

Incident Summary

Motor Vessel STELLEMARE, 1129 Gross Tons (GT ITC) is a Dry Cargo/Heavy Load Carrier built in 1982. The Vessel is flagged out of the Netherlands Antilles with Bureau Veritas (BV) as the Classification Society. Jumbo Navigation N.V. is the Owner and Jumbo Shipping serves as the Operator of the vessel. The vessel length is 88.20 meters and width with the stabilizer for heavy lift operations in place, is 27.02 meters. Dimension of stabilizer are 10.84x3.29x2.00 meters, it holds 1357 m³ total ballast. The derrick is 34.8 meter above the keel and weighs 180 Ts, with a combined weight of 360 Ts.

At about 1503 (local time) on December 9, 2003 the M/V STELLEMARE capsized while conducting heavy lift operations at the Federal Marine Terminal in Albany, NY. The vessel had completed loading a 234-MT generator that morning and was in the process of loading a 308-MT stator when the vessel lost stability and capsized to its port-side. Local emergency crews responded on-scene and immediately began to search for crewmembers that had fallen into the water. All but three crewmembers were rescued and sent to a local hospital for evaluation and treatment. Local emergency crews continued to search over the next week for the missing crewmembers.

An Incident Command Post was established at the New York Department of Environmental Conservation (NYSDEC) office located at the Port of Albany for the purposes of overseeing the search and rescue, salvage and oil spill response efforts. Local emergency crews and the USCG were conducting search and rescue operations. SMIT Salvage Company had been hired to conduct all salvage operations. Clean Harbor's Environmental Services, Miller's Environmental, and Gallagher Marine Group were hired by the vessel operator to manage the clean up operations for the #2 diesel oil that was spilling from the capsized vessel.

That evening ACTNY contacted the National Pollution Funds Center (NPFC) to open the Oil Pollution Act of 1990 (OPA 90) Oil Spill Liability Trust Fund and then proceeded to dispatch additional resources, including members of the Coast Guard Atlantic Strike Team, to assist with the management of the incident. The vessel contractors then placed boom around the vessel to prevent any more oil from heading down river and endangering sensitive areas. Once the vessel was boomed off, the contractors began to boom off sensitive areas in accordance with the Area Contingency Plan.

The next morning, vessel representatives met with the Coast Guard, State and City Officials to discuss future plans and establish an operational period as part of the Incident Command System. City divers and a SMIT diving team continued to search for the missing crewmembers and conduct safety surveys of the vessel. Ultimately, and several days later, divers discovered the three missing crewmembers in the vessel's hold. After these men had been removed from the vessel and pronounced dead by the local medical examiner, they were returned to the custody of the Russian government.

MISLE: 1961639 Investigating Officer's Report of Investigation

Conduct of Investigation

Upon notification of the incident the Vessel Traffic Service (VTS) at Activities New York (ACTNY) sent out a safety broadcast and ceased all vessel traffic on the Hudson River in the vicinity of Albany, NY. Concurrently, the Captain of the Port dispatched a marine investigation and pollution response team by car. Additionally, Coast Guard Air station Atlantic City dispatched an H-65 to ACTNY picking up additional CG representatives and flying them directly to Albany. On-scene the local police, at the request of the Coast Guard, began to conduct alcohol testing on the available crewmembers.

The next day the Coast Guard in cooperation with the Albany Police, met with the lawyers representing the vessel owner at a local hotel to conduct interviews with the crew of the vessel (an individual within the community volunteered her time serving as an interpreter during the preliminary interviews). The interviews continued for the next few days and included interviews of shore-side witnesses from Federal Marine Terminal.

A few days into the investigation the First Coast Guard District (D1) sent Coast Guard Investigative Service (CGIS) Special Agents from the New York Office to assist in determining if any criminal conduct may have led to the casualty. CGIS reported back to D1 that they had found no indications of criminal negligence on the part of the crew or the company that contributed to the casualty. The on-scene investigation was concluded and the IO team returned to ACTNY once the vessel was righted and Coast Guard Investigating Officers (IO's) were able to collect evidence from the vessel.

Throughout the investigation Coast Guard Headquarters provided the Marine Investigator with a technical expert, Mr. a civilian from the Commandant's Office of Design & Engineering Standards as well as a CG Licensed Master with heavy lift vessel operations experience. His previous experience with heavy lift ships proved invaluable as he worked with the investigative team, reviewed evidence and developed various loading scenarios using Jumbo Shipping's Loading program as provided by company.

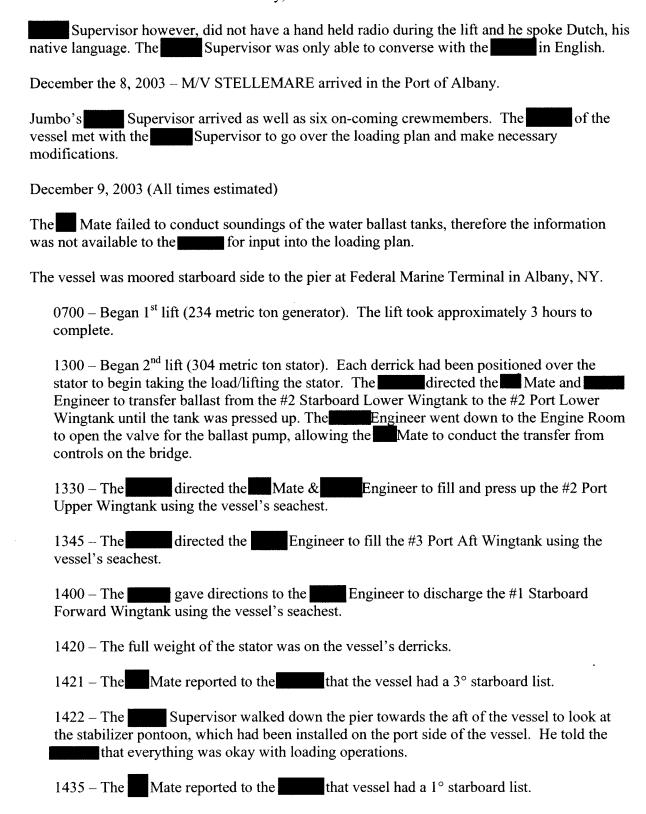
Timeline of Events

This timeline includes details leading up to the capsizing of the M/V STELLEMARE. All time entries are estimates based on interviews with the crew as well as photographs and interviews provided by employees from Federal Marine Terminal.

Prior to December 9, 2003 the had only conducted 3 heavy lift operations. Neither of the lifts entailed as much weight as the lifts in Albany nor were they accomplished in fresh water.

During the lifts all communication between the and his crew were conducted via hand held radios. During such communications, the crew spoke Russian, their native language. The

MISLE: 1961639 Investigating Officer's Report of Investigation Page 2



Investigating Officer's Report of Investigation

Page 3

MISLE: 1961639

1435 – The directed the Engineer to fill the #1 Starboard Forward Wingtank through the seachest.
1450 – The directed the crane operators to move the derricks inboard. The would direct each crane operator when to start and when to stop each movement. The crane operators would follow up each stop by engaging the derrick's brakes. There are brakes on each of the derrick winches. Each derrick had three winches, the Cargo Runner Winch and the Port and Starboard Topping Winches.
1454 – The Mate reported to the that the vessel had a 0° list.
1455 – The directed the Mate and the Engineer to discharge the #2 Port Upper Wingtank through the seachest.
1456 – The directed the crane operators to move the derricks inboard. The crane operators followed up each movement by engaging the derrick's brakes once told to stop. There are brakes on each of the derrick winches. Each derrick had three winches, the Cargo Runner Winch and the Port and Starboard Topping Winches.
1459 – The saked the Engineer if it was possible to discharge ballast faster (two tanks at the same time). The Engineer replied that it could be done. The then directed him to also discharge the #3 Port Aft Wingtank. The Engineer had made it down into the Engine Room, but had not opened the valve when the vessel capsized.
1459 – The directed the crane operators to move the derricks inboard.
1459 – The Mate reported to the that the vessel had a 1° port list.
1500 - The directed the crane operators to stop moving the derricks inboard and to engage the brakes.
1501 – The crane operator stated that he felt the vessel was losing stability so he released the brake in an attempt to move the forward derrick starboard. The crane operator was unable to complete the movement prior to the vessel capsizing.
1501 – A Federal Marine Terminal employee stated that he observed the stator to be about centerline over the vessel. Another employee stated that he observed the forward derrick to

1502 - The vessel's heeling moment exceeded the righting moment and the vessel lost

MISLE: 1961639 Investigating Officer's Report of Investigation

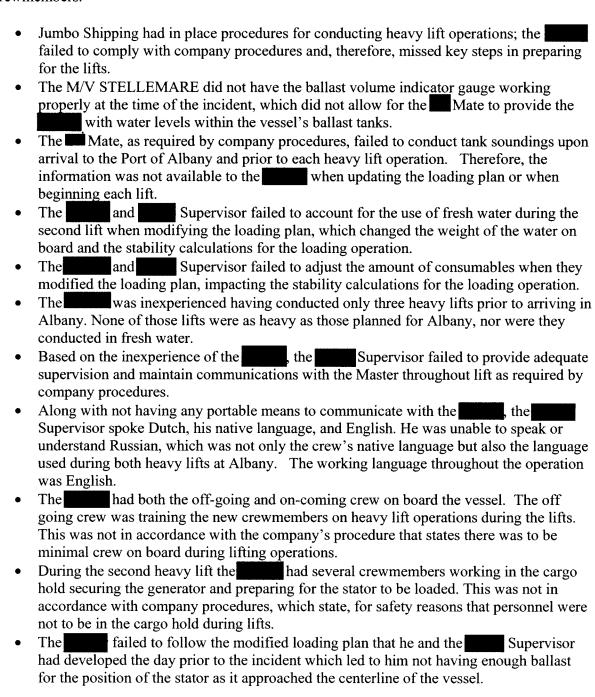
be slightly ahead of the aft derrick.

1502 – The vessel capsized to port.

stability.

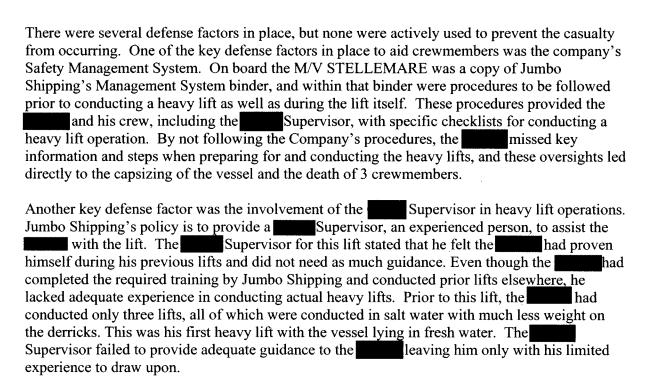
Analysis

During the course of the investigation, the investigation team determined the following factors directly contributed to the capsizing of the M/V STELLAMARE and the death of three crewmembers:



- The showed a lack of patience. He failed to allow enough time for the water ballast transfer prior to shifting the derricks, and the stator, towards the centerline of the vessel.
- During the second heavy lift the vessel's transverse heeling arm became excessive and MG' became negative causing the vessel to lose stability and roll to port capsizing.

Conclusion



Recommendation

Jumbo Shipping is one of the premier heavy lift companies in the World and during the course of this investigation it was apparent that Jumbo Shipping did have a Safety Management System (SMS) in place. However, it became apparent that the crew of the vessel was not only unfamiliar with the SMS; they failed to follow the procedures outlined in the SMS. Therefore, it is the recommendation of the investigation team that the Flag State, Netherlands Antilles, review Jumbo Shipping's Safety Management System and the implementation of the SMS.

Page 6

MISLE: 1961639 Investigating Officer's Report of Investigation