Report on the investigation into the violation of the Dover Traffic Separation Scheme by

MV Musketier (IMO 9369514)

7th August 2015

This report is subject to
the Gibraltar Shipping (Accident Reporting & Investigation) Regulations 2006.

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NOTE

This report is not intended to be used for the purpose of litigation. It endeavours to identify and analyse the relevant safety issues pertaining to the accident, and to make recommendations aimed at preventing similar accidents in the future.

CONTENTS

GLOSSARY OF ABBREVIATIONS AND ACRONYMS

BNWAS	-	Bridge Navigational Watch Alarm System
COLREGS Collisions at Sea	-	International Convention for the Prevention of
CALDOVREP	-	Pas de Calais/Dover Strait Report.
ECDIS	-	Electronic Chart Display & Information System
GMA	-	Gibraltar Maritime Administration
GoG	-	Government of Gibraltar
GPS	-	Global Positioning System
GRT	-	Gross registered tonnage
IMO	-	International Maritime Organisation
ISM	-	International Safety Management (Code)
Kts	-	knots (nautical miles per hour)
kW	-	Kilowatts
MRCC	-	Maritime Rescue Coordination Centre
Mt	-	metric tonnes
OOW	-	Officer of the Watch
PSC	-	Port State Control
SOLAS	-	International Convention for the Safety of Life at Sea
UTC	-	Universal Co-ordinated Time
VHF	-	Very High Frequency

All times used in this report are UTC unless otherwise stated

1. SYNOPSIS

On Thursday 7th August 2015 a near miss situation occurred in the Dover Straits Traffic Separation Scheme (TSS) involving a Gibraltar registered vessel 'Musketier (IMO 9369514).

The vessel was en route from St. Petersburg, Russia to Bermeo, Spain.

The vessel failed to make the CALDOVREP and did not respond to numerous attempts to contact the vessel for in excess of two hours.

At 2035 utc the vessel failed to alter course as per the passage plan and entered the north-east bound lane on a course of 210' proceeding against the general traffic flow in that lane contrary to COLREGs rule 10.

The vessel failed to respond to any communications and a French navy helicopter was sent to establish communications with the vessel.

It was necessary for the helicopter to winch a man down to the vessel to establish communications.

At 2215 utc under the guidance of 'The Navigation Assistance Service' the vessel re-entered the correct traffic lane and resumed its passage plan.

A subsequent alcohol test on the Master when the vessel arrived in Spain provided a positive alcohol specimen.

2. Factual Information

2.1 Ships Particulars

Flag – Gibraltar

IMO No – 9369514

Type – General cargo/ice class, heavy cargo

Built – 2004 Netherlands

GRT – 2545

Engine – 1520 kW

2.2

Voyage- from St. Petersburg (Russia) to Bermeo (Spain)

2.3

A near miss situation occurred in Dover Straits Traffic Separation System on 7th August 2015 at approximate time 2035utc.

2.4

A French Navy helicopter was dispatched to the location following continuous attempts to establish contact with the vessel. The winchman was landed on to the vessel and established communications.

3. Narrative

Events prior to the incident :-

The Musketier, with a crew of 8, was subject to a port state inspection on 29/7/15.

The attending surveyor discovered a defective battery charger leading to problems with Gyro, ECDIS, Echo sounder and GPS which all failed to function.

Batteries and charger were replaced locally by a shore service company.

One ECDIS remained defective.

It became apparent that no local repair service was available for the ECDIS and the owners requested permission from Flag state to sail to the next port provided that paper charts were available on board as a means of back up navigation.

The intention was to repair the defective ECDIS at the next port – Bermeo , Spain.

A "Letter of No Objection" was issued by Gibraltar Maritime Authority for the vessel to sail to the next port where repairs must be effected. There were certain provisions stipulated – The main provision being that all paper nautical charts and publications for the voyage must be in place on board and available.

No local admiralty charts were available in St. Petersburg and the owners emailed copies of the required charts for the voyage to the Master.

The Master failed to print these charts.

The passage plan made no mention of any back up navigation or contingency plans should the sole means of primary navigation fail (The remaining ECDIS).

Main Incident :-

Thursday 6th August 2015 the vessel proceeded through the Dover Straits TSS en route to Bermeo in Spain with a cargo of steel.

The Master, as was normal on board practice, kept the 2000 ~ 2400hrs navigational watch on the bridge having taken over the watch from the Chief Officer at 2000 hours.

At 1929utc the vessel failed to make the compulsory report to Dover Coastguard as required under IMO MSC 85(70).

Dover Coastguard attempted to make contact with the vessel for one hour without success.

At 2040hrs UTC Dover Coastguard informed Gris Nez traffic of the Musketier and its failure to report.

At 2035utc the vessel was proceeding on a course of approximately 210 degrees at 9.5 knots.

In a position 51' 07.1" N ; 001' 40" E , at the MPC buoy, the vessel entered the 'North-east bound lane' of the Dover TSS on a course of 212 degrees and a speed of 9.8 knots.

The vessel was proceeding against the general flow of traffic in that lane contrary to Colregs. Rule 10.

Gris Nez Traffic and Dover Coastguard attempted to make contact with the vessel by all available means (including VHF, INMSARSAT, and AIS Telegram) between 1929hrs and 2154hrs utc.

The vessel failed to respond to all attempts.

Gris Nez Traffic issued various 'Safety to Navigation' broadcasts to warn other vessels in the vicinity of the 'Musketier'.

At 2118hrs UTC it was decided to send a French Navy Helicopter to the vessel to try to establish contact.

The helicopter arrived on scene at 2134hrs UTC and reported back to Gris Nez that there was nobody on the bridge of the vessel.

The helicopter used its searchlight to try and attract attention without success.

The French salvage tug "Abeille" was also made aware of the situation.

At 2142hrs UTC the helicopter reported that 2 persons were observed walking up to the bridge.

At 2154hrs UTC the helicopter winchman was landed onto the vessel.

The winchman made VHF contact with Gris Nez once on the bridge of the Musketier.

The opinions of the winchman and Gris Nez MRCC were that "The crew's attention ability was degraded".

When the Master was asked for an explanation he responded that "he was proceeding in the right direction"

The Musketier, at this time, had been proceeding for one hour 30 minutes in the wrong direction of the Dover Straits TSS.

At 2215 UTC under the guidance of 'The Navigation Assistance Service' the vessel altered her course and re- entered the correct traffic lane.

The vessel was escorted by the Salvage Tug.

<u>Follow up enquiry :-</u>

Musketier continued its voyage to Bermeo without further incident berthing on the morning of 10th August at 0630 hours.

A company representative met the vessel on arrival and carried out alcohol tests on the Master and all crew members.

All crew provided negative alcohol test specimens. The Master provided a positive alcohol test.

An inspector from Flag State, Gibraltar Maritime Authority, attended the vessel on the request of Gibraltar MAICO to act as an expert in assessing the initial information.

Interviews were carried out and statements taken.

The Master claimed that the one working ECDIS had frozen and that he had turned the volume of the VHF radios to minimum as he was speaking on the telephone taking advice on how to correct the ECDIS problem.

He further stated that he had called the other officers to the bridge to assist him in rectifying the problem.

The Chief Officer and Officer of the Watch (OOW) initially agreed and supported the Master's statement.

In a subsequent interview the 2nd Officer stated that he had not been present on the bridge but had actually been woken on hearing the helicopter. He proceeded to the bridge and found that there was nobody there – the bridge was unmanned.

The 2nd Officer stated that he believed that the Master was under the influence of alcohol at the time of the incident and that in his opinion the Master had an alcohol problem.

The 2nd officer advised that it was he who altered course when the helicopter crew member had boarded the vessel.

The electronic data of the one working ECDIS was downloaded by an attending technician. All data was correct with no sign of a malfunction during the voyage.

A subsequent analysis of the data concurs with everything reported in respect of the vessels progress in the Dover TSS.

The Master was replaced on the vessel and repairs effected to the defective ECDIS unit.

13th August 2015 the Master attended at the Company offices for interview and to further carry out an internal investigation into the incident.

At this time the Master made a statement that all navigational equipment had been functioning correctly and that he had been sleeping due to medicine that he was taking and a small glass of wine.

He further stated that he had turned off the Bridge Navigational Watch Alarm System (BNWAS).

4. Analysis

1) The vessel is required to have a back-up system of navigation charts. This would normally be by way of a second ECDIS unit. On this occasion the ECDIS failed. The GMA, as Flag State, issued a 'letter of no objection' to paper charts forming the back-up system.
Following the Master reporting that paper charts were not available locally the appropriate charts were emailed to the ship.
The Master failed to print out the charts.
There was no confirmation given to GMA that the back-up paper charts were available and ready for use
The Master further failed to ensure that a correct back up passage plan was produced and made ready on the paper charts.

2) Various 'human errors' were noted during the port state control inspection at the previous port, St. Petersburg.
These including poor entries in the log book, Oil record book and radio log book.
Following the incident it was further noted the poor level of record keeping and entries in the log books.
Many important pieces of information were missing and entries were minimal.

3) The vessel failed to make the required reports to Dover Coastguard.

4) The vessel failed to make the required alterations of course in the Dover TSS in contravention of COLREGS rule 10 and contravened the TSS travelling the wrong way against the general traffic flow.

5) The vessel failed to keep a proper lookout as required by COLRES rule 5.

6) The vessel failed to take action to prevent collision as required by COLREGS rule 7.

7) Master left the bridge whilst on duty and slept in his cabin.

8) No lookout was present on the bridge as detailed in the on board tables of working arrangements.
A duty seaman should also have been present at this time with the sole duties of acting as a lookout.
The Company ISM manual clearly states that a lookout should be present during the hours of darkness.
Any prudent Master mariner would be expected to have a lookout posted in the Dover Straits – one of the busiest stretches of water in the world.

9) The Master contravened the Company Drug and Alcohol policy in that :-
- i) He consumed alcohol less than 4 hours before his watch.
- ii) He consumed medicine which he believed may 'contribute to unacceptable job performance'.
- iii) The Master did not inform the Company of the medicine.

10) The Bridge Navigational Watch System (BNWAS) was disabled by the Master during his navigational watch.
Company Standing orders and ISM manual are very clear in this respect that the system is mandatory at all times the vessel is underway.

11) The Master, despite feeling tired and unfit for duty due to alcohol, failed to notify other watch-keepers or his deputy (The Chief officer) of these facts.

12) The Master failed to ensure that a lookout was posted on the bridge and knowingly switched off the BNWAS when he vacated the navigational bridge.
The fact that the BNWAS was disabled indicates that his actions were pre-meditated when he left the bridge.

13) The Chief Officer and Second Officer (OOW), despite discovering the true facts initially lied in their respective statements to protect and cover up for the Master.

14) There are no entries in the log book of watch hand over as required by the Company ISM.
A mandatory checklist (B12) is in place according the Company ISM Manual.
The manual states that 'the checklist does not require to be filled or printed but should be completed and a log book entry made "watch handed over as per B12".'

15) Alcohol tests were carried out by a Company Representative with all the results being negative except that of the Master.
The Master stated that his positive result was due to a medicine that he was taking. (Extractum Propolis Spirits).
Following independent medical advice being taken from "The Maritime and Coastguard Chief Medical advisor" it is not thought that the amount of medicine consumed is likely to have caused any high readings on an alcohol test.
The Master's explanation is further brought into doubt with the OOW's opinion that the Master was drunk and had an alcohol problem.

16) There is evidence that the Masters standing/night orders were not in place or being regularly used.

5. Recommendations :-

1) The Company shall consider and further detail specific occasions in the ISM Manual when a bridge lookout should be mandatory. One such example to be added is :-

i) Transiting Traffic Separation Schemes.

Company Response - In the company's SMS the procedure for look-out is, in our opinion, clearly defined and in the case the OOW considers to be the sole look-out - ONLY at daylight he shall take into account the steps defined in the relevant section of the SMS **(see attached annex 1).**

Comment – This is a partial acceptance of the recommendation

2) The Company shall formalise the handover of the watch system to ensure that correct procedures are taking place with records maintained by way of clear log book entries.
The hand over checklist (**B12**) requires a further entry as to "the suitability of the relieving officer to take over the watch" thus placing more responsibility on the officers.
The current ISM manual explains that in the case of the relieving officer not being capable to carry out his duties then the Master shall be notified. It is not clear as to what actions should be taken if the master is incapable of carrying out his duties.
The Company should provide guidance to all Officers by way of a 'no blame culture' as to what actions they should take in the event that the Master is not capable to carry out his duties.

Company Response - Company revised its Company Policy with another paragraph which shall encourage our crews to report (annex 2). This paragraph clearly defines our requirement and will be brought to the attention of the crew during the ships visits and audits.

Comment – This recommendation is accepted

3) The intention of the Company to introduce a 'No blame' culture is noted and it is recommended that this is encouraged via frequent ship visits and audits.

Company Comment to 2).

Comment – The recommendation is accepted

1) It is noted that the Master involved in this incident had removed all copies of his standing orders.
These could be vital evidence in the case of a serious incident and it is recommended that the ISM manual is amended by the Company to ensure that all such documents are kept on board for a minimum period of 3 months following any change of Master.

Company Response - The company considers this as impracticable. In anyway special orders e.g. "when entering the TSS Master has to be informed ..." has to be entered into the watch/night order book which, as part of the SMS and an official Log book, has to be retained on board for a period of **three** years.

Comment – This recommendation is already incorporated in the ISM Manual

2) Various shortfalls have been found with regards to log book entries, in particular relating to the hand-over of watches.
It is recommended that the Company carry out a series of audits and ship visits to raise the awareness and standards of on board administrative work.

Company Response - The company will establish a program for a period of 12 month where 2 ISM Audits will be carried out and the frequency of ships visit will be increased to intervals not exceeding three (3) months, instead of every 6 month as it is the Company's minimum requirement as per the ISM Manual.

Comment – This recommendation is accepted

3) It is recommended that the Company amend its D & A policy to ensure that urine samples are gathered following any serious incident.
A system of sending such samples for expert laboratory analysis is to be set up.
The current system whilst being an effective indication is more of a 'home test' system that would show serious flaws in a court case or serious casualty investigation.
A lab analysis of samples would have permitted a very detailed test for the presence of any medicines, drugs and alcohol.

Company Response - The company has a program for unannounced Drug & Alcohol testing and testing following an incident already for the last 10 years in place. Further special campaigns are carried out following numerous of observations for the last 24 month. Those Tests is carried out by an approved company, laboratory report included. Company name and detail on request.

Comment – This recommendation is already incorporated in the present D&A policy but will be intensified

4) It is recommended that the Company re-iterate the importance of the BNWAS to their Masters and Officers by way of a Company circular.
It is further recommended that an entry is included in the ISM form B12 – (Bridge watch handover), that the BNWAS is fully operational.

Company Response - The use of the BNWAS is mandatory as per company's Circular N55 and procedures in the SMS (Annex 3). In case the BNWAS should not work the ship has to follow the reporting procedure for default of equipment set out in the company's SMS **(annex 3+4)**.

Comment – This recommendation is incorporated in the ISM

5) It is recommended that the GMA does not issue a Recognition Certificate to the Master, Mikhail Siluyanov, for a minimum period of 36 months. Any subsequent issue shall only be when he has satisfied the GMA that he is suitably competent to hold such a certificate.

Comment – This recommendation has been accepted by the GMA

6) The two deck officers involved in the incident (I.Kochkin , Chief Officer, and Pavel Blagodarov 2/O) supported the Master initially failing to cooperate with the on board investigators.

In light of the Company wishing to develop a 'no blame culture' there is no specific recommendation directed towards the two officers.
However the GMA should make note on their file and prior to the re-issue of any further certificates the GMA should be satisfied that there has been no further incidents or issues with the above two officers.

Comment – This recommendation has been accepted by the GMA

7) It is recommended that the GMA make every effort to ensure a positive report is received regarding all conditions of any 'Letter of No Objection' being met prior to a vessel leaving port.

Comment – This recommendation has been accepted by the GMA

Alan Cubbin

MAICO

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