

**ANNEX 1****IMO MARINE CASUALTY AND INCIDENT REPORT****SHIP IDENTIFICATION AND PARTICULARS**

Administrations are urged to supply the ship identification information listed in this annex for all marine casualty reports submitted to the Organization.

**SHIP PARTICULARS**

1. **IMO Number:** 7341685
2. **Name of Ship:** WILSON MUUGA
3. **Flag State:** CYPRUS
4. **Type of Ship:** .5 Bulk Dry (general, ore) Carrier **[X]**
5. **Type of service:** International **[X]**
6. **Were any voyage related restriction limits placed on the ship?** Explain: NO
7. **Gross Tonnage:** 3658
8. **Length overall:** 102.25
9. **Classification Society:** DNV
10. **Registered Shipowner:** Unistar Shipping Co. Ltd
11. **Ship Manager/Operator:** Wilson Shipmanagement AS
12. **Previous names:** Selnes, Risnes
13. **Previous Flag:** Iceland
14. **Previous Class Society:** N/A
15. **Date of contract /delivery:** 1975
16. **Date of major conversion:** N/A
17. **Deadweight:** 5790
18. **Hull material:**  
 . 1 steel **[X]**
19. **Hull construction:**  
 . 1 single hull **[X]**  
 .3 double bottom **[X]**

20. **Propulsion Type (type, fuel, etc.):** Diesel ☒ [X]
- .1 Bunkers:  
Heavy Fuel Oil (HFO) ☒ [X] Medium Fuel Oil (MFO) ☐ Marine Diesel Oil (MDO) ☒ [X]
21. **Nature of cargo:** N/A
22. **Building yard:** Appledor
23. **Hull number:**
24. **Date of total loss:** 19/12/2006
25. **Number of Crew on ship's certificate:** [ 9]
26. **Number of Passengers on ship's certificate:** [N/A]
27. **Number of persons onboard at the time of the casualty / accident:**
- .1 Crew: 12

#### PRELIMINARY CASUALTY DATA

1. **Date and time (local onboard):** 05.00
2. **Position/location:** 63°59'13N – 22° 45' 20W
3. **Initial event<sup>1</sup>:**  
[X] grounding
4. **Consequences:**  
[X] total loss of the ship  
[X] loss of life

#### 4. Summary of events

Note: Times differ 2-3 minutes between those stated by the crew, i.e. the Master and the C/O and those of the ECDIS print-out. In this section the times stated by the crew are mentioned.

1. 19/12/06 - 01.25 Hours: Vessel sailed without pilot from Grundartangi (Iceland) in ballast condition. Destination Murmansk for loading. Fwd Draft = 3.03m - Aft Draft = 4.62m. Bunkers ROB: FO=90MT - DO=40MT. Ships time UTC+1.  
Navigation Watches schedule: Master 8-12, Chief Off. (C/O) 4-8, Second Off. (2/O) 12-4  
No Engine Room (E/R) Watches (Periodically Unattended Machinery Spaces Vessel)
2. 19/12/06 - 01.30 Hours: Commenced sea passage – Set initial course 252°. Master and Second Officer (2/O) on Bridge. Weather: WSW 4B - Westerly swell up to 3m.
3. 19/12/06 – 03.00 Hours: Master left the Bridge after he had given instructions to the 2/O to call him immediately in case the weather had deteriorated or in any doubt or dangerous situation.
4. 19/12/06 – 04.00 Hours: 2/O handed over watch to Chief Officer (C/O). Course 252°. 2/O plotted position (psn) on the navigation chart – vessel on course.
5. 19/12/06 – 04.08 Hours: C/O altered course from 252° to 223°. (By turning the knob of the auto-pilot). C/O did not plot psn on the navigation chart. C/O stated that he was not plotting psns on the navigation chart, but that he was checking the psn of the vessel on Electronic Chart Display System (ECDIS)
6. 19/12/06 – 04.32 Hours: C/O altered course from 223° to 175°. (By turning the knob of the auto-pilot) at position: Lat: 64 03' 75N – Long: 022° 49' 87W. C/O did not plot psn on the navigation chart.
7. 19/12/06 – 04.50 Hours: C/O sent the A.B. of the watch for the regular safety check.
8. 19/12/06 - 04.56 Hours: C/O observed shore lights straight ahead.  
C/O took the following actions:
  - a) Checked the course on radar screen & gyrocompass, which were indicating that the course was unaltered i.e. 175°. At the same time he realised that the vessel was turning to port (p).
  - b) Tried to change the course to starboard (stbd) with auto steering but the vessel did not answer the helm.
  - c) Changed steering pump No1 to steering pump No2 and tried again to change the course to stbd with auto steering but again the vessel did not answer the helm.
  - d) At 05.00 Hours he changed from automatic to manual steering and put the helm by hand all-to-stbd, with one pump (then called the Master on the telephone) and then by both pumps but again the vessel did not answer the helm.
  - e) At 05.04 Hours he felt strong vibration while speaking on the telephone with the 2/E who called him from the Engine Room (E/R) and reported main engine's overloading. The C/O stopped the main engine by putting the telegraph to stop.
9. At 05.04 Hours the vessel started vibrating, shaking and striking the sea bottom.
10. At 05.05 Hours the vessel grounded at psn Lat.: 63°59'135N – Long.:022°45,208W off Hvalsnes, Reykjanes Peninsula, SW Coast of Iceland. Master went on Bridge.
11. At. 05.06 Emergency Alarm Sounded – Crew mustered at Muster Station.
12. At 05.15 Master informed “Wilson Contingency Team” about the grounding.

13. At 05.22 Master informed the Icelandic Coast Guard about the grounding.
14. At 05.25 the C/E reported from the E/R that the E/ R was flooded and that the engines were dead . Water was entering in the E/R from the bilges and he started pumping out waters from the E/R.
15. At 05.37 was found that the following tanks were ruptured: FPT, DBT No.1, DBT No.2 p & stbd and DBT No. 3 p & stbd. In No. 2 hold Fuel Oil was mixed up with water.
16. At 06.00 the Master was informed that the Danish Cost Guard (CG) vessel “TRITON” was proceeding to his vessel to render assistance.
17. At about 07.15 eight crewmembers from TRITON boarded a rescue craft and were trying to approach the grounded vessel but the craft capsized and one of the crewmen drowned.
18. Icelandic CG Helicopters and members of local rescue teams began searching for the eight sailors immediately. They were found at 08.00 and the seven survivors were brought to a hospital.
19. About 200 rescue team members, two helicopters and three rescue boats arrived at the scene to save the crew of the vessel which grounded about 150m off the coast. At 15.30 all 12 crewmembers were evacuated by Icelandic rescue helicopter TF-SIF.
20. Pumping equipment was brought onto the vessel. Oil removal completed as of 05 January 2007. About 40 MT were pumped out from hold No2 and about 90 MT from the tanks. No oil pollution has been reported on the shores.
21. The Icelandic authorities consider that it is the shipowner’s responsibility to remove the vessel which is total loss, from the grounding site (dismantling of the vessel and taking its parts away).

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## ANNEX2

### IMO MARINE CASUALTY AND INCIDENT REPORT DATA FOR VERY SERIOUS AND SERIOUS CASUALTIES

#### CASUALTY DATA

- 1 Date and local time of casualty: (24 hr clock) (19/12/2006): 05.01**
- 2 Position of casualty (Latitude, Longitude): 63°59'13N – 22° 45' 20W**
- 3 Location of casualty:**
  - 3.1 Coastal waters (within 12 miles) **[X]**
- 4 Pilot on board** **[NO]**
- 5 Type of casualty (initial event):**
  - 5.2 Stranding or grounding: being aground, or hitting/touching shore or sea bottom or underwater objects (wrecks, etc.). **[X]**
- 6 Type of subsequent events:**
  - 6.2 Hull failure or failure of watertight doors, ports, etc. **[X]**
  - 6.6 Machinery damage which necessitated towage or shore assistance. **[X]**
- 7 Consequences of the casualty:**
  - 7.1 Consequences to the ship involved in the casualty:**
    - 7.1.1 Total loss **[X]**
  - 7.2 Consequences related to human beings:**
    - 7.2.1 Number of other dead or missing persons (1)
  - 7.3 Consequences to the environment (pollution):**

**8 Primary causes of the initial event:**

Coding principle:

- a The human element is a complex multi-dimensional issue that affects maritime safety and marine environmental protection. It involves the entire spectrum of human activities performed by ships' crews, shore based management, regulatory bodies, classification societies, shipyards, legislators and other relevant parties.
- b Effective remedial action following maritime casualties requires a sound understanding of the human element involvement in accident causation. This comes by the thorough investigation and systematic analysis of casualties for contributory factors and the causal chain of events.

**8.1 Internal causes (related to the ship where the casualty occurred): [X]**

## 8.1.1 Human violations or errors by the crew: [X]

. 1 Human violations [ ]

. 2 Human error [X]

## 8.1.2 Human violations or errors by the pilot: [N/A]

. 1 Human violations [N/A]

. 2 Human error [N/A]

## 8.1.3 Structural failures of the ship [N/A]

## 8.1.4 Technical failure of machinery/equipment including design errors: [X]

.1 Failure of propulsion machinery [ ]

.2 Failure of essential auxiliary machinery [ ]

.3 Failure of steering gear [ ]

.4 Failure of closing arrangements or seals [ ]

.5 Failure or inadequacy of navigational equipment [X]

## 8.1.5 The ship's cargo: [N/A]

**8.2 External causes (outside the ship): [X]**

## 8.2.1 Another ship or ships (improper actions, etc.) [N/A]

## 8.2.2 The environment: [X]

.1 Heavy sea [X]

.2 Wind [X]

.6 Restricted visibility [X]

8.2.3	Navigational infrastructure:	[N/A]
8.2.4	Criminal acts	[N/A]
8.2.5	Other "external" causes (i.e. not associated with the ship itself)	[N/A]
<b>8.3</b>	<b>Unknown causes</b>	<b>[N/A]</b>
<b>9</b>	<b>Violations and error types:</b>	
<b>9.1</b>	<b>Violation (deliberate decision to act against a rule or plan):</b>	<b>[N/A]</b>
9.1.1	Routine (cutting corners, taking path of least effort, etc..)	[ ]
9.1.2	Necessary (due to inadequate tools or equipment, improper procedures or regulations)	[ ]
9.1.3	"For kicks" (thrill seeking, to alleviate boredom, macho behaviour)	[ ]
9.1.4	Exceptional (taking risks to help people in distress, lack of system knowledge)	[ ]
<b>9.2</b>	<b>Slip (unintentional action where failure involves attention</b>	<b>[N/A]</b>
9.2.1	Incorrect operation of controls or equipment	[ ]
9.2.2	Left/Right, reversal	[ ]
9.2.3	Failure to report due to distraction	[ ]
9.2.4	Other	[ ]
<b>9.3</b>	<b>Lapse (unintentional action where failure involves memory):</b>	<b>[N/A]</b>
9.3.1	Forgetting to report information	[ ]
9.3.2	Failure to advise Officer on the Watch	[ ]
<b>9.4</b>	<b>Mistake (an intentional action where there is an error in the planning process; there is no deliberate decision to act against a rule or procedure):</b>	<b>[X]</b>
9.4.1	Error in judgement	[X]
9.4.2	Inappropriate choice of route	[ ]
9.4.3	Deciding not to pass on information	[ ]
9.4.4	Failure to respond appropriately	[ ]
9.4.5	Other	[ ]
<b>10</b>	<b>Underlying factors:</b>	
<b>10.1</b>	<b>Liveware:</b>	<b>[X]</b>

10.1.1	Physiological	[N/A]
.1	Fatigue	[ ]
.2	Stress	[ ]
.3	Alcohol/illegal drug	[ ]
.4	Prescription medicine	[ ]
10.1.2	Psychological	[X]
.1	Excessive workload	[ ]
.2	Communication	[ ]
.3	Standards of personal competence	[X]
.4	Lack of familiarity or training	[ ]
.5	Panic and fear	[ ]
.6	Boredom	[ ]
.7	Mental and emotional disorders	[ ]
10.1.3	Physical	[N/A]
.1	Hearing problem	[ ]
.2	Visual problem	[ ]
.3	Injuries and illness	[ ]
.4	Less than adequate medical fitness	[ ]
10.1.4	Others	[ ]



- |             |   |            |
|-------------|---|------------|
| <b>10.2</b> | <b>Hardware:</b>  | <b>[X]</b> |
| 10.2.1      | Equipment not available                                 | [ ]        |
| 10.2.2      | Ergonomics  | [ ]        |
| 10.2.3      | Design failures (other than ergonomics)                 | [ ]        |
| 10.2.4      | Maintenance and repair                                  | <b>[X]</b> |
| 10.2.5      | Other   | [ ]        |
| <b>10.3</b> | <b>Software:</b>  | <b>[X]</b> |
| 10.3.1      | Company policy and standing orders                      | [ ]        |
| 10.3.2      | Less than adequate operating procedures and instruction | <b>[X]</b> |
| 10.3.3      | Management and supervision                              | [ ]        |
| 10.3.4      | Other   | [ ]        |
| <b>10.4</b> | <b>Environment:</b>                                     | <b>[X]</b> |
| 10.4.1      | Ship movement/Weather effects                           | <b>[X]</b> |

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## **ANNEX3**

### **IMO MARINE CASUALTY AND INCIDENT REPORT**

#### **SUPPLEMENTARY INFORMATION ON VERY SERIOUS AND SERIOUS CASUALTIES**

To assist completion of marine casualty analysis, in addition to the information in annexes 1 and 2, the following information is required:

##### **1. Principle findings and form of casualty investigation:**

Factors which contributed to the accident:

- A) Adverse weather conditions
- B) Overconfidence of experienced navigators
- C) Reliance only on electronic equipment

Note: Times differ 2-3 minutes between those stated by the crew, i.e. the Master and the C/O and those of the ECDIS print-out.

The Gyro Compass feeds the other navigational instruments RADAR, ECDIS, ARPA, GPS. It had been repaired 12 days before on 07/12/2006 at Hartlepool-England. It stuck, on 175 degrees at 04.51 hours, while the vessel was being navigated two nautical miles away from the shores of the SW coast of Iceland.

The vessel was being pushed to the shores because of the SW winds and seas direction. (adverse weather conditions). No counterbalance course was being kept by the C/O.

According to C/O statement, the A.B. of the watch was sent for the regular safety check at 04.50 hours. So, the C/O remained alone on the Bridge.

The C/O was not plotting positions at regular intervals, actually he was not plotting positions at all during his watch, even when he was changing courses (overconfidence). He was only looking at the ECDIS to see that the ship was on course and at the Radar to check the distance from the shores (reliance only on electronic equipment).

The ECDIS print-out shows that the vessel started turning to port (to the shores) at 04.51 hours and according to the C/O statement he saw shore lights at about 04.55 to 04.56 hours. He took immediately action by turning the wheel to starboard and changing from auto-pilot to manual but it was too late. The vessel was on the reefs at 04.58 hours and finally grounded at 05.01.

##### **2. Action taken:**

The Cyprus Maritime Administration sent an investigator in Iceland.

The investigator interviewed the crew involved, collected documentary evidence and visited the site of the grounding and got photographs.

He also attended statutory hearing at the local court of Reykjanes where the crew involved in the accident was interrogated.

**3. Findings affecting international regulations: No**

**5. Assistance given (SAR operations):**

Eight crew members from Danish Coast Guard vessel TRITON boarded a rescue craft and were trying to approach the grounded vessel but the craft capsized and one of the crewmen drowned. Icelandic Coast Guard Helicopters and members of local rescue teams began searching for the eight sailors immediately. They were found at 08.00 and the seven survivors were brought to a hospital in Reykjavik.

About 200 rescue team members, two helicopters and three rescue boats arrived at the scene to save the crew of the vessel, which grounded about 150m off the coast. At 15.30 19/12/2006 all 12 crew members were evacuated by Icelandic rescue helicopter TF-SIF.

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