Maritec Tanker Management Pvt Ltd
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SAFETY CIRCULAR ***02/2020***

Date: 30th Jan 2020

TO: Fleet

DPA's REPORT

Incident Investigation

Incident: Grounding

Location: Escravous River, Nigeria

Date of Incident: 17th November 2019

Date re-floated: 10th December 2019

Method of Investigation:

- VDR analysis by 2 independents 3rd party
- Interview with Master in office.
- Analysis of Documents and Logs.

Financial Impact: Approximately $561321.29/-

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The Incident:

One of our managed vessel whilst enroute to berth to Sapelle ran aground near Bouy No. 23 at shallow patch outside of the channel at high tide on 17th November 2019 at 0930 Hrs.

The External Environment:

The vessel was under pilotage and transiting narrow channel of river Escravous enroute to Sapelle. Restricted visibility ensued from the commencement of passage.

The depth at various locations in the channel required constant monitoring and proper height of tide.

The passage requires vessel to follow approximately a bank to bank passage- meaning the depth in the channel required for passage is limited only to certain area of channel.

A change of Pilot is required, and the agents often calls the vessel to book the pilot accordingly.

Passage Analysis:

Investigation of Voyage Data Recorder was given to two independent companies. The root cause pointed by both companies states that

- there was lack of situation awareness- people on the bridge did not know the vessel's locations, dangers such as shallow patch or even that the VESSEL HAS RUN AGROUND.
- the bridge team did not challenge the Pilot's decision- there was no attempt to understand pilot's plan or challenge / support pilot's order

Conduct of passage right from the commencement reveals that vessel has had as many as five near misses in form of collision, allision, non-compliance with COLREG and a near grounding (Smelling of ground).

Besides other conduct such as master taking permission from office to anchor due poor visibility, leaving the Bridge without handing over the Conn for routine communication, not informing office when she ran aground, radar not being used during the passage, unjustified use / non-use of Bow Thruster etc are much more alarming and warrants Immediate and long term corrective action.

Post grounding, the master and his team did not attempt to find the location of the grounding and find and execute required corrective action. There was panic on board and the vessel was ordered ahead rather than astern, thereby presumably embedding the vessel deeper.

During the meeting in office, the Master revealed that the local depth contours changes frequently and in absence of any reliable updates to charts or ENC, it is a common practice to rely on the Pilot. However, the master failed to explain why he had not discussed pilot's

intention or challenge his decision or amend the passage plan as per his experience from previous voyages.

It was also noted that proper record keeping was not maintained onboard.

Root Cause (Immediate):

Failure of Bridge Team Management

Over-reliance on Pilot.

Other Underlying Factors:

- Lack of familiarity of ship staff with own vessel manoeuvring data
- Lack of Situational Awareness
- Lack of Understanding of Roles and Responsibilities by Bridge Team
- Complacency due past several passages
- Lack of willingness to follow procedures
- Lack of prioritizing jobs at hand
- Lack of confidence

Preventive Action

Basis the various cause and after evaluating the VDR analysis in details, the following actions are proposed to prevent future occurrence:

1- Shore based 3-day BTM refresher course for Deck Officers every 3 years before joining wef 01st January 2020 has been made mandatory.
2- Videotel based BTM (CBT) training to be completed prior joining on annual basis.
3- 3rd party to conduct the following twice a year
    a. Sailing Navigation Audit
    b. Contingency Drills
    c. Marine Resource Management Training
4- VDR Analysis to be carried out once every 3 months for pilotage and non-pilotage critical approaches during the initial 6 months period ending July 2020, thereafter frequency to be increased once every 6 months.
5- This circular must be repeated during safety meeting onboard all vessels managed by Maritec Tanker Management for next 3 months.
6- Additional guidance to be provided to vessel calling Sapele and Port Harcourt.
7- Scrutinizing the employment process /criteria.

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Actions required onboard with immediate effect

The bridge Team of all vessels to immediately conduct the following training as per publications available onboard and revert with training report:

1- Refresh Bridge Procedures Guide
2- Master's role in collecting Evidence
3- Familiarize with Company's SMS with special regards to Passage Planning, ECDIS Procedures

The Bridge Team to keep in mind the safe navigation and operations of the vessel is the responsibility of the team and not of individual. In executing the duties, the Bridge team should feel intimidated by either the Pilot or the Company and should challenge or discuss in the most diplomatic manner while executing the duties.

Thank You,

Maritec Tanker Management Pvt Ltd