further to starboard, close to 3°, probably due to the fact that the upper car decks no 5, 7 and 8 were still loaded and her stability during the discharging could not be managed by the stabilization system connected to the anti-heeling tanks that was inoperative due to the insufficiency of electrical power.

The Master immediately ordered the Chief Officer and Deck Officers who were supervising the operation, to cease the unloading process.

At that time, the divers who were still wedging the breached bottom hull, were also instructed to halt their activities.

The discharge undertaking was recommenced a few minutes later, once the Master was reassured that Europolink's stability was observed to be stabilized and he furthermore requested the assistance of tug Thiela as well, that had been deployed from Igoumenitsa and was standing by on scene.

The Master then ordered to cautiously continue with the operation by progressively discharge vehicles parked at upper decks while additionally unload trucks parked at starboard side of deck no 3. The operation was controlled and directed by the competent Officers and crew by calling the drivers in turn based on trucks parking positions using their plate numbers.

The gradual discharge of the vehicles from the upper car decks and the continuous underwater wedging and sealing operation of the breached bottom that had notably and progressively resulted in lightening Europolink's displacement and decreasing her draught had a positive effect on the sea water ingress containment.

At approximately 1800 on 21 September 2014, the unloading operation was completed, however the vehicles parked in no 3 lower car deck could not be discharged, as the ramp leading to it could not be operated due to the fact that its control unit was installed inside the flooded compartments. Following the vehicles' discharging it became apparent that her floating condition was significantly improved (Figures 3.6.7/ 9 & 10).



Fig. 3.6.7/ 9 & 10: *Europolink floating condition after vehicles were discharged.*

On the next day, that is on 22 September 2014, a diver connected the control unit actuators and the unit became operable. The ramp was opened and the vehicles were discharged from no 3 car deck.

3.7 The Company's response and the recovery Operations

The Company's DPA together with the technical Manager and a Naval Architect arrived in Corfu on the same day the marine casualty occurred, that is on 21 September, in order to support and manage the evolving situation by assisting the Master.

The Company contracted with a Salvage Company to undertake the recovery operation project and provisional repairs with a group of specialized co-contractors. The Salvage Team consisted of a Salvage Master, Salvage Engineers, Naval Architects and Divers.

The Salvage Tug Megas Alexandros was also dispatched from Piraeus and arrived at Corfu on 25 September 2014.

The anti-pollution-oil recovery vessel Aegis, with full anti-pollution equipment (skimmers, oil booms etc.) was deployed from Piraeus and arrived on site on 30 September 2014.

Tug Hermes was mobilized from Patras with portable salvage equipment (pumps, compressors, generators etc.) and arrived at Corfu on 01 October 2014.

The anti-pollution oil separator boat Aktea 15 was deployed from Piraeus and arrived in Corfu on 03 October 2014.

Europalink compartments were internally inspected by the salvage team and underwater by the co-contracting diving team while her stability and hull condition was monitored using 3D modeling software.

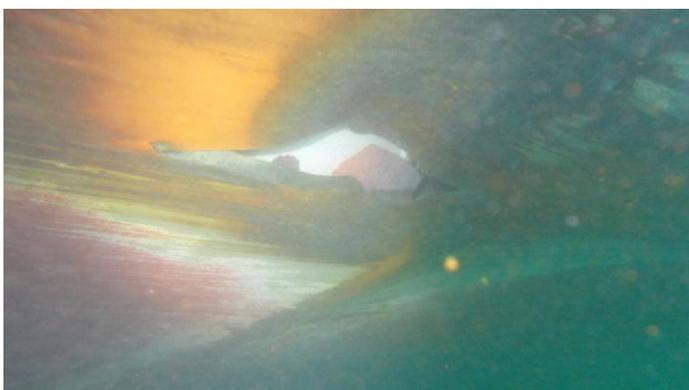
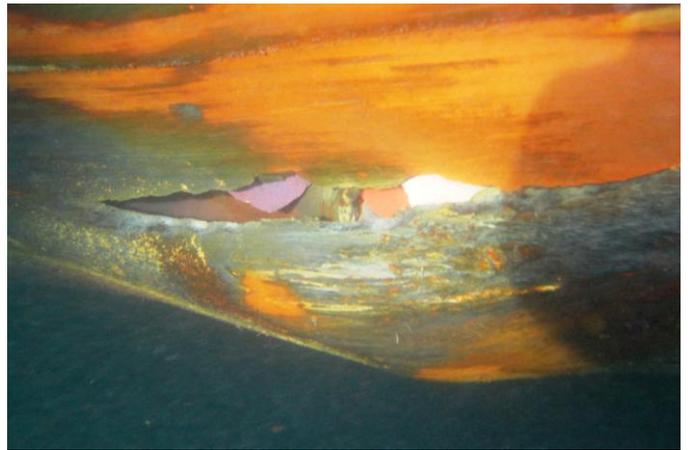
3.8 Damage and provisional repairs

3.8.1 Damage report

The damage report of the Classification Society Surveyor was completed on 21 October 2014 and was based on the underwater surveys performed from 21 September until 21 October 2014.

According to the provided information, Europalink, following her raking impact on Peristerai Islet had sustained hull damages on both sides, extended lengthwise for 62.3m of length at port bottom shell plating and for 50.4m of length at starboard side bottom shell plating as shown in [Appendixes 1 & 2](#).

The bottom plating of the damaged area was deformed, cracked and holed and internal structural damages and fractures were caused to the adjacent transverse and longitudinal strengthening components. Indicative hull damages wedged by the diving team are depicted in figures 3.8.1/ 1 to 12.



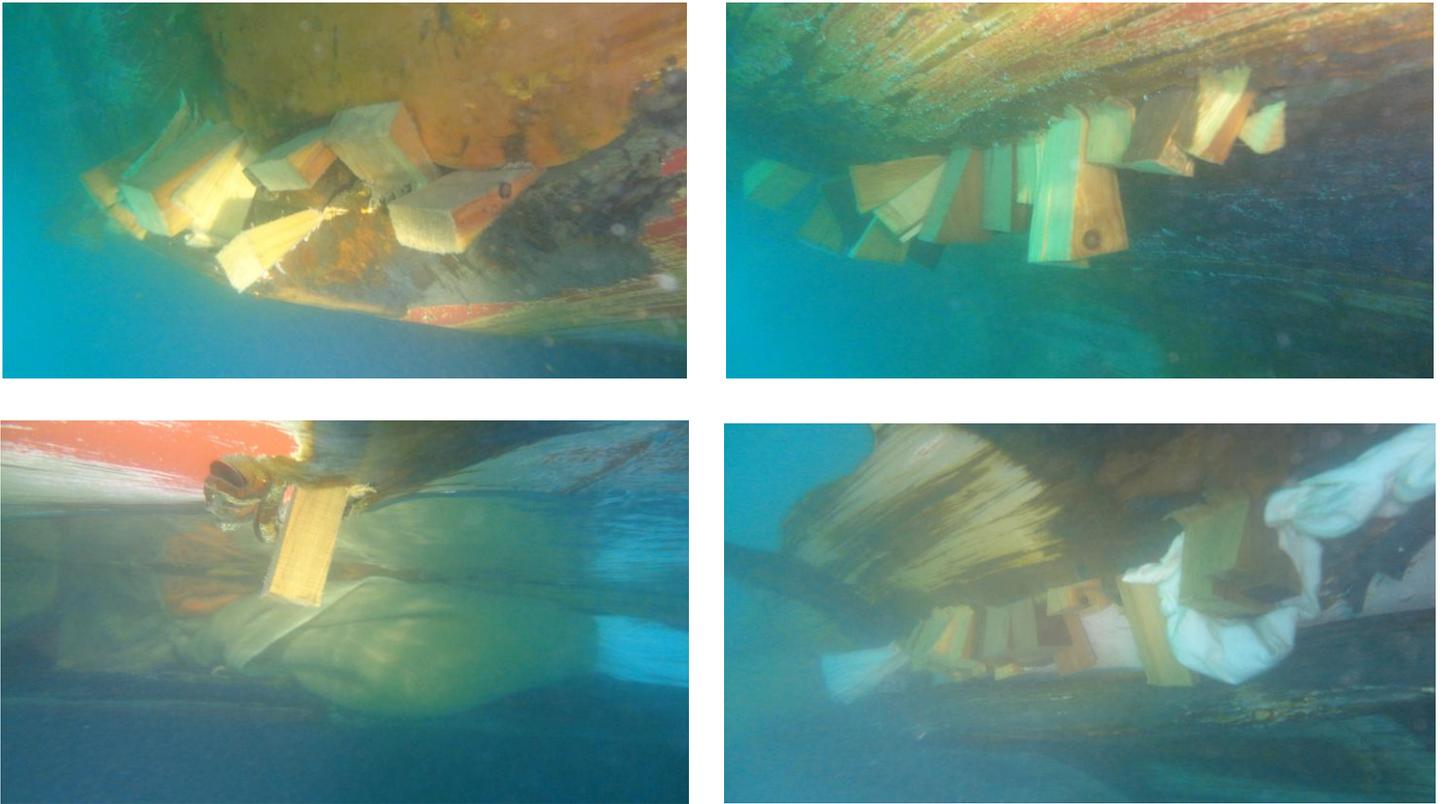


Fig. 3.8.1/ 1 to 12: Photos from the bottom damage and counter flooding underwater operations carried out by the local diver’s team (Source: Diving Team video file).

Resultantly, all void spaces of the double bottom from frame 59 up to frame 207 were flooded (figure 3.8.1 / 13) and huge quantities of sea water ingressed into the following compartments over the double bottom (figure 3.8.1 / 14) (see also Europolink’s Sounding table report in [Appendix 3](#)):

- the Boiler Room and Purifier Room, that were completely flooded;
- the Diesel Generators room, that was flooded up to the under deck No. 2 level;
- the main engines room, that was flooded up to 2.30 meters from the top;
- the stabilizers rooms, that were flooded up to 2.50 meters from the top.

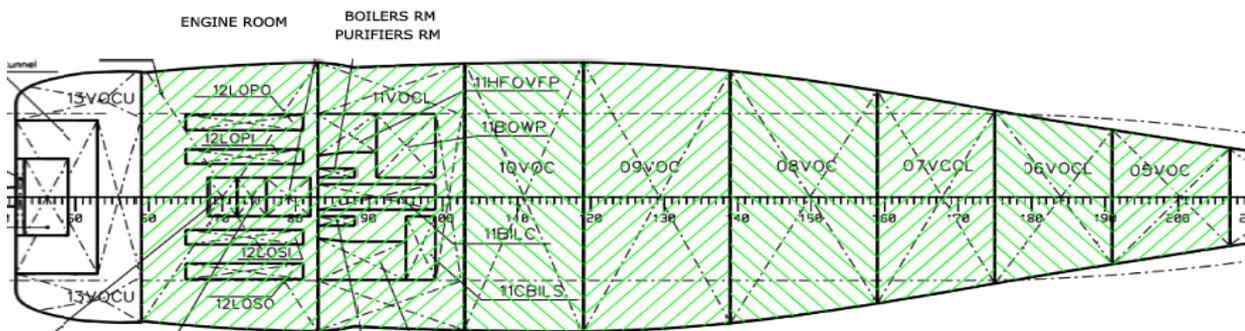


Figure 3.8.1 / 13: Flooded compartments of the double bottom.

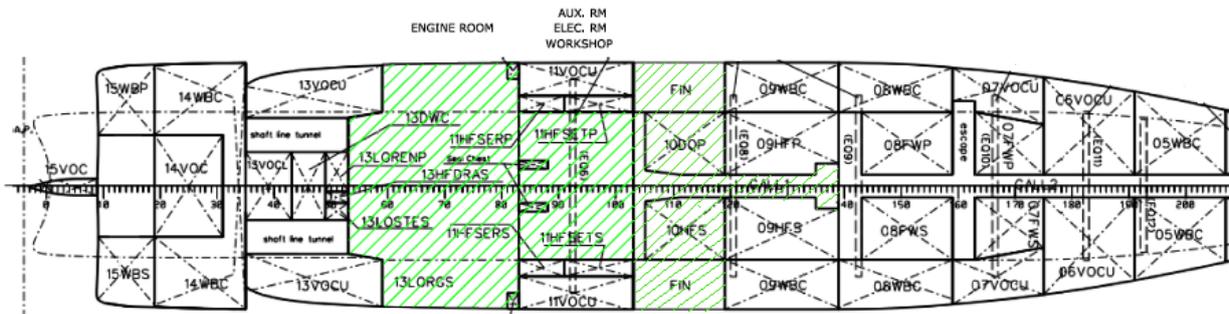


Figure 3.8.1 / 14: Flooded compartments above the double bottom

The sea water covered most of the critical equipment that were submerged and rendered them inoperable, such as:

→ Main Engines	→ Diesel generators
→ motors	→ bilge pumps
→ boilers	→ electronic

Having scrutinized the available data, it is inferred that the water ingress into abovementioned compartments resulted as follows:

- the great friction and upright forces that were generated during the heavy impact and dragging, caused breaches to several sections of the hull plating;
- seawater flooded the void spaces of double bottom tanks as well as the Boiler Room compartment;
- seawater came in the Purifier Room through the non watertight door;
- seawater from the Purifier Room (workshop area) entered into the Stabilizers Room through a cable penetration box fitted above its watertight door in way of the bulkhead at frame 103, as well as through the main ballast line piping which had been cracked at its passage from the bulkhead at fr. 103 (Stbd side) on deck no 1;
- seawater ingress into the Stabilizers Room was also directed to the forward Fresh Water Tanks' compartment through the main ballast line piping which had been cracked at its passage from the bulkhead at fr. 139 (Stbd side) on deck no 1;
- sea water from the Boilers Room entered the Main Engine Room compartment through a cable penetration frame fitted on the bulkhead dividing the two compartments, at frame no 83 above its watertight door;
- flooding sea water ingressed from the Engine Room to the Diesel Generators compartment through an opening in way of the bulkhead at frame 55 on deck no 1, as well as through the tailshaft seals in way of the abovementioned bulkhead.

No pollution was reported to have been caused by the accident.

3.8.2 Flooding of the Main Engine Room

Regarding the damages Europolink sustained due to the casualty, apart from the sea water ingress in compartments which had been breached due to the impact, a water ingress was also encountered in the Main Engine Room as seawater was entering from the adjacent Boiler Room. That water ingress occurred through a cable penetration box in way of the bulkhead between the two compartments, at frame 83 (figure 3.8.2 /1).

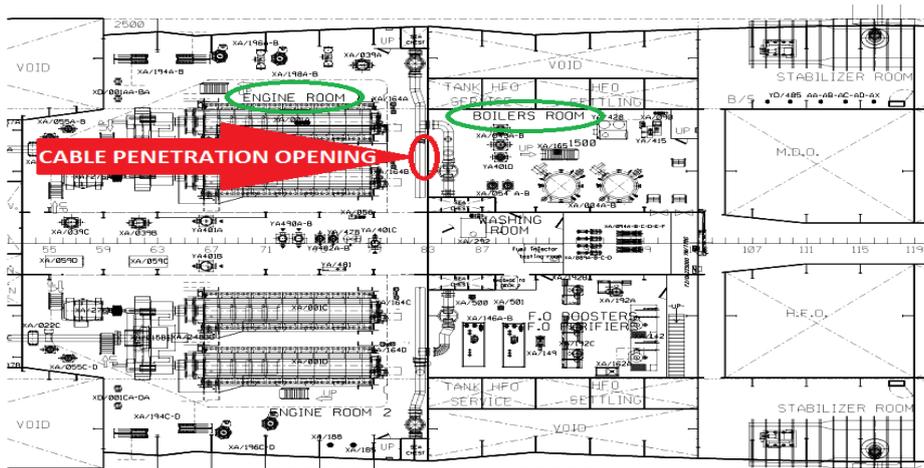


Figure 3.8.2 / 1: Red circle depicts the cable penetration box on the bulkhead between the engine room and the boiler room

The progress of the sea water ingress inside the Engine Room after the flooding of the Boiler Room is presented in following figures 3.8.2 / 2a & 2b.

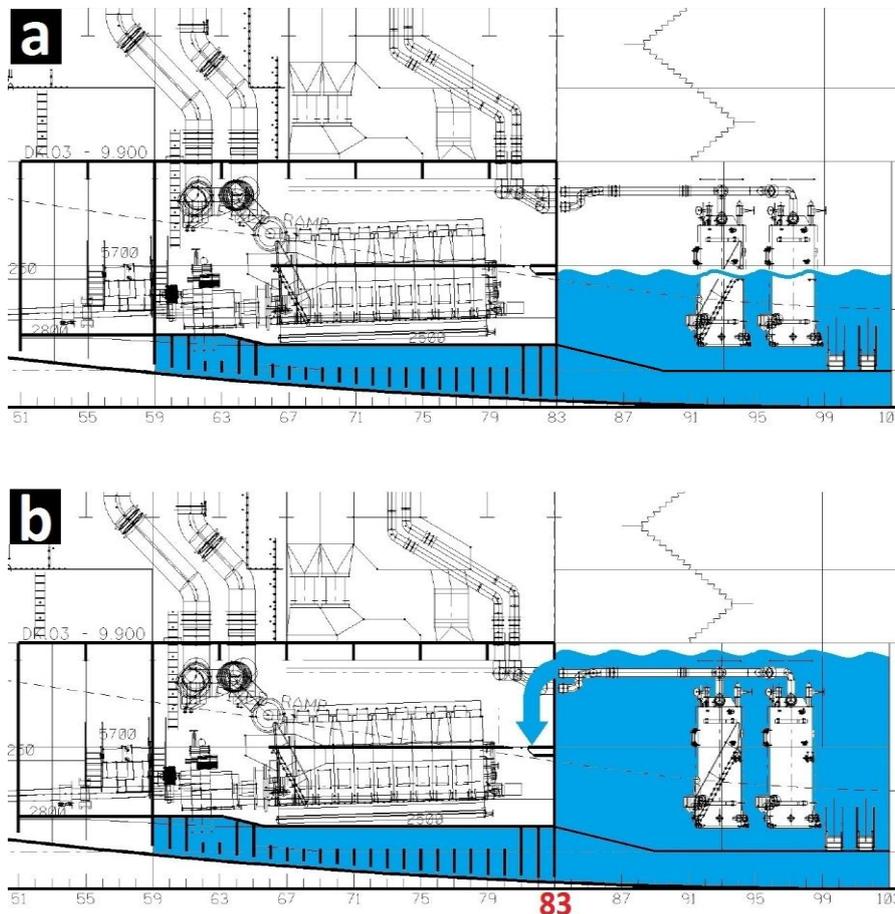


Fig. 3.8.2 / 2a & 2b: Illustration of the sea water ingress inside the Void Spaces and the Boiler Room and of the waterway (cable penetration opening) i.w.o. the bulkhead at frame 83 for the water ingress inside the Engine Room.

After both compartments were flooded, a diver of the contracting Salvage Company (SVITZER) was deployed, in order to assess the situation and provide information for the provisional repairs. It was decided that in order to pump the water out from the Engine Room and the Boiler Room, the cable penetration opening on the bulkhead had to be sealed.

Subsequently an underwater operation was carried out and the cable penetration opening was sealed with a steel plate which was fastened against the opening, as shown in following figures 3.8.2 / 3 & 4.



Fig. 3.8.2 / 3 & 4: The cable penetration opening i.w.o. the bulkhead at frame 83 sealed by the steel plating, as seen from both compartments, after pumping operation's completion.

The sealing component parts which had been dislodged following the incident and the flooding were not found when compartments were emptied.

Although the area was damaged due to Europolink impact, further information for the setting of the cable penetration box deemed to be necessary.

To that end information was sought from Europolink Sister ship relating to the referred mounting setting, that was operating in Finland ports. The investigation team addressed the respective Safety Investigation Authority on said issue and cooperation and assistance was directly offered.

Following, the cable penetration box mounting setting of Europolink's sister ship is shown in figures 3.8.2 / 5 & 6 while the installation information for the sealing component by the manufacturer is shown in figure 3.8.2 / 7.

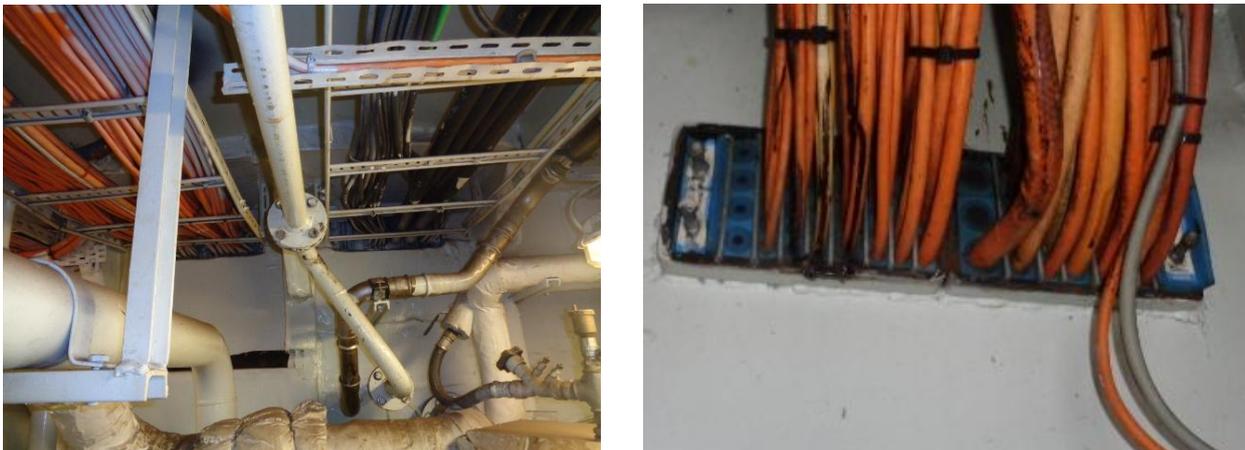


Fig. 3.8.2 / 5 & 6: The cable penetration opening i.w.o. the bulkhead at frame 83 at EUROPALINK's sister vessel. (Source of photographs: Safety Investigation Authority of Finland)

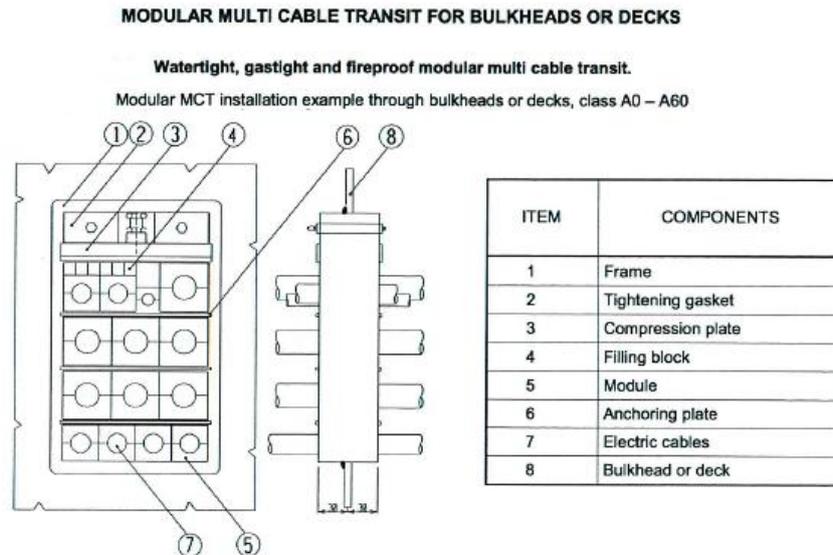


Fig. 3.8.2 / 7: Installation information for the sealing component for the cable penetration opening i.w.o. the bulkhead at frame 83.
(Source: Manufacturer's installation manual)

Having regard to the examination of the collected information and data on said subject and taking into consideration the events of the occurrence, it was found that the bulkhead separating the two Engine compartments at frame 83, had been deformed to some extent causing bending damages at the point of the cable penetration opening mounting as a consequence of Europolink's raking on the shelves and the forces developed. Consequently the mounting sealing modules were breached and detached allowing the water ingress from the Boiler Room into the Main Engine Room.

3.8.3 Provisional repairs

As already recorded, initial counter flooding measures were undertaken by divers, shortly after Europolink berthed at Corfu port, in order to restrain the flooding seawater and remain afloat.

During the first days following the occurrence, that is from 23 September until 28 September 2014, no repair works were carried out. Europolink's stability condition, longitudinal and transverse strength and soundings were being comprehensively monitored and recorded by the RO, P&I and Salvage technical experts using 3D modeling software thereto.

According to the report of the RO's Surveyor the provisional repairs included the following procedures:

- The damaged plantings' hanging out of the hull were cut off in order for new "doubler" plates to be overlapped and welded in the area.
- Crack arresters (drilling holes) were fitted in way of the cracks detected, with regard to the form and position of the damaged area.
- The repairs were extended to the entire damaged area and all individuated cracks were sealed by means of doubler plates.
- The repair of the bigger cracks in way of Stbd side fr.81-93 and Port side fr.128-141, was carried out by the use of plating of 8 mm thickness and external reinforcement by transverse stiffeners. Internal stiffeners in addition to the externals were used in the case of the opening at Port side at fr.128-141.

After the completion of the provisional hull repairs and further to a final underwater survey carried out on 20 October 2014, it was verified that the watertightness of the entire bottom of the vessel had been reinstated.

The layout of the repairs may be seen in the plans attached in [Appendixes 1 and 2](#) as presented according to the Europolink's Classification Society's Surveyor report on 21 October 2014.

3.9 Detention and permanent repairs

On 23 September 2014, EUROPALINK was detained by the Port State Control of the Central Port Authority of Corfu until the sustained damages were provisionally repaired. On 01 November 2014, EUROPALINK was permitted to sail under tow for one single voyage to a shipyard in Turkey in order to undergo permanent repairs.

On 22 September 2015, almost one year after the casualty the repairing works and services were completed and Europolink sailed to Italy and came back into service.

3.10 HBMCI Safety Investigation

The Hellenic Bureau for Marine Casualties Investigation launched a safety investigation on the examined marine casualty on the grounds of respective provisions of Directive 2009/18/EC, as incorporated in national legislation by Law 4033/2011 (government gazette A' 264) and IMO Casualty Investigation Code.

Having notified all interested parties involved in the marine casualty as well as the vessel's Flag State and the respective Italian Investigation Authority (DIGIFEMA), HBMCI immediately deployed an investigation team consisted of two investigators and one trainee, that arrived in Corfu, on 21 September 2014 and stayed for the next 04 days.

HBMCI investigation team had a close cooperation with all the involved parties (Master, Company's representatives, RO's Surveyor, P&I representatives, Salvage Contractors) and Authorities (Corfu Coast Guard, Hellenic Maritime Administration, Corfu Port Authority) in the marine accident and was invited and participated in several meetings held in Corfu Port Authority's premises.

On 24 September 2014, DIGIFEMA deployed an Investigation team of two Investigators that arrived in Corfu on the same day.

Following a common agreement under article 7 of Directive 2009/18/EC, HBMCI was afforded with the role of the lead investigating State whilst DIGIFEMA participated in the investigation process, as Substantially Interested State (Flag State). Both Investigation Authorities worked closely on scene during the evidence collection process and jointly interviewed the Master and part of Europolink's crew.

4. Analysis

4.1 Europolink's key personnel

4.1.1 The Master

The 40 year old Italian Master was a holder of a Master's Certificate of Competency, since 2003. Having graduated from the Marine Academy "Istituto Tecnico Nautico Statale Nino Bixio", located in Piano di Sorrento, in Naples, his seagoing career was started in 1995, as a Deck Cadet contracting with an Italian Company on Bulk Carriers and Containers until he obtained his Chief Officer's COC. Following, he served on Tugs and Barges, as Captain and occasionally, as Master on motor yachts. He had also 4 years of experience as Chief Mate and Master on Passengers vessels, operating between the ports of Sicilia and Genoa. Additionally, he had served as Captain on ferries, daily operating between the ports of Salerno and Messina.

He had started contracting with Europolink's Company, since 2008, firstly as Chief Officer and Stuff Captain and since 2010 as Master on ROPAX, mostly operating in the Adriatic Routes.

He had joined Europolink on 08 August 2014 after being transferred from another Company's ROPAX.

4.1.2 The Chief Engineer

The Chief Engineer started his seagoing career on cargo ships in 1980. He obtained the 3rd Engineer's COC in 1984 and the 2nd Engineer's in 1986 and was regularly employed on Tankers and Cargo ships until 1989.

Following, he continued his seagoing career on ROPAX and in 2001 he acquired the Chief Engineer's COC. He had started contracting with Europolink's Company on a permanent basis since 2006. He joined Europolink, as Chief Engineer on May 2014 and it was his fourth time of service.

4.1.3 The 1st Engineer

The 1st Engineer was 30 years of age and he had been graduated from the "Istituto Tecnico Nautico Statale Nino Bixio", in Piano di Sorrento, in 2003. His seagoing service started as Engine Cadet in 2003 and included only Company's ROPAX. In 2005 he started being employed as a 3rd Engineer and since 2007 as 2nd Engineer.

He was firstly assigned with the duties of the 1st Engineer in 2010, whilst in 2012 he obtained the Chief Engineer's COC.

He was recruited on Europolink on 27 June 2014 and it was the first time he served onboard her.

He was assigned with organizing the Engine Department's daily work tasking and with the inspection and maintenance of the engine department's equipment as well as of other auxiliary equipment such as air-conditioning units, freezers, kitchen electrical equipment etc.

He was in charge of a team of engine crew performing maintenance, trouble shooting works etc.

At the time of the marine accident he was sleeping in his cabin.

4.1.4 The 2nd Engineer

The 2nd Engineer, 28 years of age, had graduated the “Istituto Professionale Marittimo di Pira”, in Sardinia, in 2006.

He started his sea service as Engine Cadet, in 2006, on Company’s Cargo ships. In 2010, he gained the 3rd Engineer COC and was recruited on Company’s ROPAX while in 2010, he started contracting as a 2nd Engineer after obtaining the required COC.

He was performing the 1200-1600/2400-0400 engine watch and he was on duty during the marine accident.

4.1.5 The Chief Officer

The 28 year old Chief Officer of EUROPALINK had acquired his Chief Officer’s Certificate of Competency in 2012. He had graduated the “Nautical Institute of Manfredonia”, in Italy, in 2004. He had been contracting with the Company since the beginning of his seagoing career as a deck cadet. In 2006, he was recruited as 3rd Officer while in 2007, he was promoted to 2nd Officer.

In 2010, having gained his Chief Officer COC, he started serving as Chief Mate onboard ROPAX. His seagoing career development was marked only on Company’s ROPAX.

He had joined Europolink on 14 July 2014, almost 2 months prior to the casualty and was recruited as Staff Captain. Amongst others duties, he was charged with supervising the freight handling and with the Ship’s Security Officer’s duties.

At the time of the marine casualty he was on the bridge carrying out clerical work related to loaded cargo.

4.1.6 The 2nd Officer

The 29 years of age 2nd Officer was the Officer on the Watch during the time of the marine accident.

He had graduated the Secondary School “Technical Nautical Institute Domenico Millelire”, in Sardinia, in 2004. He had been serving on Company’s Cargo Vessels from 2008 to 2013, mostly as deck cadet and deck rating.

In 2013, after gaining the 2nd Officer’s COC, he was recruited as a 3rd Officer on Company’s ROPAX. He had joined Europolink on 11 July 2014 and it was the first time he was holding the position of the 2nd Officer, performing the 1200-1600/2400-0400 navigational watch.

4.1.7 The 3rd Officer

The 3rd Officer was 26 years old and he had been graduated from the Technical Nautical Institute “Francesco Caracciolo”, in Bari, in 2010.

He had been serving on Company’s Cargo vessels since 2011, as Deck Cadet and 3rd Officer. He was recruited on Europolink in June 2014 and he was assigned with the 0800-1200/2000-2400 navigational watch.

4.1.8 The Helmsman

The 49 year old AB, who was performing the 1200-1600/2400-0400 Look Out watch and was steering Europolink just prior to the marine accident, had joined Europolink on 10 June 2014.

He had started his sea service career in 1985 and had been employed as AB on Tankers and Cargo ships. In 2011, he began serving on ROPAX while in 2012 he contracted with the Company of Europolink for the first time.

4.2 Manning and personnel

The crew of Europolink had a complement of 69 crew members in total, out of which 37 crew members were Italians and 32 were Greeks. One Bulgarian national was also employed as the cashier of the convenience store.

The Deck Department was consisted of 19 crew members and the Engine Department of 16 crew members. The Accommodation Department was counting 33 crew members and one doctor.

Europolink's crew complement was complying with the requirements in numbers, capacities and grades determined by her Flag for carrying up to 730 passengers. The Minimum Safe Manning Document envisaged a minimum number of 44 seafarers in total, and more specifically, 11 seamen for the Deck Department, 13 for the Engine Department and 22 for the Accommodation Department.

4.3 The Company's recruiting policy

ISM Chapter 5 "Resources and personnel" amongst others sets out the main principals for a Company's recruiting policy.

Europolink Company's recruiting policy, established under its Safety Management Manual/Chapter 5.3 was mainly based on its own crew pool recruiting system, especially for ROPAX while recruited seafarers were also sourced through manning and recruitment agencies.

Available pool Crew personnel for employment was registered in a database stored with all crew related information.

Having viewed Europolink's key personnel credentials and seagoing experience it was deduced that the implemented practice established a pool of qualified seafarers that were serving on Company's vessels on a permanent rotating system with "leave" and "service" ratios varying from 4 to 6 months "on" and 2 to 4 months "off" service.

Furthermore, based on the provided data during the interview process it was derived that Deck and Engine Officers were either recruited on Company's vessels since the begging of their seagoing career or at a later stage of their professional path. Furthermore, the Company was practicing a recruiting policy of employing new Officers on cargo ships and having gained experience, they were recruited on owned ROPAX.

Having regard to contracting dates at the time of the marine casualty it was observed that most of the crew members had been recruited on Europolink during the summer months and only 16 crew members were serving for more than three months prior to the casualty.

4.4 Bridge & Engine Department shipborne watch arrangement

ROPAX Europolink shipboard watch arrangement was structured under the directions of her Safety Management Manual relevant sections and available crew resources. The watch system was performed by implementing a 04-hour bridge and engine watch pattern.

4.4.1 The bridge watch arrangement

According to her Safety Management Manual, “Chapter 4/Organization on Board/Section 4.6/ Watch” composition of the watches, as well as “Chapter 12/Procedures and Instructions/ Safety during navigation, anchoring and maneuvers/ Section 12.2.2/iii watches”, the navigational watches consisted of one Deck Officer as the OOW and one AB as a Look Out and Helmsman, if required as presented in the following table 4.4.1 / 1.

	Navigational watch	Position/duties	Rank
1	0800-1200 / 2000-2400	OOW	3 rd Officer
		Look Out / Helmsman	AB
2	0000-0400 / 1200-0400	OOW	2 nd Officer
		Look Out / Helmsman	AB
3	0400-0800 / 1600-2000	OOW	2 nd Officer
		Look Out / Helmsman	AB

Table 4.4.1 / 1: Navigational Watches

The Chief Officer (Staff Captain) was not taking part in the navigational duty schedule, as Europolink was manned with an additional Deck Officer that was forming part of the navigational watch.

The Chief Officer was mainly assigned with the loading and unloading operational duties as well as other tasks and responsibilities as were listed in Europolink’s Manual, Chapter 4/Organization on Board/section 4.5.1.2.

4.4.2 The Engine watch arrangement

The Engine Watch arrangement was scheduled under the instructions included in section 4.6 of the Company’s Safety Management Manual and section 12.2.3/(ii) watches.

In view of the Engine Department available manning, the watch was conducted by the senior 2nd Engineer, the junior 2nd Engineer and the 3rd Engineer while three Fitters were forming part of the engine watch, at support level, as seen in the following table 4.4.2/1:

	Engine watch	Position	Rank
1	0800-1200 / 2000-2400	OOW	3 rd Engineer
		Supporting watch	Fitter
2	0000-0400 / 1200-0400	OOW	Senior 2 nd Engineer
		Supporting watch	Fitter
3	0400-0800 / 1600-2000	OOW	Junior 2 nd Engineer
		Supporting watch	Fitter

Table 4.4.2 /1: Engine Watches

The First Engineer was not performing engine watches as he was assigned with maintenance and repair duties and responsibilities as described in Chapter 4/Organization on Board/section 4.5.2.2.

4.4.3 Fatigue - Working and resting hours

Europolink’s working and resting hours records were examined during the investigation process and were found in order.

The “on board working and resting arrangement” was normal as she was operating on scheduled itineraries and no indication was found denoting that Master’s and involved crewmembers performance was affected by fatigue in the examined case.

4.5 Conning position’s visibility, bridge design and layout

PORAX Europolink bridge was an open one-room wheelhouse, designed to allow almost 360° field of vision with panoramic bridge windows. The horizontal vision field could offer an excellent aspect of the navigated sea area to the conning Officer and the bridge team, meeting the requirements of SOLAS 74/Chapter V/Reg. 22, as applied (figure 4.5/1).



Fig. 4.5 / 1: Europolink arrangement from her starboard wing.

4.5.1 Bridge design and layout arrangement

SOLAS 74/Chapter V/Reg.15, that entered into force on 1 July 2002, set out the fundamental principals related to the bridge design, design and arrangement of navigational systems and equipment and bridge procedures and foresees that all relevant decisions shall amongst others be taken with the aim of:

“Reg.15.subpar. 6:

Preventing or minimizing excessive or unnecessary work and any conditions or distractions on the bridge which may cause fatigue or interfere with the vigilance of the bridge team and the pilot;”.

MSC/Circ. 982 (20 December 2000) was developed in order to support the provisions of SOLAS regulation V/15 and to assist designers in realizing a sufficient ergonomic design of the bridge, with the objective of improving the reliability and efficiency of navigation.

Aforementioned Circular incorporates guidelines to enable consistent, reliable and efficient bridge operation, that sets the provisions of many aspects of bridge ergonomic requirements such as Bridge Layout, Work Environment, Workstation Layout and lighting devices, alarms, and so forth as well as outlines seven bridge workstations, as quoted in following table 4.5.1/1.

Workstations	Basic Functions	Indicative Equipment
navigating and manoeuvring	working in seated/standing position with optimum visibility and integrated presentation of information and operating equipment to control and consider ship's movement and to operate the ship safely, in particular when a fast sequence of actions is required	ECDIS, AIS info, main engines controls, rudder controls, thrusters controls, engine rpm, ruder angle & rate of turn indicators, VHF, group alarms for decision making, lighting controls, BNWAS reset, etc.
monitoring	operating equipment and surrounding environment can be permanently observed in seated / standing position	Radar, ARPA, BNWAS reset, internal communication, VHF, windscreen wiper, washer, heater controls, propellers revolutions, rudder angle, rate of turn, water depth, & alarms indicators, etc.
manual steering (Helmsman's workstation)	the ship can be steered by a helmsman as required or deemed to be necessary, in seating preferably conceived for working in seated standing position	Steering wheel, steering lever, rudder selector, gyro and magnetic compass indicators, rate of turn indicator, etc.
docking workstation	enable the navigator together with a pilot (when present) to observe all relevant external and internal information and control the manoeuvring of the ship	main engines controls, rudder controls, thrusters controls, various indicators such as gyro compass, BNWAS reset etc.
planning and documentation	ship's operations are planned (e.g. route planning, deck log). Fixing and documenting all facts of ship's operation	Chart table, route planning devices, charts folios, barograph, air and water temperature indicators, VHF, etc.
safety	monitoring displays and operating elements or systems serving safety are co-located	Fire alarm & fire extinguishing system, watertight doors control & monitoring system, bilge monitoring system, VHF, strength loads indicators
communication	operation and control of equipment for distress and safety communications (GMDSS) and general communications	GMDSS equipment as required for the applicable sea area e.g. VHF DSC, MF/HF DSC, NAVTEX etc.

Table 4.5.1/1: Bridge workstations

An example diagram of the bridge workstations areas and layout is depicted in below figure 4.5.1/1.

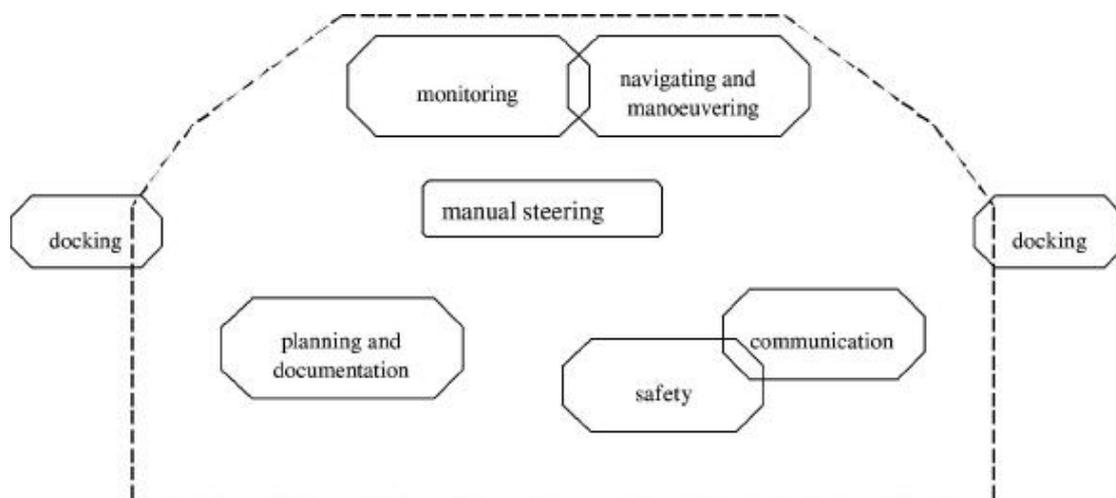


Figure 4.5.1 / 1: Example of workstation location and layout

4.5.2 Europolink's Bridge layout arrangement

Europolink's wheelhouse was a modernized navigational bridge, basically designed under the standards of ISO 8468 and 14612.

In accordance with the additional RO notation (* SYS-NEQ) in her Class Certificate, she was fitted with a centralized navigation control system so laid out and arranged that it enabled normal navigation and maneuvering operation by two persons in cooperation. The principal requirements for the bridge design and arrangements under the rules foreseen in SOLAS 74/Chapter V/Reg. 15 and respective IMO performance standards for navigational equipment were applied, taking into account that Europolink keel was laid on 05 August 2005.

The bridge layout was featuring the following workstations as shown in figure 4.5.1 / 2.

- one centralized navigation control system with two monitoring positions;
- two docking stations, mounted at port and starboard side respectively;
- the Helmsman workstation;
- one planning and documentation workstation, practically the “chart room”;
- one safety monitoring workstation.

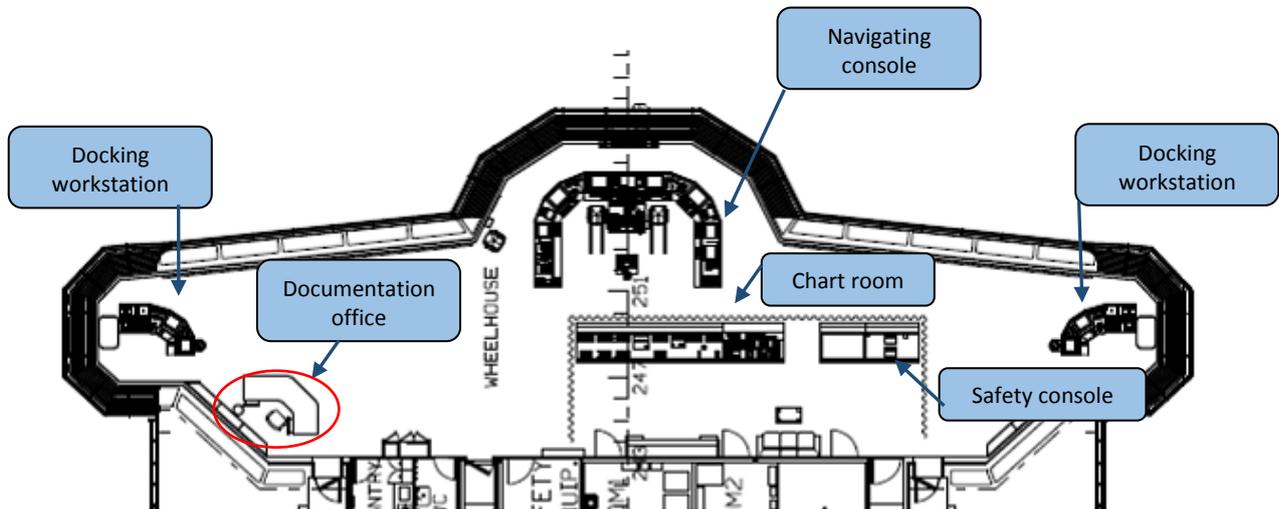


Figure 4.5.1 / 2: Europalink bridge layout and workstations.

4.5.2.1 Navigating, steering & docking workstations

The bridge layout was fitted with one single main navigation console, offering two workstations with two seats located at each one. Each workstation was equipped with navigational instruments (ARPA, ECDIS, AIS, GPS, VHF, etc.) easily visible and accessible while radio communication equipment and maneuvering controls (autopilot, hand steering, engines control lever, thrusters etc.) could be effortlessly handled by the OOW and a second navigational Officer or the Master from the afforded individual positions. Both navigational watch positions could enable watchkeeping Officers to perform navigational duties and functions as well as to maintain a proper lookout.

The helmsman workstation console was fitted behind the main console and two docking workstations were mounted at starboard and port bridge wing respectively.

4.5.2.2 Chart room & safety monitoring console

The chart room was located at the aft section and almost in the middle of the bridge; further to starboard the safety monitoring console was mounted, fitted with NAPA loading Master, watertightness and fire alarm monitoring systems.

Both working stations being in line, could be peripherally covered by curtains mounted on a ceiling headrail so as to keep their space insulated; to control the light levels of the workstations illumination; and avoid light reflections in windows during night time when the OOW was performing route checking, fixing, logbook entries or other watchkeeping tasks.

4.5.2.3 Documentation Office

The bridge was also fitted with a documentation office, located at its port side, slightly backwards and to starboard from the port docking station.

The office was equipped with a desk top computer used for cargo recordings as well as for other clerical work relevant to Europalink operational procedures, as it was connected to her network and it was offering a sitting position. A table lamp, placed on it, could provide illumination during night time tasking as shown in figure 4.5.2.3/1.



Figure 4.5.2.3 / 1: The documentation office equipped with a desk top computer and a table lamp marked in circles.

Taking into consideration the provisions of SOLAS/ Reg.15³ and moreover subpar. 6, it is inferred that bridge should be designed and equipped with the aim to effectively navigate a vessel at all times, offering the appropriate operational environment to the bridge watchkeeping team, minimizing any conditions that may cause distractions or interfere with the assigned duties, as it is imperative for the individuals involved in watchkeeping to focus in safe of navigation, in particular when crossing restricted waters.

Consequently, any other tasks that were not directly related with the vessel's safe navigation would have to be carried out in locations other than the bridge.

At the night of the marine accident, it was stated that the Chief Officer, was doing paperwork related to cargo recordings, on the bridge office using the desk top computer. However, it was not evident whether the table light was switched on while he was working.

³ SOLAS Chapter V/Regulation 15: "Principles relating to bridge design, design and arrangement of navigational systems and equipment and bridge procedures".

All decisions which are made for the purpose of applying the requirements of regulations 19, 22, 24, 25, 27, and 28 of this chapter and which affect bridge design, the design and arrangement of navigational systems and equipment on the bridge and bridge procedures** shall be taken with the aim of:

** Refer to Guidelines on ergonomic criteria for bridge equipment and layout (MSC/Circ.982) and Guidelines for bridge equipment and systems, their arrangement and integration (BES) (SN.1/Circ.288) and, for INS, to Recommendation on performance standards for an integrated navigational system (resolution MSC.86(70), annex 3, as amended).

- .1 facilitating the tasks to be performed by the bridge team and the pilot in making full appraisal of the situation and in navigating the ship safely under all operational conditions;
- .2 promoting effective and safe bridge resource management;
- .3 enabling the bridge team and the pilot to have convenient and continuous access to essential information which is presented in a clear and unambiguous manner, using standardized symbols and coding systems for controls and displays;
- .4 indicating the operational status of automated functions and integrated components, systems and/or sub-systems;
- .5 allowing for expeditious, continuous and effective information processing and decision-making by the bridge team and the pilot;
- .6 preventing or minimizing excessive or unnecessary work and any conditions or distractions on the bridge which may cause fatigue or interfere with the vigilance of the bridge team and the pilot; and
- .7 minimizing the risk of human error and detecting such error if it occurs, through monitoring and alarm systems, in time for the bridge team and the pilot to take appropriate action.

Nevertheless, levels of light illumination⁴ either from the computer's monitor or from the table lamp could have a negative effect on the observations of the OOW on the navigable sea area and the visual monitoring of the surrounded targets based on the fact that when the desk top computer was in use, its monitor illumination could be reflected on bridge windows and have a deleterious result on the vigilance of the watchkeeping team. In any event, the use of any light during night time that is not sourced from the bridge instruments or devices that their luminance⁵ can be easily adapted to night vision, as provided by IMO Circ. 982, can have a serious impact in watchkeeping performance. In view of the above, it is considered that the documentation office located in the bridge was not in line with the relevant provisions of bridge equipment and arrangement, as it is not considered as basic navigational equipment, thus it is questioned whether its location was designed under the aforementioned IMO guidelines and relevant provisions directly related with the safe navigation, such as SOLAS /Chapter V/Regulation 15, as already mentioned, as well as STCW Code Part A/ Chapter VIII/Part 4/Watchkeeping at sea/4-1/ Principles applying to watchkeeping generally and notably in par. 15 by which it is stated that :

"The lookout must be able to give full attention to the keeping of a proper lookout and no other duties shall be undertaken or assigned which could interfere with that task."

Respective principal in regard to the undertaking or assigning other duties, although may directly refer to "other tasks" that are not to be undertaken by the OOW, it could be also broadly interpreted, as a primary principal for any duty or assignment other than watchkeeping not to be executed on the bridge by any other individual when underway.

Moreover, in following par.17 of the same STCW part, it is provided that:

"the configuration of the bridge, to the extent such configuration might inhibit a member of the watch from detecting by sight or hearing any external development;"

In view of the aforementioned provisions a vessel's bridge should not in any way constitute a place for tasks or activities other than the primary bridge functions such as ship's safe navigation, maneuvering, docking and so forth as well as additional bridge functions (communication, monitoring and control of ballasting, machinery, cargo operation etc.) according to respective provisions and guidelines.

In relevance it is noted that British Standards ISO 8468:2007⁶ thoroughly specifies the functional requirements for bridge configuration, arrangement, workstations and environment.

More specifically, under par. 5 *"Bridge functions and tasks and their relations to workstations"* and its subparagraphs, directions and guidelines are cited for bridge primary functions as well as for additional functions and the equipment to be distributed in the workstations, provided that the performance of such functions does not interfere with the tasks of maintain safe control of the ship.

Additionally, in following ISO Standards par. 6 *"Bridge equipment"* sub. 6.4.1.3 it is highlighted that unnecessary light sources in the front area of the bridge have to be avoided and only equipment necessary for the safe navigation of the ship should be located in this area.

⁴ IMO Circ. 982/Appendix 1/Definition: The amount of light (luminance flux) falling on a surface, measured in lumen/m² = lux.

⁵ IMO Circ. 982/Appendix 1/Definition: Luminance is the amount per unit area emitted or reflected from a surface and is measured in candela per square meters (cd/m²).

⁶ BS ISO 8468:2007 "Ships and marine technology - Ship's bridge layout and associated equipment - requirements and Guidelines" as referenced in MSC/Circ.982/Appendix 3 "Existing international standards dealing with ergonomic criteria for bridge equipment and layout". Also related to SOLAS Chapter V/Reg. 15 "Principles relating to bridge design, design and arrangement of navigational systems and equipment and bridge procedures".

Further in following par. 7 “Lighting” sub. 7.4.1 it is recorded that “a *satisfactory level of lighting shall be available to enable the bridge personnel to complete such tasks as chart at sea, and maintenance and office work in port, by daylight or darkness*”.

Taking into consideration the aforementioned it is deduced that the documentation office mounted in Europolink’s bridge should be a workplace for office work only during port and the desk top computer and table lamp should have not been fitted on it or been used during navigation, especially in night time⁷.

It is considered highly possible that the clerical work conducted by the Chief Officer using the desk top computer deteriorated the vigilance as well as the visual observation and monitoring of the sailing boat, sailing at Europolink’s port bow and consequently it is presumed as a contributing factor in the examined case.

4.6. Main navigational equipment & aids

4.6.1 Navigational Charts

Europolink primary means of navigation were standard paper Nautical Charts of British Admiralty while Electronic Navigational Charts were also provided through the ECDIS system, installed as a component of her centralized Navigation Control System.

Based on the above the navigating Officer could either monitor Europolink’s passage from the paper charts by entering fixes or continuously check and control her followed courses electronically through ECDIS and Radar, fitted in the main navigation console.

Her passage plan was plotted on the voyage paper charts as well as in ECDIS, allowing the Officer on the watch to electronically monitor her track and execute course progress from his posted position.

4.6.2 Radars

Europolink was equipped with 02 desk top display Sperry Marine Bridge Master “E” Radars (figures 4.6.2/ 1 & 2).

The X-band (9 GHz) Radar was mounted on the starboard side of the central console and the S-Band (3 GHz) Radar was installed on central console’s port side configuring utilities such as Electronic Plotting Aid, Automatic Tracking Aid, Automatic Radar Plotting Aid, plotting courses, automatic and manual target acquisition, guard zones, targets alarms etc. Both radars had also capabilities of displaying AIS data enhancing the OOW’s situational awareness by providing real time data on a target ship’s position and courses.

The incorporated capabilities provided enhanced situational awareness to the OOW as well as effective and efficient navigation.

At the night of the marine accident, both radars were operating.

The 2nd Officer on the watch was utilizing the port S-Band radar operating at the range of 03 nm and the Master was using the starboard X-Band at 3nm of range too.

⁷ HBMCI Investigation team having carried out targeted visits on 07 ROPAX operating in domestic and international voyages in order to ascertain if documentation offices were located in any of their bridges, found that only one ROPAX built in 2000 by Fincatiery Shipyard had one documentation office which however was not equipped with a computer or table lamp. Relevant photos are attached in Appendix 5.

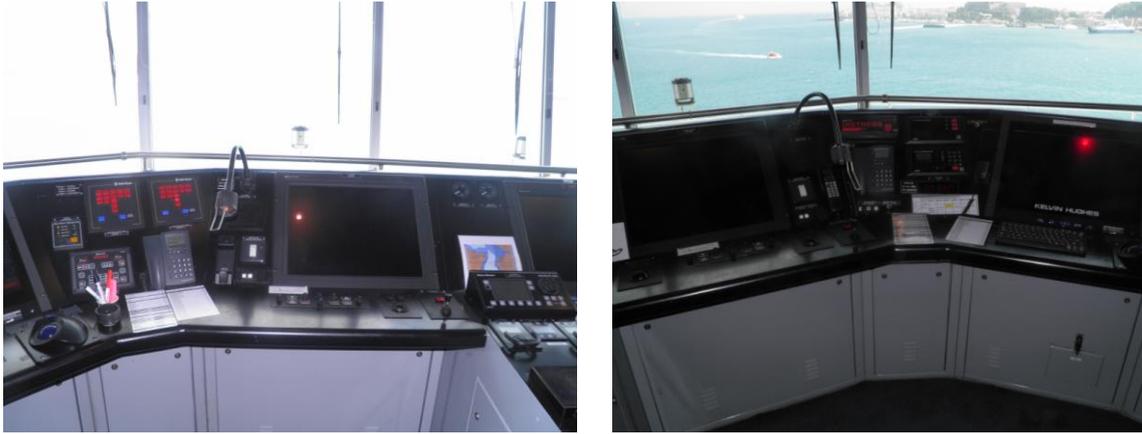


Fig. 4.6.2/ 1&2: S-band Radar and X-band Radar fitted in navigating console's port and starboard side respectively

4.6.3 ECDIS

Europalink's navigation console was fitted with two advanced "Kelvin Hughes"⁸ Electronic Chart Display and Information Systems (figure 4.6.3/1 & 2).



Fig. 4.6.3/1&2: ECDIS systems fitted in navigating console's port and starboard side respectively

They were offering a large cluster of features to the OOW, indicatively such as:

- **situational awareness**, by displaying ship's navigation parameters, with own ship graphic, heading, track and route on the chart;
- **route monitoring** of vessel's position against the planned track look ahead is also performed with warnings generation;
- **navigation tools** with range and bearing cursors, manual fixing and traditional route planning tools;
- **route planning**, by using drag and drop waypoints, defining channel widths, turn radius and planned speeds for each leg check, planned routes against safety parameters of the ship before activation rhumb line, great circle lengths and traditional planning tools with radar transfer;
- **vessel position prediction**, a useful tool providing close quarter manoeuvring on large chart scales and graphics used to show up to 6 minutes forward prediction of vessel's position;

⁸ Notice: Europalink ECDIS system as recorded in her "Passengers Ship Safety Equipment" Record was probably erroneously listed to be a Sperry Marine VMS-Naviecdis.

- **alarm functionality**, in order to alert the OOW if a safety set parameter is predicted to be or is breached;
- **track control**, allowing the autopilot to receive steering instructions from the ECDIS according to preset parameters; and transfer data to the radar to facilitate the presentation of curved heading line showing the turn to be executed.

In view of the above, both conning positions were equipped with electronic navigational aids providing advanced and advantageous easy to use and time saving features for enabling the OOW to monitor the passage planning, navigate safely and effectively perform the watchkeeping duties.

4.6.4 Autopilot

Europalink was equipped with two Sperry Marine “Navipilot 4000”, fitted at each navigational watch positions easy to operate by both OOW from their sitting positions (figure 4.6.4/1).

The autopilot model was featuring dynamic real time course adjustments for accurate steering and self turning adaptation offering operational safety and efficient steering. It was furthermore presenting optimized handling with easy to use hard keys, analogue selection of set heading by means of the control disk and other major parameters by means of soft keys shown on a LCD display.



Fig. 4.6.4/1: Autopilot devices systems fitted in front to each navigating sitting positions.

4.6.5 Rate of Turn indicator

The Rate of Turn Indicator, provided by SOLAS/Chapter V/Reg. 19 “Carriage requirements for shipborne navigational systems and equipment” par. 2.9.1, was fitted together with the other heading and steering instruments over the bridge front windows and could be easily observed by the watchkeeping personnel (figure 4.6.5/1).

The ROT unit was interfacing with ECDIS and ARPA and the indications of Europalink’s turning in degrees per minute were also presented in their displayed data.



Fig. 4.6.5/1: Rate of turn indicator fitted over the bridge front windows.

4.6.6 Navigational performance

Having examined Europolink's critical navigational equipment and aids no problems were reported or difficulties in their operation.

In view of the above and taking into consideration that notwithstanding Europolink's bridge was fully equipped with modernized up-to-date navigational equipment it is inferred that the navigational team performance was poor and the bridge team failed to effectively monitor her navigation and safely direct her through the passage of Peristerai. The lack of effectively utilizing the navigational data and information sourced from Europolink's navigational equipment by the watchkeeping team is considered to have been a contributing factor in the examined marine accident.

4.7 Passage planning

STCW Convention & Codes, Manila Amendments 2011/Chapter VIII/Part 2 "Voyage planning" sets out the general requirements for the obligation of the Masters to plan the intended voyage taking into account all pertinent data that amongst others concern the "up to date" information regarding navigational limitations and hazards which are of a permanent or predictable nature and which are relevant to the safe navigation of the ship. Withal SOLAS/Chapter V/Reg. 34, as applied, determines the fundamental principles for "Safe navigation and avoidance of dangerous situations" in relation to the Master's obligation to ensure that the intended voyage has been planned using the appropriate nautical charts and publications and also determining a route which inter alia ensures sufficient sea room for the safe passage of the ship throughout the voyage and anticipates all known navigational hazards.

Furthermore, aforementioned SOLAS Regulation addresses the "Guidelines for voyage planning", that were established by IMO Assembly Resolution 893 (20), to be taken into account by Masters when developing the passage plan with the objective to safely and effectively navigate a vessel and to monitor the progress and execution of the planned routes.

In particular, aforementioned resolution conceives passage planning as a four phases procedure, that is:

→ **appraisal**, pertain to all information relevant to the contemplated voyage to be considered;

Appraisal phase, includes seven basic factors that should be taken into account while the hindmost under the title "any relevant up-to date additional information", is subdivided to nine important items that inter alia include the following, pertinent to the examining case, factors:

Item 6: "*volume of traffic likely to be encountered throughout the voyage or passage*" and;

Item 9: *“any additional items pertinent the type of the vessel or its cargo, the particular areas the vessel will traverse, and the type of voyage or passage to be undertaken”.*

- **planning**, preparing the voyage plan on the basis of the fullest possible appraisal, covering the whole voyage from berth to berth.
Planning phase or procedure, foresees two main factors to be considered whilst underlines, without being exhaustive, a list of nine primary items that deemed critical to ensure safety of life at sea, safety and efficiency of navigation, and protection of the marine environment during the intended voyage or passage. Aforementioned list, amongst others, includes two items directly related with the examining case such as:
Item 1. *“safe speed, having regard to the proximity of navigational hazards along the intended route or track, the manoeuvring characteristics of the vessel and its draught in relation to the available water depth;”*
Item 2. *“necessary speed alterations en route, e.g., where there may be limitations because of night passage, tidal restrictions, or allowance for the increase of draught due to squat and heel effect when turning;”*
- **execution**, the conduct of the passage in accordance with the plan or any changes made thereto.
Execution phase, presents five factors that should be taken into account when carrying out the plan with the last factor referring to the *“traffic conditions, especially at navigational focal point”*.
- **monitoring**, the progress of the vessel in accordance with the voyage close and continuous control.
Monitoring phase does not require any specific factors or items to be considered, as it falls under the relevant provisions for watchkeeping duties of STCW Code and respective rules of COLREGS.

4.7.1 Eurolink’s Passage planning

The Company, recognizing the importance of the voyage planning procedures for the ships’ safety, had provided fleet-widely, a specific publication “Passage Planning - Principles and Practice”, as a guide for the passage planning preparation, based on IMO Resolution A. 893 (20).

In view of the above mentioned regulated framework, Eurolink’s voyage plan had been developed prior to her departure from Patras port and was including all passage segments from Patras to Igoumenitsa Channel Entrance, from the Channel Entrance to Igoumenitsa passenger terminal and from Igoumenitsa to Ancona port.

Based on the respective provisions given through her Safety Management Manual (Section 4 “Organization on board”⁹), the 3rd Officer was assigned with the passage planning preparation which was approved by the Master and was respectively acknowledged by the watchkeeping Officers (see [Appendix 4](#)).

The voyage plan routes were plotted on the appropriate nautical charts and were also entered and displayed on Eurolink ECDIS system.

Under the requirements of ISM Code/Chapter 7 “Shipboard operations”¹⁰, Eurolink’s Safety Management Manual, in Section 12.2 “Procedures and instructions” - “Safety

⁹ ISM Code/Chapter 3 “Company responsibilities and authority”.

Par. 3.2 The Company should define and document the responsibility, authority and interrelation of all personnel who manage, perform and verify work relating to and affecting safety and pollution prevention.

¹⁰ The Company should establish procedures, plans and instructions, including checklist as appropriate, for key shipboard operations concerning the safety of the personnel, ship and protection of the environment. The various tasks should be defined and assigned to qualified personnel.

during navigation, anchoring and manoeuvres” laid down specific instructions for the voyage and passage planning preparation that had to be taken into account by the assigned Officer.

The incorporated instructions referred in Europolink Safety Management Manual, Section 12.2.2 that deemed pertinent to the examined case, inter alia emphasized that:

- no-go-areas should be marked on the nautical charts;
- the Master is high principled to decide the limits of no-go-areas in view of deriving factors such as local restrictions, limited depth, currents etc.;
- voyage plan must be planned in view of possible dangers and difficulties that may be encountered (e.g. shallow waters in relation to the immersion of the ship, large variations in tides, crossing narrow channels, crossing areas with strong undertow etc.)

Likewise, Safety Management Manual referred section was itemizing a cluster of elements to be considered during the voyage planning and to be recorded in a specific “Voyage Planning” form, as presented in the following table 4.7.1 / 1.

1	ship data and voyage number	14	under keel clearance
2	departure/arrival dates, drafts, air draft	15	minimum safe distance to be kept from obstacles
3	way points	16	positioning methods (GPS etc.)
4	way point coordinates	17	current data – speed/direction
5	date on which the way points are expected to be passed	18	need to be on stand by in the engine room
6	route between two consecutive way points	19	tidal data (times-heights)
7	estimated speed between way points	20	miles between pilot embarkation and berth and vice versa
8	distance in miles between the way points	21	miles between locks and berth and vice versa
9	miles to arrival	22	ports of refuge
10	nautical charts to use	23	nautical publications to be consulted
11	ship reporting systems (ARES/IMOT etc.)	24	use of traffic separation schemes
12	VTS stations to contact and radio channels	25	any additional information
13	MARPOL special areas		

Table 4.7.1 / 1: Voyage planning itemized elements.

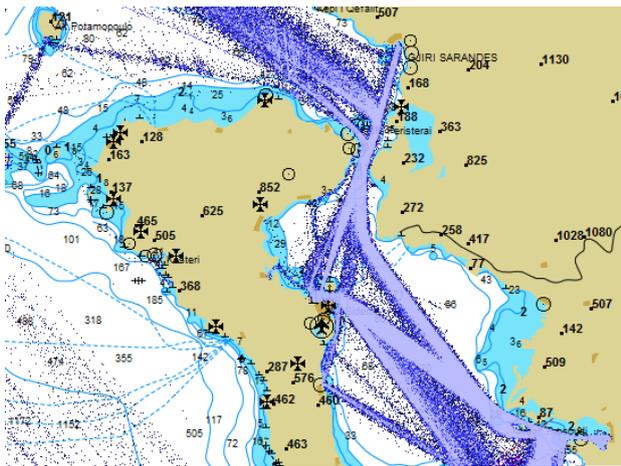
Considering the above, it derives that the instructions given through the Company’s Safety Management System in relation to voyage planning, although to some extent detailed, were not encompassing the issue of marine traffic, that could be anticipated or likely to be encountered, as a parameter to be taken into account when navigating in narrow channels or near coastal waters.

It is noted that Corfu Channel as well as its north and north east waters, are sea areas that appear to be of increased marine traffic, especially from May to October. The experiencing traffic mostly concerns small passenger vessels and high speed crafts that operate between Othonoi Island (12 nm northwest of Corfu) as well as between Corfu and Albanian ports. However, referred itineraries are generally conducted during day time.

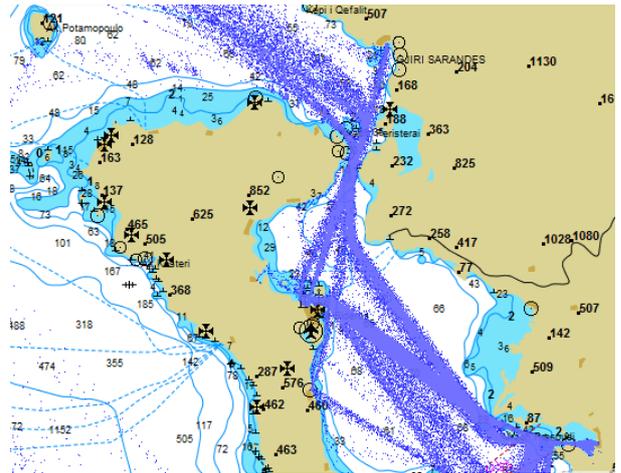
ROPAX’s Adriatic Routes passages are always plotted and executed through Corfu Channel.

Additionally, Corfu Channel sea area and further to its north boundaries, is also experiencing sailing boats and motor yachts traffic, mainly from May to the begging of October while small coastal fishing boats and trawlers are operating during day and night time throughout the year.

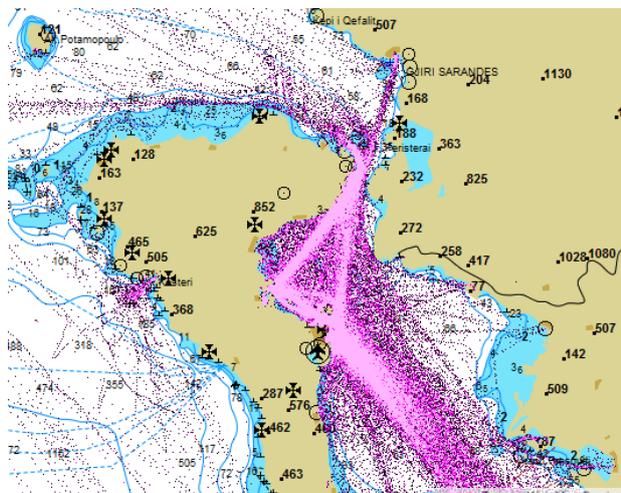
Indicative marine traffic in said areas for the years 2013 and 2014 is presented below, as sourced through AIS Marine Traffic (figures 4.7.1 / 1 to 6).



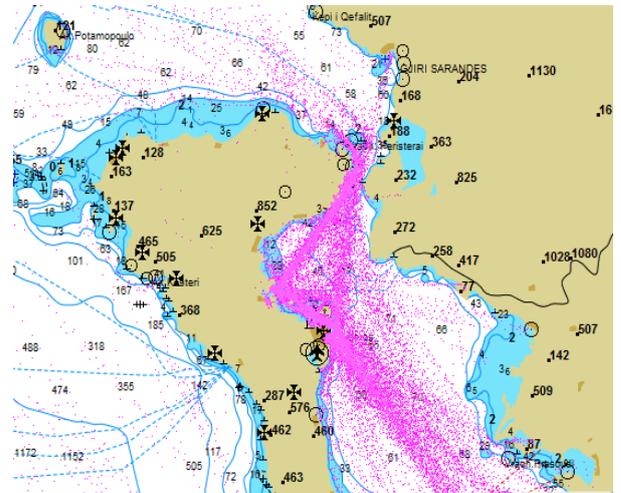
Passenger including ropax- high speed crafts 2014



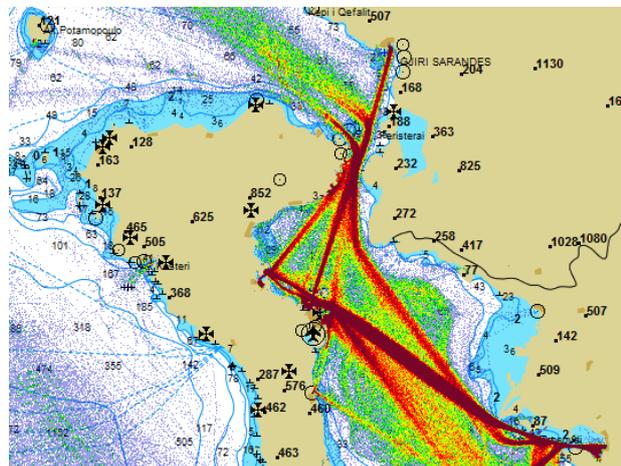
Passenger including ropax- high speed crafts 2013



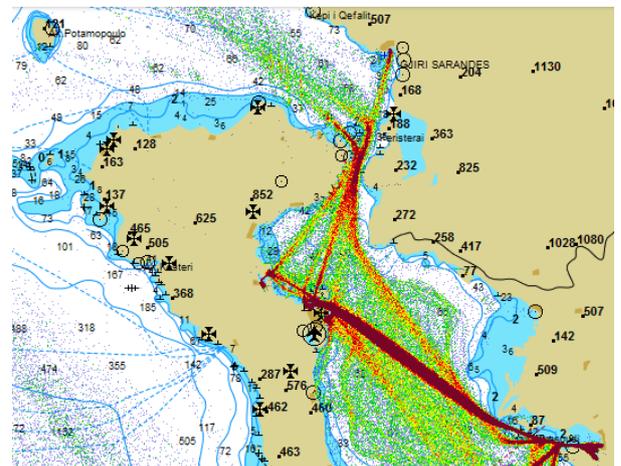
Recreational crafts 2014



Recreational crafts 2013



All traffic 2014



All traffic 2013

When viewing “All traffic”, the colour coding represents traffic density in each area, as shown in following bar density indicator:



figures 4.7.1 / 1 to 6: Indicative marine traffic in the Corfu Channel sea area for the years 2013 and 2014. (source: AIS Marine Traffic)

In view of the above, it arises that had a specific instruction been recorded in relevant Europalink’s Manual Section 12.2.2 (ii) and its emanating “voyage planning form” to draw the attention to the appointed Officers for the voyage planning as well as to Masters for identifying narrow channels with anticipated or likely to be encountered marine traffic,

as no-go-areas, if the option for another route is eligible, the passage planning would probably have been directed to “Peristerai outer passage” and the marine casualty would have not occurred.

The failure to encompass all factors given by Resolution A.893 (20) “Guidelines for voyage planning”, is considered to have been a contributing factor into the examined marine accident.

4.7.2 Europolink’s Passage planning appraisal from Igoumenitsa to Ancona

Europolink’s voyage segment from Igoumenitsa to Ancona was prepared according to the FM/USQA/VR/MDG/027 form by the 3rd Officer, as provided through her Safety Management Manual and was approved by the Master.

The prepared voyage segments were the routine passages that were navigated while Europolink was executing the round-itineraries in the Adriatic Routes that linked Greece and Italy.

The so called “Peristerai inner passage” was planned to be navigated following the exit of Corfu Channel and was actually leading to the next voyage segment at open sea, towards Ancona.

The investigation process has highlighted that despite the fact that “Peristerai inner passage” was a route that offered a width of approximately 0.5 nm navigable waters, most of the ROPAX vessels operated in the same itinerary with Europolink were following the “outer passage” east of Peristerai Islet maintaining their service speed, in order to avoid any navigational dangerous situations, such as head on or crossing, give-way or stand-on vessel situations etc.

As already stated, the sea areas between Peristerai Islet and the northeast coast of Corfu, although not considered a passage for cargo vessels, are areas navigated by pleasure yachts and sailboats usually on passage under sails that may sail or navigate with variable courses, especially during the holidays period, as well as by small fishing boats, fishing in the approaches of the formulated narrow channel, as previously mentioned in par. 4.7.1.

The option to navigate through the “inner passage” was only offering a less than 0.5nm saving of running distance that was almost 02 minutes less navigating time until the next port of Ancona.

Having scrutinized the aforementioned, it is considered that Europolink voyage planning for the specific voyage segment was not developed in full regard of all given or likely to be encountered parameters.

The failure to fully appraise the passage planning procedure is deemed to have been a contributing factor into the impact of Europolink on Peristerai Islet.

4.7.3 Europolink’s Passage planning execution from Igoumenitsa to Ancona

4.7.3.1 Courses planning execution

On the day of the marine casualty the execution of the planned passage during its commencement from Igoumenitsa was mostly following the plotted routes. Nevertheless, by the time Europolink was approaching Superfast II a minor deviation from the plotted planned course was carried out, by 4° to port, approximately post to WP no 3 and was maintained throughout Europolink passage in Corfu straight, as she was gradually overtaking the stand-on ROPAX Superfast II.

By the time Europolink was inbound to “Peristerai inner passage”, the followed course was still slightly to port from the plotted on ECDIS, however the observed and plotted target on her port side, led the Master to decide to alter her course slightly to starboard, nevertheless she was still being out of the plotted planned route on ECDIS.

Based on the information collected during the interview process and the navigational data available, it is inferred that neither the Master nor the watchkeeping Officer reassessed the evolving situation in order to take any actions considering that the original plotted passage plan was not in accordance with the executed, as deemed appropriate under the “execution phase” of voyage planning guidelines (IMO Res. A.893(20)).

It is considered likely that had the Master decided, or the OOW advised, to reassess the projected voyage plan, based on the encountering traffic conditions, appropriate actions such as manual steering or speed reducing, would have been taken and Europolink would probably have avoided the impact on Peristerai Islet.

The lack of the effectively execute the passage planning is considered to have been a contributing factor into the examined marine accident.

4.7.3.2 Passage planning speed

According to Europolink’s passage plan her sailing speed was planned to be kept at 24 knots after exiting Igoumenitsa Channel. The same speed was further planned at the same rate apart from the small voyage segment of approximately 1.3 nm after exiting Corfu Channel and entering Peristerai Passage.

Europolink speed reducing during her passage through Peristerai Islet is considered to fall within the passage appraisal and planning phases parameters as already recorded in par. 4.7, that is:

- volume of traffic likely to be encountered throughout the voyage or passage;
- any additional items pertinent to the type of the vessel or its cargo, the particular areas the vessel will traverse, and to the type of voyage or passage to be undertaken;
- safe speed, having regard to the proximity of navigational hazards along the intended route or track, the maneuvering characteristics of the vessel and its draught in relation to the available water depth;
- necessary speed alterations en route, e.g. where there may be limitations because of night passage, tidal restrictions, or allowance for the increase of draught due to squat and heel effect when turning;

and seemingly within the instructions given through Europolink Safety Management System reported in par. 4.7.1.

However, neither the Master decided to reduce her speed to 20 knots as planned nor the OOW advised the Master to follow the voyage plan speed for the specific part of the passage, probably due to the fact that Europolink was behind her scheduled itinerary and the Master was making up for the delay.

Seeing the aforementioned, it is presumed that had the Master reduced Europolink’s speed to 20 knots, as provided by the voyage plan it is highly possible that her turning circle advance and turning radius could have been respectively reduced and she could have made a timely and safe turn that could have led to her safe passage.

The lack of the voyage plan speed full implementation is presumed to have been a contributing factor in the examined case.

4.7.4 Europolink’s Passage planning monitoring from Igoumenitsa to Ancona

Europolink bridge team at the night of the marine casualty was electronically monitoring the progress of her passage through the ECDIS system, installed on the main navigation console. The OOW was also entering fixes on the charted courses, when practicable, using GPS and RADAR.

By the time Europolink was inbound to “Peristerai inner passage” her course was monitored through ECDIS and ARPA systems facilitating simultaneous plotted route and

actual course monitoring which could easily lead to decision making for the safe conduct of her passage.

However, the evolving situation that led to the impact of Europolink on Peristerai shelves, indicated that the bridge team was not closely and continuously monitoring the progress of her passage in relation to the plotted voyage plan.

The ineffective Europolink's passage plan monitoring is suggested to have been a contributing factor in the examined case.

4.7.5 Risk assessment

4.7.5.1 General requirements

The International Safety Management Code (ISM Code-SOLAS 74), as applied in Chapter. 1.2.2 & 1.2.2.2 states that: "The Safety Management objectives of the Company should inter alia assess all identified risks to its ships, personnel and the environment and to establish appropriate safeguards".

Even though, the ISM Code does not provide any further explicit reference apart from the above general requirement, risk assessment¹¹ or risk analysis is fundamental for the compliance with most of the Code's clauses.

It is to be noted that although there is not an exact formal definition of risk, IMO defines it as: "The combination of the frequency and the severity of the consequence".¹²

The risks concerned are those that are reasonably expected and are related to shipborne procedures or operations in respect to:

- the health and safety of all those who are directly or indirectly involved in the activity, or who may be otherwise affected;
- the property of the company and others;
- the environment.

A hazard could be defined as a situation or practice that has the potential to cause harm. Hence a risk analysis process or management of risk could concisely include the following phases:

- the identification of hazards;
- the assessment of the risks associated with those hazards;
- the application of controls to reduce the risks that are deemed intolerable.

The controls may be applied either to reduce the likelihood of occurrence of an adverse event, or to reduce the severity of the consequences;

- the monitoring of the effectiveness of the controls.

The ISM Code does not lay down any particular venue models to the management of risk and therefore the company is to stipulate methods in view of its organizational structure, its ships and operations. The methods should be systematic, if assessment and response are to be complete and effective, and the procedures should be documented so as to provide evidence for the decision-making process.

¹¹ Risk management may be defined as: "The process whereby decisions are made to accept a known or assessed risk and/or the implementation of actions to reduce the consequences or probability of occurrence." (ISO 8402:1995/BS 4778)

¹² Reference to (MSC Circ.1023/MEPC Circ.392)

4.7.5.2 Europolink risk assessment

The risk assessment policy of Europolink was thoroughly promulgated through her SMS providing procedures for conducting risk assessments to key shipboard activities by the safety or responsible officers and to be recorded in specific checklist and documented.

Nevertheless, the instructions projected in SMS was indicatively referred to the Dardanelles Strait, Bosphorus strait, Panama Canal, Suez Canal, Messina Strait, Bonifacio Strait and Dover Strait while Corfu Channel and Peristerai Islet surroundings passages were not included.

However, a risk assessment process should have been conducted for the passage plan prepared in order to identify any risks or hazards that could be encountered on the grounds of COLREGS and STCW respective requirements related with safety of navigation and taking into account the appraisal phase of voyage planning in relation to local traffic conditions, restricted waters etc.

Seeing the afforested, it is inferred that had a risk assessment been conducted for the voyage plan to be executed in order to identify potential navigational hazards and dangerous situations for the specific period of the year that is considered to be of high small recreational crafts and fishing boats traffic, it is highly possible that Peristerai passage would have been identified as sea area to present potentials risks to navigation. The failure to conduct the risk assessment procedure for the intended voyage plan is considered to have been a contributing factor in the examined marine casualty.

4.8 Navigational Watchkeeping

Bridge watchkeeping is regarded as the most important procedure when a vessel is at sea and hence it is essential that officers in charge of the navigational watch appreciate that the efficient performance of their duties is necessary in the interests of the safety of life and property at sea and of preventing pollution of the marine environment¹³.

In view of the above international rules and regulations are dealing with the important issue of keeping a safe navigational watch.

4.8.1 COLREGS - Proper Look Out & Safe Speed

4.8.1.1 Proper Look Out

COLREGS '72, as applied in rule 5 requires that:

“Every vessel shall at all times maintain a proper look-out by sight and hearing as well as by all available means appropriate in the prevailing circumstances and conditions so as to make a full appraisal of the situation and of the risk of collision”.

“Look out” aspect is also sharply defined in STCW Code/Part A/Chapter VIII/ Part 4-1, par. 14 stating that:

“14. A proper lookout shall be maintained at all times in compliance with rule 5 of the International Regulations for Preventing Collisions at Sea, 1972, as amended and shall serve the purpose of:

- .1 maintaining a continuous state of vigilance by sight and hearing, as well as by all other available means, with regard to any significant change in the operating environment;*
- .2 fully appraising the situation and the risk of collision, stranding and other dangers to navigation; and*

¹³ Reference to STCW Code/Part B/Part 4-1/par. 3

.3 detecting ships or aircraft in distress, shipwrecked persons, wrecks, debris and other hazards to safe navigation.

During Europolink's passage through Corfu Channel and by the time she was exiting it, the Master and the Navigating Officer on the watch were maintaining a proper look-out. The sailing boat that appeared ahead and slightly to port of Europolink was early detected through ARPA and respectively acquired and plotted.

The acquired sailboat's position and course were displayed in Master's and 2nd Officer's ARPA and ECDIS displays, offering awareness of the situation that was to be evolved, as Europolink was speedily approaching her next voyage waypoint.

4.8.1.2 Safe Speed

COLREGS '72, as applied in rule 6 requires that:

"Every vessel shall at all times proceed at a safe speed so that she can take proper and effective action to avoid collision and be stopped within a distance appropriate to the prevailing circumstances and conditions."

Further specific factors are listed that have to be taken into account by all vessels in determining a safe speed.

Apart from the general rule, at least two factors are considered to be pertinent with the examined case, that is:

- the traffic density including concentrations of fishing vessels or any other vessels;
- the manoeuvrability of the vessel with special reference to stopping distance and turning ability in the prevailing conditions;
- the proximity of navigational hazards;
- the draught in relation to the available depth of water.

Rule 6 adherence is a critical factor for a vessel's safe passage at all times. It is directly related with Rule no 5 and both lead to safe decision making for a safe passage progress as the OOW is required to pay attention to the encountering conditions and navigational situations as well as to those that are anticipated to be encountered.

The determination of an appropriate speed can support effective decisions and time to elaborate data and information for prompt actions in order to avoid collision, navigational hazards etc. Safe speed should not be overlooked and disregarded for commercial purposes as such a decision could lead to unsafe speed and hazardous situations.

In the examined case Europolink safe speed was not maintained at least for the voyage segment of Peristerai passage as already reported in par. 4.7.3.2.

Apart from the above and taking into account that prior to the accident she was overtaking Superfast II while navigating in Corfu Channel, an area with restricted waters, it is considered that maintained speed had not been decided under the respective provisions of COLREGS.

In view of the above it is inferred that safe speed COLREGS rule was disregarded by the Master and is considered to have been a contributing factor in the examined case.

4.8.2 Situational Awareness

Situational awareness is the perception of the elements in the external and internal environment, the understanding of their meaning and the projection of their status in the near future that is considered to be linked with COLREGS rule 5 "Proper Look out and indirectly with rule 6 "Safe speed".

It is construed as a critical element for standard watch management and safe navigation, broadly involving human performance under the influence of environmental, personal, organizational and informational factors.

In conclusion, it is the accurate perception of factors and conditions that affect the vessel's safety during a specified period of time.

Situational awareness is one of the elements included in STCW/Chapter II/Section “Table A-II/1” for the function: “Navigation at the operational level”, related with the knowledge, understanding and proficiency of the navigational Officer whilst in Section/Table A-II/2 for the function: “Navigation at the management level” is pertinent to the knowledge, understanding and proficiency of the Master and the Chief Officer. The competency for both functions is demonstrated through seagoing experience and training.

4.8.2.1 The Master’s situational awareness

According to the collected data as well as VDR voice recordings, it was presumed that the situation on the bridge, minutes before the accident, was controlled by the Master and considering his seagoing experience it is deduced that he was confident with the evolving situation.

As the Master was following a routine passage, repeatedly executed, he was self-assured that Europolink would make a turn to port in time to follow the next course plotted in ECDIS.

Based on the evolving situation it is deduced that Europolink course and rate of turn data through ECDIS were not properly monitored or were disregarded as no maneuvering actions were taken, until seconds before the impact, that is at the time hand steering was ordered.

Consequently, it is inferred that by the time Europolink course was being altered to port, the Master was believably under complacency status probably due to his overconfidence that led to the loss of his situational awareness refraining him from taking prompt and vigilant actions. Said conclusion is also supported by the fact that the Master did not order the two stand by steering pumps to be activated as it was an action carried out by the Chief Officer’s own initiative who was not forming part of the navigational watch.

In regard to the above it is presumed that Master’s loss of situational awareness to take prompt vigilant actions have been a contributing factor in the examined case.

4.8.2.2 The 2nd Officer’s situational awareness

Based on Europolink’s watchkeeping arrangement, the 2nd Officer was the OOW, yet he was performing his duties under the supervision and orders of the Master, as following her departure from Igoumenitsa, she had to sail Corfu Channel and navigate in confined waters near the coastline.

As, according to the interviews information, the Master had the Con, he ordered the 2nd Officer to initiate the course alternation as soon as the plotted nearby sailing boat mast light would be observed abeam of Europolink’s port wing.

Having examined the aforementioned as well as the rate of turn of Europolink by the time the 2nd Officer started adjusting the autopilot by pressing the turn button, it was inferred that the “turn executing Officer” had realized the slow turning response of Europolink and he continued by firmly increasing the rate of turn practically by speeding up the setting degrees.

Prior to that time it is presumed that the 2nd Officer had lost his situational awareness by not properly assessing the informational factors sourced through the navigational aids of ECDIS and ARPA along with the accurate perception of the navigated sea area that could lead to proper actions such as an early report to the Master. In fact, the evolving dangerous situation was not perceived as such at any moment and it was the Master that having realized the imminent danger of grounding, took over the turning execution and ordered to set the manual steering in order to perform a faster turn.

The 2nd Officer’s loss of situational awareness is also supported by the fact that it was the Chief Officer that took action and activated the stand by steering pumps who happened to be present on the bridge.

The 2nd Officer’s loss of situational awareness is considered to have been a contributing factor into the examined marine accident.

4.8.3 Bridge Resource Management (BRM)

4.8.3.1 BRM general provisions

STCW Convention & Codes, Manila Amendments 2010/Chapter II/Section A-II/1 sets out the “Mandatory minimum requirements for certification of officers in charge of a navigational watch on ships of 500 gross tonnage or more”.

Table A-II/1 of said section specifies the “minimum standard of competence for officers in charge of a navigational watch on ships of 500 gross tonnage or more”.

The respective Columns of the Table in “Function: Navigation at the operational level” determines the subjects of competency for OsOW in respect to safety of navigation and watch.

Bridge Resource Management (BRM) principals, introduce an important aspect for Masters and Officers in Charge of navigational watch.

BRM is 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. In conclusion optimized bridge resource management shields safe navigation by fully utilizing all the technical advantages of bridge navigational equipment, maintaining the situational awareness of the watchkeeping Officers as well as appropriate communication and exchange of information at all levels of the bridge team.

More specifically, under STCW Code/Part A/Chapter VIII/Part 3 “Watchkeeping Principles in general” the Bridge Resource Management principals have been introduced while Chapter VIII/Part 4-1 have laid down a set of mandatory “principals to be observed in keeping a navigational watch”.

Aforementioned provisions incorporate instructions to ensure that Masters take all the appropriate actions for the bridge watch arrangement and management, and the Navigational Officers perform their duties effectively.

To that end the bridge team is assisted for the command decision making and possible failures are blocked and counteracted to avoid or lessen consequences of a likely to occur marine accident.

Bridge Resource Management (BRM) or Engine-room Resource Management (ERM) training is not required to be completed until 1 January 2017 (STCW.7/Circ.17- 24 May 2011).

4.8.3.2 Europolink’s BRM performance

In the examined case it was emerged that certain tasks and functions, as foreseen and emanating through said STCW Code applicable standards, were not observed in full by the Master and the OOW.

An abstract of the provisions, as numbered in the respective parts of the Code, that are considered to be linked and pertinent to the sequence of events leading to the examined marine accident, is presented in below table 4.8.3.2 / 1.

STCW Code Part A/Chapter VIII/Part 3
Watchkeeping Principles In general
8. Watches shall be carried out based on the following bridge and engine-room resource management principles:
understanding of watchkeeping personnel regarding their individual roles, responsibility and team roles shall be established;
the master, chief engineer officer and officer in charge of watch duties shall maintain a proper watch, making the most effective use of the resources available, such as information, installations/equipment and other personnel;

7. information from the stations/installations/equipment shall be appropriately shared by all the watchkeeping personnel;
8. watchkeeping personnel shall maintain an exchange of appropriate communication in any situation;
STCW Code Part A/ Chapter VIII/Part 4-1
Watchkeeping at sea / Principles applying to watchkeeping generally
9. Parties shall direct the attention of companies, masters, chief engineer officers and watchkeeping personnel to the following principles, which shall be observed to ensure that safe watches are maintained at all times.
10. The master of every ship is bound to ensure that watchkeeping arrangements are adequate for maintaining a safe navigational or cargo watch. Under the master's general direction, the officers of the navigational watch are responsible for navigating the ship safely during their periods of duty, when they will be particularly concerned with avoiding collision and stranding.
Look out
15. The lookout must be able to give full attention to the keeping of a proper lookout and no other duties shall be undertaken or assigned which could interfere with that task.

Table 4.8.3.2 / 1: STCW provisions linked with the examined case

In the same direction, the same Part 4-1 of the Code, under the title “Performing the navigational watch” in par. 24.3, provides that:

“24. The officer in charge of the navigational watch shall:

.3 continue to be responsible for the safe navigation of the ship, despite the presence of the master on the bridge, until informed specifically that the master has assumed that responsibility and this is mutually understood.”

Said provision had also been incorporated in Master's Standing orders by addressing a specific order to be adhered by the Bridge Teams, as follows:

“The exact time in which the Master takes/leave the command of the bridge (both during maneuver and during sea passage) shall be clearly specified, understood, and properly recorded into Nautical Log Book)”.

During the examination of the collected data no recording was found in Europolink's Log Book stating that the Master had taken the command of the bridge.

Furthermore, and based on the data deriving from the VDR recordings, it became apparent that, although during the interview process it was alleged that the Master had the Con of the watch, no verbal orders were recorded to have been given to the OOW at any stage of Europolink's passage towards the exit of Corfu-Albania channel or prior to any alternation of her course.

Based on the above it is considered that the Master involvement in Europolink's navigation was exercised whenever it was deemed necessary according to his personal judgment and experience.

Consequently, the OOW, being self-assured under Master's presence, although aware of the evolving situation, could have been led to undervalue and misjudge a prompt turn and the potential dangerous navigational situation, failing to perceive the imminent danger of hitting on Peristerai shelves.

Related to this, the fact that the Master ordered to set steering to manual mode, only until it was foreseeable that the OOW “turning by autopilot” action at waypoint no 4 was not effective, that is less than a minute before the hit on Peristerai shoal reef, further enhances the conclusion that the conning control role was unclear.

In light of the above it is deduced that had Europolink Bridge resource management been sufficiently implemented in particular during her transit from Corfu Channel to Peristerai Passage, it is highly possible that the developed perilous situation would have been recognized and perceived and appropriate actions could have promptly been taken to brake the error chain sequence, such as reduce of speed or earlier order for manual steering as already highlighted.

Europolink Bridge resource management lack of implementation prior to the marine accident is considered to have been a contributing factor in the examined case.

4.9 Master's Standing Orders

ISM Code/Chapter 5.1 provides that: *"The Company should clearly define and document the Master's responsibility with regard to, amongst others, issuing appropriate orders and instructions in clear and simple manner."*

By virtue of said provision the Master issues "The Standing Orders" which is a set of instructions to ensure safe ship navigation and operations whether at sea or at port. This set of directives encompasses a list of navigation aspects and other issues related to ship's safe operation for the Officers to be observed.

Standing Orders are to be followed at all times by the Officer on duty and are duly signed by every Officer on board, making them liable to adhere to the orders. That means that the standing orders are in-force and applicable at all times the ship is at sea, at port or at anchor.

4.9.1 Europolink Master's Standing Orders

The Company, under the aforementioned provision of ISM Code, in Chapter 4 of the Safety Management Manual had charged the Master with the responsibility of issuing "Standing Orders" for the safe and efficient operation of Europolink.

Europolink's Master's Standing Orders were incorporating a list of specific orders related to safe navigation and cargo handling operations.

Furthermore said orders were including an instruction providing that:

"The exact time in which the Master takes/leaves the command of the bridge (both during maneuver and during sea passage) shall be clearly specified, understood and properly recorded into the Nautical Log Book (Giornale Nautico Libro III)."

Aforementioned instruction is considered to be based on STCW/Part 3-1/Principles to be observed in keeping a navigational watch, in which inter alia, in par. 23, it is stated that: *"23 The officer in charge of the navigational watch shall:*

...

.3 continue to be responsible for the safe navigation of the ship, despite the presence of the master on the bridge, until informed specifically that the master has assumed that responsibility and this is mutually understood; and

.4 notify the master when in any doubt as to what action to take in the interest of safety."

During the crew interviews it was stated that at the time Europolink was navigating Corfu Channel bounding for Peristerai inner passage, the Master had the con and he was giving orders to the OOW related to the encountering navigational situation.

As already reported, no recording was found in Europolink's log book indicating the exact time the Master took over the command as it was a practice to stay on the bridge especially in restricted waters while as already mentioned in par. 4.8.3.2, no verbal orders were recorded in VDR to had been given to the OOW at any time towards Europolink exit from Corfu Channel or to any alternation of her course.

On above grounds it is inferred that Masters Standing Orders were not followed in full by the OOW. As a consequence, it is presumed that the Con role was unclear causing ambiguity to the roles and responsibilities of the OOW.

The unclear role of Conning is suggested to have been a contributing factor in the examined marine casualty.

4.10 Environmental Conditions

The environmental conditions at the time prior to the marine casualty were reported to be good. As Europolink was sailing through Corfu Channel, bound for Peristerai

encountering sea state and wind, as shown in table 4.10 / 1 were reported that were not posing any particular concerns on Europolink navigation. Visibility was also reported to be very good and visual observations could be easily practiced by the navigational team.

Sea state	moderate
Wind speed	2-3 beaufort of variable direction
Air temperature	28 ° C
Barometric pressure	1013 mb
Visibility	Very good

Table 4.10 / 1: Actual weather conditions

4.11 Ship damage stability assessment

4.11.1 Special requirements for passenger ships stability

Special requirements concerning passenger ships are foreseen in SOLAS/Chapter II-1/Reg. 8 and Reg. 8-1 as amended by Res. MSC.325(90) “System capabilities after a flooding casualty on passenger ships¹⁴” that came into force on 1 January 2014 . More specifically Reg. 8-1 lays down the requirements for passenger ships to be provided with a computer either on board or ashore which can calculate stability after damage to ship’s compartments which is applicable to passenger vessels constructed after 1 July 2010. Furthermore, referenced Circ. 1400 (2011) in Reg. 8-1 provides guidance on operational information for Masters for safe return to port by own power or under tow for said regulation implementation.

4.11.2 Europolink damage stability data

Europolink that was built in 2007, was equipped with a “NAPA” Loading Master Computer Software System that was installed on the Bridge on the safety monitoring workstation and a second System in the Engine Control Room. The System was used to calculate the vessel’s stability after the cargo loading and could work only on the basis of an intact ship structure. Therefore the System could not be used to assess the stability damage after the ship’s hull breach and consecutive flooding of her compartments.

4.11.3 Europolink damage stability data utilization

As already reported following Europolink impact on Peristerai the Chief Engineer had originally reported to the Master the developed situation in affected and damaged

14 1 Application
 Passenger ships having length, as defined in regulation II-1/2.5, of 120 m or more or having three or more main vertical zones shall comply with the provisions of this regulation.

2 Availability of essential systems in case of flooding damage*
 * Refer to the Interim Explanatory Notes for the assessment of passenger ship systems' capabilities after a fire or flooding casualty (MSC.1/Circ.1369) and Unified Interpretations of SOLAS regulation II-2/21.4 (MSC.1/Circ.1437). A passenger ship constructed on or after 1 July 2010 shall be designed so that the systems specified in regulation II-2/21.4 remain operational when the ship is subject to flooding of any single watertight compartment.

3 Operational information after a flooding casualty
 For the purpose of providing operational information to the Master for safe return to port after a flooding casualty, passenger ships constructed on or after 1 January 2014 shall have:
 .1 onboard stability computer; or
 .2 shore-based support,
 based on guidelines developed by the Organization**.
 ** Refer to the Guidelines on operational information for Masters of passenger ships for safe return to port by own power or under tow (MSC.1/Circ.1400).

compartments due to her raking on the shelves and the flooding progress that led to the initial Master’s decision to return to the Port of Igoumenitsa.

According to information provided through the interview process the evolution of the events and mainly the ongoing flooding was continuously reported to the Master by the Chief Engineer, on information that was practically established through flooding compartments monitoring by the engine crew and CCTV system.

However, the Master’s initial decision to return to Igoumenitsa and at a later time to head to Corfu resulted to be appropriate.

Nevertheless, taking into account that his decision was taken approximately 08 minutes after the occurrence, (see plotted course in Figure 4.11.3 / 1) it is considered that it was to some extent delayed, as the evolution of the events and the time lapse from the casualty event until the approaching and berthing in Corfu proved to be only just sufficient before the hull breaching and flooding consequences were experienced that led to the loss of her propulsion and power.

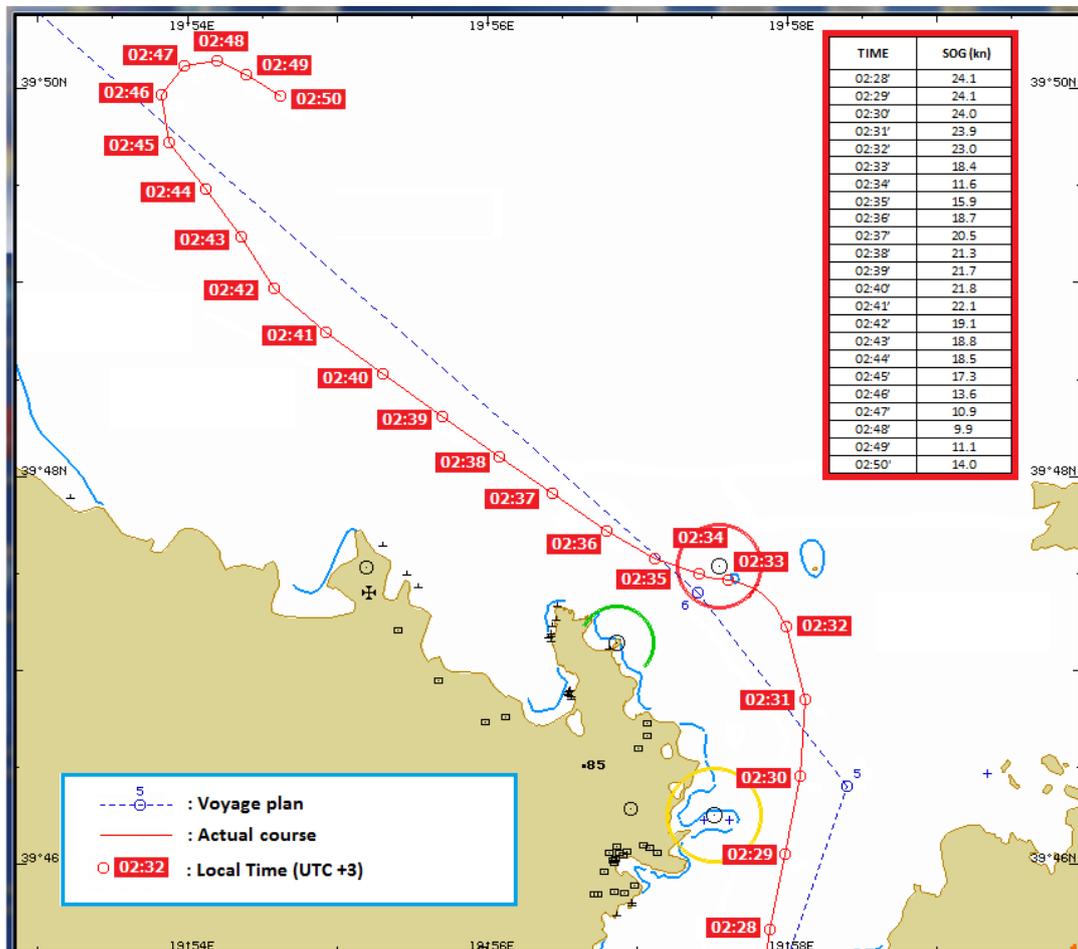


Fig. 4.11.3/1: Actual Route of Europalink a few minutes before and after the grounding (02:33':09"). Her Speed Over Ground (SOG) is shown in attached table.

4.11.4 Safety management emergency response procedures

Europalink Safety Management System incorporated procedures and instructions for emergency situations in Par. 12.7.3 “Emergencies on the ship” as quoted below:

- 12.7.3.1 Unexpected heeling of the ship
- 12.7.3.2 Flooded compartments
- 12.7.3.3 Collision
- 12.7.3.4 Grounding

In particular for “flooded compartments” cases, the following procedures were recorded:

“Par. 12.7.3.2 Flooded compartments

The following procedure must be used:

- (i) check the new state of stability due to the effect of possible free liquids*
- (ii) check the shear stress and bending moments along the ship in the new state: if outside safe limits, these stresses may be reduced by transferring ballast. This operation is only feasible if it does not compromise stability*
- (iii) when transferring ballast, have due regard to the reduction of stability due to the new free liquids caused by filling or emptying compartments*
- (iv) Inform the “**Designated Person Ashore**” as soon as possible*
- (v) Check the integrity of all the compartments adjacent to the flooded compartment*
- (vi) Repeat these checks at least every change of watch*
- (vii) Ensure that the updated position of the ship is available at the satellite terminals and the other automatic distress transmitters, if fitted.*

According to statements following the casualty, the Master informed the Designated Person Ashore and the Company’s Emergency Unit Ashore contacted the technical advisor of R.I.N.A. in order the vessel’s damage stability to be calculated.

However, based on the VDR data, the decision for the ship’s return to the nearest refuge port was made following an assessment of the situation by the Master and the Chief Engineer and prior to any calculations’ results from the prementioned technical advisor ashore.

4.12 Emergency Passengers evacuation**4.12.1 General provisions**

Emergency situations that require the life saving appliances to be serviced for ships’ evacuation are comprehensively addressed and stipulated in SOLAS/Chapter III “Life-Saving Appliances and Arrangements” and relevant provisions.

4.12.2 Europolink emergency passengers’ disembarkation

Europolink 700 passenger full scale evacuation was carried out without considerable problems, despite the fact that her hull was severely damaged, holed and cracked at both sides and flooding was ongoing.

The procedure was planned based on the experience of the Master and Officers as Europolink was berthed alongside and the disembarkation ramp could not be used.

However, it is considered very fortunate that Europolink berthing position at least facilitated the passengers’ exit through the Bunkers station side door. Moreover, during the passengers’ emergency disembarkation that lasted for almost one hour the vessel’s stability did not deteriorate, an event which, if had occurred, could have panicked the passengers, notwithstanding the emergency temporary counter flooding by divers operation (chocking, wedging e.t.c) had not started yet.

4.12.3 Emergency evacuation shore based arrangement at the berthing or safe return port

Several emergency situations that have occurred on board ships either in port or close to them and “safe return to port” option was practiced, have highlighted the necessity of an emergency evacuation arrangement to be supplied by the shore side in cases where the disembarkation decks are not accessible due to the casualty’s consequences (e.g. fire on ro-ro car decks, heavy damaged disembarkation deck and so forth).

In the examined case as already reported, the bow visor, that was the only mean of massive passengers' evacuation access directly to the dock, was not operable leading to a slow evacuation rate through the bunkers station side door.

Aforementioned situations identify similar cases which could be also encountered in ports facilitating either the regular commercial operation of passenger ships (ROPAX, Cruise Ships etc whose emergency occurs while berthed) or the "safe return to port" emergency of a nearby navigating passenger ship such as Eurolink.

4.13 Corfu Channel boundaries' speed limitation

In 1998, Corfu Coast Guard Authority, issued an Order regarding "speed limitation" for ROPAX vessels when navigating the sea areas defined between the parallels of $39^{\circ} 54'$ N and $39^{\circ} 39'$ N as depicted in below figure 4.13/1.



Figure 4.13/1: Limited speed sea area. (Map Source: Google Maps)

The instruction therein provided that ROPAX when transiting the defined areas should maintain a speed of less than 19 knots.

The restriction was posed on the grounds that ROPAX wakes when navigating at high speeds affected the nearby coastline activities. However, eventually since no complaints had been recorded in recent to the occurrence past, the limitation had implicitly become inactive.

The following conclusions, safety measures and safety recommendations should not be taken as a presumption of blame or liability under any circumstances. The juxtaposition of these should not be considered with any order of priority or importance.

5. CONCLUSIONS

(references denote respective parts of the analysis)

5.1 Conclusions and safety issues leading to safety recommendations

- 5.1.1 The loading documentation work was inappropriately conducted on the bridge by the Chief Officer disregarding relevant provision and requirements for bridge watchkeeping (*par. 4.5.1. & 4.5.2.3*).
- 5.1.2 The desk top computer and table lamp fitted on Europolink documentation Office was in contravention with relevant requirements for bridge design and layout arrangement and equipment (*par. 4.5.1, 4.5.2 & 4.5.2.3*).
- 5.1.3 Europolink navigational team performance was poor failing to effectively utilize state of the art navigational aids (*par.4.6.1, 4.6.2, 4.6.3, 4.6.4, 4.6.5 & 4.6.6*).
- 5.1.4 Europolink Safety Management System “Voyage Planning form” was not incorporating in full the requirements foreseen in IMO Resolution A.893 (20) that is volume of traffic in “appraisal planning phase” (*par. 4.7.1*).
- 5.1.5 Europolink voyage planning for Peristerai voyage segment was not developed in full regard of all given or likely to be encountered parameters (*par. 4.7.2*).
- 5.1.6 The execution phase of Europolink voyage plan was not effectively performed under the respective section of IMO Resolution A.893 (20) (*par 4.7.3.1*).
- 5.1.7 The voyage plan speed limit for Peristerai passage segment was disregarded by the Master and the OOW (*par. 4.7.3.2*).
- 5.1.8 The Master was focused in Europolink’s trading operational demands (itinerary) at the cost of her navigational safety (*par. 4.7.3.2 & 4.8.1.2*).
- 5.1.9 Europolink’s passage planning was ineffectively being monitored (*par. 4.7.4*).
- 5.1.10 No risk assessment had been conducted for the intended passage under the prepared voyage plan disregarding respective requirements of International Safety Management (*par. 4.7.5, 4.7.5.1 & 4.7.5.2*).
- 5.1.11 COLREGS safe speed rule was disregarded by the Master (*par. 4.8.1.2*).
- 5.1.12 The Master’s situational awareness had been notably lessen under complacency and overconfident status (*par. 4.8.2 & 4.8.2.1*).
- 5.1.13 The OOW situational awareness had been notably lessen failing to perform a safe turn based on the information sourced from the navigational aids and the external environment (*par. 4.8.2 & 4.8.2.2*).
- 5.1.14 Bridge Resource Management provisions were not practiced by the Master and the OOW (*par. 4.8.3.1 & 4.8.3.2*).
- 5.1.15 The OOW was considered to perform his duties under complacency and self assured status with the Master’s presence on the Bridge (*par. 4.8.2.2*).
- 5.1.16 Master’s Standing Orders in relation to Master’s presence on the bridge were not followed by the OOW (*par. 4.9 & 4.9.1*).

- 5.1.17** The Navigational Command was unclear and put into question watchkeeping roles and responsibilities (**par. 4.9.1, 4.8.2.2 & 4.8.3.2**).
- 5.1.18** Passengers' evacuation and vehicles' discharging was exercised and completed without significant problems given Eurolink condition and the emergency's favorable development (**3.6.5, 3.6.7, 4.12.1 & 4.12.2**).
(Conclusion NOT leading to Safety Recommendations)
- 5.1.19** Passengers' emergency evacuation, although successfully completed, highlighted the issue of a shore based passengers' evacuation arrangement (**par. 4.12.1, 4.12.2 & 4.12.3**).
- 5.1.20** Corfu Channel speed limitation that had implicitly become inactive deems relevant to be reactivated (**par. 4.13**).

6. ACTIONS TAKEN

1. According to a reply received by Eurolink Managers/Owners after the Investigation Report's consultation process period, a Vessel Incident Report was compiled (SMS Form: FM/UTEC/AB/PB/030) as well as a Company Analysis on 22/10/2014, in accordance with the Company's SMS. Following said process, a Notice was sent to the entire managed fleet vessels, drawing the attention of their Masters on the Company's policy regarding the restrictions for narrow passage and / or passage close to coastline, as said restrictions had been recorded in the past in a Company's message with reference: dpa/sms/585/13 since September 2013. Those restrictions requested for the following actions by the Masters:
 - *"to deep check ANY voyage planning before approval, in order to assure that any passage has been planned to match company policy and avoid, as far as possible, transit too close to the coastline"* and
 - *"to proper verify / amend master's standing instructions for deck officers"*.
2. Corfu Coast Guard Authority took the following actions:
 - in view of the recommendation addressed thereto has issued an Order regarding Vessels' speed limitation when transiting Corfu Channel and Peristerai Passage (Order no 2221.6/4236/18-08-2016).
 - Referred Order also recommends that vessels navigating the Corfu NE sea area should transit through the "outer passage" that is between Peristerai Islet and Albanian Coast.
3. Additionally, Corfu Coast Guard Authority has issued Order 2131.12/4474/30-08-2016 by which it is specified that the time response of the stand-by port tug from 2200 until 0600 should be twenty minutes.

7. SAFETY RECOMMENDATIONS

(references denote conclusions' based grounds)

Taking into consideration the analysis and the conclusions derived from the safety investigation conducted, the following recommendations are addressed:

7.1 The Owners/Managers are recommended to:

- 29/2014** take appropriate actions in order to remove computer desk top from the documentation office located in Europalink's bridge as well any other sources of light that are not included in respective provisions of SOLAS and related regulations and guidelines for "Bridge design and layout arrangement and equipment" and if required proceed accordingly to owned/managed vessels.
(con. 5.1.1 & 5.1.2)
- 30/2014** supplement respective Safety Management System respective section and "voyage plan form" in full regard of all IMO Res. A. 893 (20) factors for safe navigation by stressing to Masters the importance of fully implementing all voyage plan phases preparation as well as of fully adhere to voyage plan execution and monitoring, focusing in safe navigation.
(con. 5.1.4, 5.1.5, 5.1.6, 5.1.7, 5.1.8 & 5.1.9)
- 31/2014** emphasize fleet-wide the significance of "risk assessment" procedures prior to voyage plan executions in order to identify all anticipated dangerous navigational situations or situations likely to be encountered and establish appropriate safeguards in the interest of safe navigation.
(con. 5.1.10)
- 32/2014** stress fleet-wide that Masters navigate in full regard of COLREGS Rule 6 "Safe Speed".
(con. 5.1.11)
- 33/2014** take appropriate actions fleet-wide either through familiarization or training to ensure that Masters and watchkeeping Officers perform their duties in full regard to "Situational Awareness" and "Bridge Resource Management" principals linked with the respective provisions of STCW Code and COLREGS.
(con. 5.1.3, 5.1.12, 5.1.13, 5.1.14 & 5.1.15)
- 34/2014** stress fleet-wide the importance that Master's Standing Orders are followed and call the attention to Masters and navigating Officers that the Conning roles and responsibilities have to be clear at all times in line with STCW Code respective requirements and Company Safety Management System's directives.
(con. 5.1.15, 5.1.16 & 5.1.17)

7.2 The Safety of Navigation Directorate and the Directorate for Ports Infrastructure of the Hellenic Shipping Administration are kindly invited to:

35/2014 consider of taking appropriate actions in cooperation with the competent Port Authorities in Greece in order to introduce a “shore-based transportable Passengers emergency evacuation arrangement” capable for facilitating passengers’ disembarkation-evacuation from ROPAX or passenger ships upper decks in emergency situations that are regularly call at major Greek Ports or may use them as a “safe return port”.
(con 5.1.20)

7.3 The Hellenic Shipping Administration Safety of Navigation Directorate and the Competent Directorate and the Italian Shipping Administration are kindly invited to:

36/2014 consider of bringing forward to competent European and international Bodies the advantage of a “shore-based” transportable Passengers emergency evacuation arrangement” capable for facilitating passengers’ disembarkation-evacuation from ROPAX or passenger ships upper decks in emergency situations that regularly call at major Ports or may use them as a “safe return port”.
(con. 5.1.20)

7.4 The Corfu Coast Guard Authority is kindly invited to:

37/2014 consider of reintroduce ROPAX speed limitation when transiting Corfu Channel and Peristerai Passage for safe navigation purposes.
(con. 5.1.21)

Prepared and edited by the Hellenic Bureau for Marine Casualties Investigation (HBMCI), under the provisions of the article 16 of Law 4033/2011 (Government Gazette A' 264)

This report has been solely published for the purposes of the investigation and is uploaded on the website of HBMCI (see below)

Accident Investigation Report 04/2014

Hellenic Bureau for Marine Casualties Investigation

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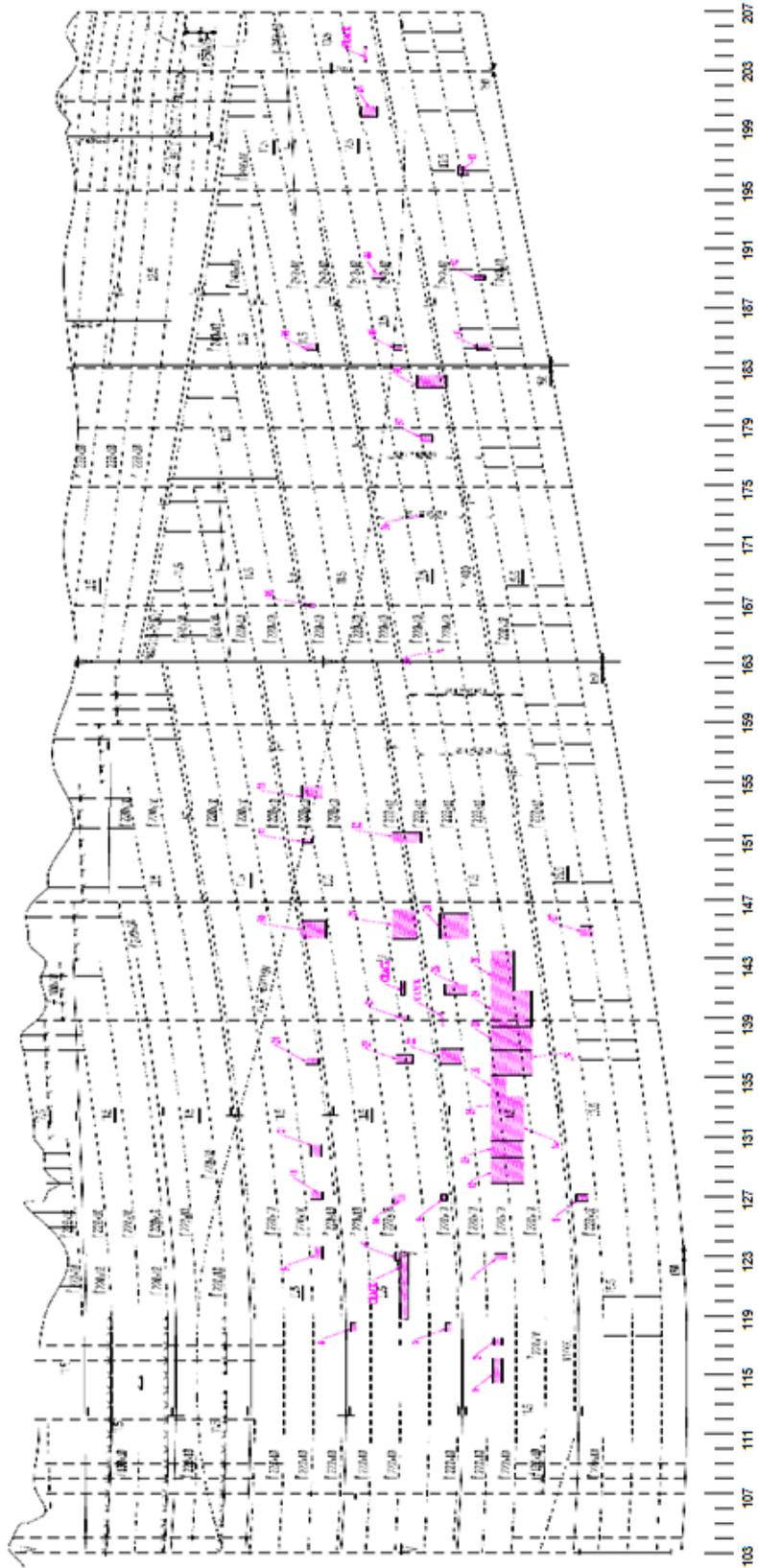
E-mail: hbmci@yna.gov.gr

Website: <http://hbmci.gov.gr>

Appendix 1

Provisional repairs in Port side of the hull.

DAMAGE REPAIRS DESCRIPTION
SHELL EXPANSION
PORT SIDE



Appendix 3

Fllooded compartments as recorded by Europolink crew in Corfu a few hours after the occurrence.

M/V EUROPALINK

Date: 21/10/2014

SOUNDING TABLE

Tank / DB	Total Capacity	Sounding (mt)	M/T	FLOODED DAMAGED COMP.	Frames	Notes
WATER BALLAST TANKS						
01 WBC	365,4	0,95	10,4	NO	267-292	
05 WBC	1173,5	0,00	0	NO	191-207	
08 WBC	351	0,00	0	NO	139-159	
09 WBC	1407,8	0,10	19	NO	119-139	
14 WBC	1004,1	1,82	217	NO	19-35	
15 WBP	339,9	1,55	67,6	NO	5-19	
15 WBS	339,9	1,88	88,6	NO	5-19	
16 WBC	413,1	0,00	0	NO	-19 / - 7	

Tank / DB	Total Capacity	Sounding (mt)	M/T	FLOODED DAMAGED COMP.	Frames	Notes
VOID SPACES						
02 VOC	226,2	0,00	0	NO	243 - 267	
04 VOC	1099	0,00	0	NO	207 - 223	
05 VOC	154	Full	154	YES	191 - 207	Damaged
06 VOCL	216,9	Full	216,9	YES	175 - 191	Damaged
06 VOCU	1037,2	0,00	0	NO	175 - 191	
07 VOCL	284,4	Full	284,4	YES	159 - 175	Damaged
07 VOCU	974,6	0,00	0	NO	159 - 175	
08 VOC	461	Full	461	YES	139 - 159	Damaged
09 VOC	552	Full	552	YES	119 - 139	Damaged
10 VOC	462,4	Full	462,4	YES	103 - 119	Damaged
11 VOCL	367,5	Full	367,5	YES	83 - 103	Damaged
11 VOCU	795,8	0,00	0	NO	83 - 103	
12 VOC	685,7	Full	685,7	YES	59 - 83	Damaged
13 VOCL	107,4	0,00	0	NO	35 - 53	
13 VOCU	1099,6	0,00	0	NO	35 - 59	
14 VOC	209	0,00	0	NO	19 - 31	
15 VOC	226,4	0,00	0	NO	- 4 / 59	

Tank / DB	Total Capacity	Sounding (mt)	M/T	FLOODED DAMAGED COMP.	Frames	Notes
FRESH WATER TANKS						
07 FWP	141,3		119,8	NO	163 - 175	Full
07 FWS	141,3		110	NO	163 - 175	80%
08 FWP	207,1		207,1	NO	143 - 159	Full
08 FWS	207,1		207,1	NO	143 - 159	Full
11 BOWP	28,8		28,8	NO	91 - 99	Full
13 DWC	100,5		100,5	NO	43 - 49	Full

Tank / DB	Total Capacity	Sounding (mt)	M/T	FLOODED DAMAGED COMP.	Frames	Notes
GREY WATER TANKS						
03 GWC	366,3	1,27	51	NO	223 - 243	
04 BWC	99,8	2,38	Full	NO	207 - 223	

Tank / DB	Total Capacity	Sounding (mt)	M/T	FLOODED DAMAGED COMP.	Frames	Notes
HEELING TANKS						
08 HEP	500,4	1,45	122,6	NO	139 - 159	
08 HES	500,4	3,95	342,8	NO	139 - 159	

Tank / DB	Total Capacity	Sounding (mt)	M/T	FLOODED DAMAGED COMP.	Frames	Notes
FUEL OIL TANKS						
09 HFP	249,4	0,10	14,65	NO	119-139	
09 HFS	249,4	0,18	17,29	NO	119-139	
10 HFS	178,7	0,62	44,53	NO	105-119	
11 HF OVFP	43,3		43,3	YES	83-91	Empty bef acc.
11 HF SERP	82,4	5,82	59,86	NO	83-91	
11 HF SERS	82,4	6,52	67,97	NO	83-91	
11 HF SETP	102,3	4,98	69,73	NO	91-103	
11 HF SETS	102,3	3,60	54,49	NO	91-103	
12 HF DIRC	17,3		6,98	NO	76-82	Imp. to check
13 HF DRAS	8,3		4,99	NO	49-53	Imp. to check

Tank / DB	Total Capacity	Sounding (mt)	M/T	FLOODED DAMAGED COMP.	Frames	Notes
OIL TANKS						
12 LODIRC	23,02			NO	68 - 72	
12 LOPI	15,9			NO	65 - 81	
12 LOPO	15,9			NO	65 - 81	
12 LOSI	15,9	1		NO	65 - 81	
12 LOSO	15,9			NO	65 - 81	
13 LODGS	14,6		4,5	NO	55 - 57	
13 LORENP	29			NO	49 - 53	
13 LORESS	79,3		48	NO	45 - 55	
13 LORGP	13,7		1,47	NO	57 - 59	
13 LORGS	13,7		6	NO	57 - 59	
13 LOST	31,9		6,2	NO	45 - 49	
13 LOSTES	12,4		5	NO	49 - 53	

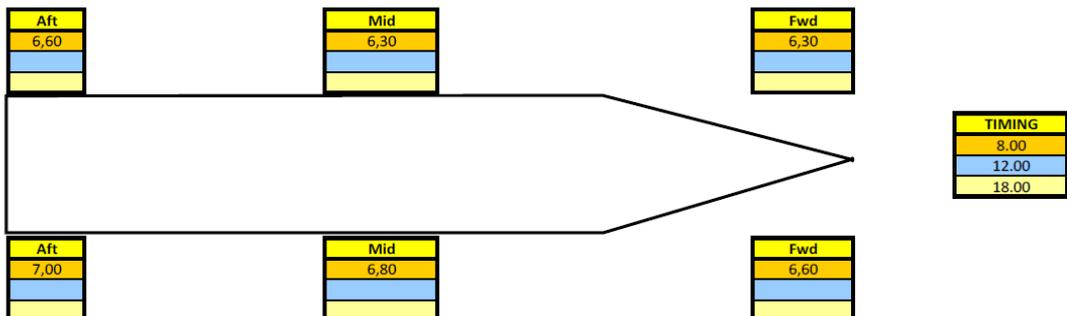
Tank / DB	Total Capacity	Sounding (mt)	M/T	FLOODED DAMAGED COMP.	Frames	Notes
DIESEL OIL TANKS						
10 DOP	178,6	1,82	113,8	NO	105-119	
13 DOSERA	82,4		13,67	NO	49-51	
13 DOSERF	82,4		8,34	NO	51-53	
13 DOSETP	30,1		17,6	NO	53-57	Imp. to check

Tank / DB	Total Capacity	Sounding (mt)	M/T	FLOODED DAMAGED COMP.	Frames	Notes
SLUDGE TANK						
11 SLUS	61,3		61,3	YES	83 - 95	Damaged

Tank / DB	Total Capacity	Sounding (mt)	M/T	FLOODED DAMAGED COMP.	Frames	Notes
MISCELLANEOUS						
11 BILC	52,5		52,5	NO	83 - 99	
11 CBILS	28,7		28,7	YES	95 - 99	Damaged
12 DRWC	11,5		11,5	NO	72 - 76	

Name	Frame	Damaged	Notes
Propeller shaft spaces		NO	Leakage solved on 02/10/2014 - Now empty
Main SW board	19-35	NO	Empty
D/G Room	35-53	NO	From deck 2 to top EMPTY - Under deck 2 FULL
M/E Room	53-83	YES	Pumping out in progress - around 1,00 m
Boiler / Purifier room	83-103	YES	Pumping out in progress - around 1,00 m
Stabilizers rooms P/S	103-119	YES	Some leakage solved, around 0,10 m
Cargo hold deck 2	103-228	NO	Empty
Space as ECR changing room and other		NO	Empty
Bow thruster		NO	Empty
Aux room	243-267	NO	Empty

DRAFTS



Appendix 4

Europalink's Passage Planning



PIANIFICAZIONE DEL VIAGGIO
Voyage Planning

SAFETY MANAGEMENT SYSTEM

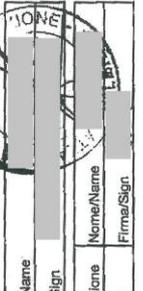
NOME NAVE/Ship's Name **EUROPALINK**

Immissione/Draft: 1.72 No./Voy nr: 1.72 DA/Fram: Goumenitsi ATO: ANCONA DATA, ORA PARTENZA/ETS: 21/04/2016 01:50 DATA, ORA ARRIVO/ETA: 21/04/2016 17:30
 AMERSONE/Draft: 6.70 CN/Center: 6.70 PPI/AF: 6.70 Altezza albero dai galleggianti/Air Draft: 49.30

Way Points nr.	Position - Lat/Long.	Date	Rotta	Course	Velocità stimata (di sicurezza)	Miglia tra waypoints	Miglia all'arrivo	Carta da usare No.	Sistema di segnalazione (ARES, Eco, etc.)	Stazioni VTS e canale VHF	VTS station and VHF Channel	Aree speciali Marpol S/VNO	Effetto squat	Squat effect	Maximum lookout clearance included squat effect	Distanza di sicurezza da ostacoli	Metodo posizionamento (GPS, ecc.)	Ship positioning system (GPS, etc.)	Corrente - Direzione/Velocità	Current Direction/Speed	Prontezza/Attenzione in macchina S/N	Stand by in the engine Yes/No	Da Plotta a banchina o viceversa From pilot station to the key or v.v.			Porto di rifugio o punto di ancoraggio in caso di emergenza	Publicazioni nautiche da usare	Notes
																							Bassa / Low	Alta / High	Stanza / Slack			
1	39°30'10 N 020°11'50E	21/04/2016	270	270	12	1,94	401	2408	ARES	VHF 16/14	YES	YES	VAR	39m	0,5 Nm	GPS Radar	GPS Radar	YES	N.A.	N.A.	YES	N.A.	N.A.	Miglia fino alla chiusa	IGOUUMENTSA FWB			
2	39°30'10 N 020°09'00E	21/04/2016	319	319	15	13	369	2408/205	ARES	VHF 16/14	YES	YES	VAR	55m	0,5Nm	GPS Radar	GPS Radar	NO	N.A.	N.A.	NO	N.A.	N.A.	Miglia pickberth (or v.v.)	IGOUUMENT			
3	39°40'00N 019°58'00E	21/04/2016	358	358	24	4,96	366	205/188	ARES	VHF 16/13	YES	YES	VAR	60m	0,5Nm	GPS Radar	GPS Radar	NO	N.A.	N.A.	NO	N.A.	N.A.	Miglia pickberthina (o v.c.)	CORFU			
4	39°45'00N 019°58'00E	21/04/2016	13	13	24	1,47	381	205/188	ARES	VHF 16/13	YES	YES	VAR	52m	0,5Nm	GPS Radar	GPS Radar	YES	N.A.	N.A.	YES	N.A.	N.A.	Miglia fino alla chiusa	CORFU			
5	39°46'40N 019°59'40E	21/04/2016	322	322	20	1,25	379,5	188	ARES	VHF 16/13	YES	YES	VAR	63m	0,5Nm	GPS Radar	GPS Radar	YES	N.A.	N.A.	YES	N.A.	N.A.	Miglia pickberthina (o v.c.)	CORFU			
6	39°47'40N 019°57'40E	21/04/2016	308	308	24	216	378,3	186	ARES	VHF 16/13	YES	YES	VAR	600m	1 Nm	GPS Radar	GPS Radar	YES	N.A.	N.A.	YES	N.A.	N.A.	Miglia fino alla chiusa	CORFU			
7	42°01'30N 016°37'48E	21/04/2016	313	313	24	151,8	182,2	220	ARES	VHF 16/13	YES	YES	VAR	189m	1 Nm	GPS Radar	GPS Radar	NO	N.A.	N.A.	NO	N.A.	N.A.	Miglia fino alla chiusa	VIESTE			
8	43°44'50N 013°42'00E	21/04/2016	238	238	24	10,3	10,3	220	ARES	VHF 16/12	YES	YES	VAR	55m	1 Nm	GPS Radar	GPS Radar	NO	N.A.	N.A.	NO	N.A.	N.A.	Miglia fino alla chiusa	ANCONA			
9	43°38'00N 013°30'00E	21/04/2016	-	-	-	0	0	220 / 1444	ARES	VHF 16/12	YES	YES	VAR	44m	0,5Nm	GPS Radar	GPS Radar	NO	N.A.	N.A.	NO	N.A.	N.A.	Miglia fino alla chiusa	ANCONA			

Data/Date: _____ Foglio/Slide Nr: **1** DI/OF **2**

Ufficiale delegato	Nome/Name	Comandante	Nome/Name
Delegated Officer	Firma/Sign	Master	Firma/Sign
Ufficiale di Guardia per accettazione	Nome/Name	Ufficiale di Guardia per accettazione	Nome/Name
Duty Officer for acknowledgement	Firma/Sign	Duty Officer for acknowledgement	Firma/Sign



Appendix 5

ROPAX built in 2000 by Fincatiery Shipyards with a documentation office

