MCIB

Marine Casualty Investigation Board

Bord Imscrúdú Taismí Muirí

REPORT OF THE INVESTIGATION INTO THE BOTTOM CONTACT OF THE *'M.V. CIELO DI MONACO'* AT GREENORE PORT ON 28th SEPTEMBER 2015

REPORT NO. MCIB/250
(No.8 OF 2016)

The Marine Casualty Investigation Board (MCIB) examines and investigates all types of marine casualties to, or on board, Irish registered vessels worldwide and other vessels in Irish territorial waters and inland waterways.

The MCIB objective in investigating a marine casualty is to determine its circumstances and its causes with a view to making recommendations for the avoidance of similar marine casualties in the future, thereby improving the safety of life at sea.

The MCIB is a non-prosecutorial body. We do not enforce laws or carry out prosecutions. It is not the purpose of an investigation carried out by the MCIB to apportion blame or fault.

The legislative framework for the operation of the MCIB, the reporting and investigating of marine casualties and the powers of MCIB investigators is set out in The Merchant Shipping (Investigation of Marine Casualties) Act, 2000.

In carrying out its functions the MCIB complies with the provisions of the International Maritime Organisation's Casualty Investigation Code and EU Directive 2009/18/EC governing the investigation of accidents in the maritime transport sector.

MCIB
Marine Casualty Investigation Board

Leeson Lane, Dublin 2.
Telephone: 01-678 3485/86.
Fax: 01-678 3493.
email: info@mcib.ie
www.mcib.ie

REPORT OF THE INVESTIGATION INTO THE BOTTOM CONTACT OF THE *'M.V. CIELO DI MONACO'* AT GREENORE PORT ON 28th SEPTEMBER 2015

The Marine Casualty Investigation Board was established on the 25th March, 2003 under the Merchant Shipping (Investigation of Marine Casualties) Act, 2000.

REPORT NO. MCIB/250
(No.8 OF 2016)

Glossary of Abbreviations and Acronyms

Aft	After end of vessel (at stern)
Draft	Depth of vessel in water
Fwd	Forward end of vessel (at bow)
GRT	Gross Registered Tonnage
ISM	International Safety Management
IMO	International Maritime Organisation
HW	High Water
LW	Low Water
LOA	Length Overall
m	metre
P+I	Protection & Indemnity Insurer
RINA	Registro Italiano Navale Classification Society
SMS	Safety Management System
UKC	Under Keel Clearance (depth of water under the vessel)
UTC	Universal Co-ordinated Time

Report MCIB/250 published by The Marine Casualty Investigation Board.
Printed 21st November 2016.

CONTENTS

1. SUMMARY

On Sunday the 27th September 2015 the 39,000 tonne (t) cargo vessel *'MV Cielo Di Monaco'* berthed at the Port of Greenore. The following morning whilst reading the draft before discharge of cargo had commenced the Chief Officer noticed that the vessel was aground forward. Further investigation found there was ingress of water into the forepeak ballast tank. Subsequent inspection by divers and inside the tank found damage to the shell plating and frames of the vessel. Temporary repairs were carried out under the supervision of a Classification Society Surveyor before the vessel sailed. There was no pollution or injury to persons.

Note all times are local time = UTC + 1

2. FACTUAL INFORMATION

2.1. The vessel

Name:	*'MV CIELO DI MONACO'.*
Flag:	Malta.
Port of Registry:	Valletta.
IMO No:	9638147.
Call Sign:	9HA3501.
LOA:	179.99 metres (m).
Beam:	30.0 m.
Summer Draft:	10.5 m.
Gross Tonnage:	25,303 t.
Deadweight:	39,202 t.
Year:	2015.
Type of Vessel:	Bulk carrier.
Classification:	RINA.
Number of crew:	21.
Registered Owner:	D'AMICO DRY LTD, 17-19, Sir John Rogerson's Quay, Dublin 2, Ireland.
Ship managers:	D'AMICO SOCIETA DI NAVIGAZIONE, Corso d'Italia 35B, 00198 Rome RM, Italy.
Managers:	D'AMICO SOCIETA DI NAVIGAZIONE, Corso d'Italia 35B, 00198 Rome RM, Italy.

2.2. Voyage Particulars

31st August 2015:	Vessel loaded cargo of steel products – Nemrut, China.
25th September:	Vessel part discharged at Sheerness, UK.
27th September:	Arrived at Greenore, Ireland to complete discharge. Arrival draft Fwd. 7.23 m and Aft. 7.40 m.

2.3. Marine Incident Information

Type:	Vessel contact with bottom.
Date:	28th September 2015.
Time:	06.30 hrs.
Position:	Greenore, Co Louth, Ireland.
Ship Operation:	Vessel alongside quay.
Location:	Ireland – East Coast.
Human factors:	Not following safe practices/procedures.
Physical factors:	Configuration of mooring arrangements.
Consequences:	Damage to vessel and water ingress calculated at 17cm per hour.
Weather:	Wind SE / Var 2/3. Cloudy and clear. Sea state slight (See Appendix 7.1 Met Éireann Weather Report).

Tide at Greenore: (Source: Admiralty Tide Tables)	27th Sept	HW 11.25 hrs	5.4 m.
		LW 17.34 hrs	0.3 m.
		HW 23.31 hrs	5.8 m.
	28th Sept	LW 06.05 hrs	-0.1 m.
		HW 12.04 hrs	5.5 m.

3. NARRATIVE

3.1. Events before the incident

3.1.1. The Port of Greenore is a privately owned port. The port came under new owners and managers, the Doyle Shipping Group, in December 2014. A decision was made to dredge the deep-water berth to accommodate larger vessels at even keel draft. Dredging work was completed in May 2015. A yellow line was painted on the quay wall to show the extent of the dredged deep water berth, which allowed for about three metres clearance from the shallow water and rocky bottom (See Appendix 7.2 Plan of No. 1 berth). Since May 2015 over 20 vessels in the 150 to 200 m Length Overall (LOA) range have berthed without incident.

3.1.2. At the time of the incident the Port Company had a health and safety statement and an emergency plan. It should be noted that the Safety Statement only relates to occupational safety aspects in the Port under the Safety, Health and Welfare at Work Act 2005. There were no risk assessments or operating procedures for the docking and management of vessels alongside, particularly large vessels that extended beyond the quay.

3.1.3. On the 27th September the Master had calculated that the vessel would have at least one metre Under Keel Clearance (UKC) at all times during arrival and stay at Port of Greenore. Under the vessel's safety management system there must be at least 0.6 m UKC at all times.

3.1.4. Greenore Port is a private port and it does not come under the jurisdiction of the Harbours Acts. Greenore Port is not established on a statutory basis and it is not a port authority. It does not have any bye-law making powers and it cannot regulate pilotage or make it compulsory. The vessel proceeded to the berth under Pilot's advice so as to berth on slack high water at 11.25 hrs. Four linesmen attended to take the lines. The Pilot stated that he was normally in communication with the linesmen by radio, but on this occasion there was no reply to his radio communications. He stated that a linesman forward raised his hand and he took this to mean the vessel was in position. The linesmen stated they did not signal the pilot. The vessel was secure on the berth at 12.00 hrs and the Pilot disembarked by tug on the offshore side of the vessel.

3.1.5. The vessel was secured with four headlines, two forward springs, four stern lines and two stern springs (see Appendix 7.2 Plan – note only single spring lines are shown for clarity). The stern of the vessel extended 58 m beyond the end of the quay.

3.1.6. There was a yellow line painted on the quay wall to indicate the limit of the deep water berth. Neither the linesmen present on this occasion nor the Pilot were aware of this line. The line was obscured by dust and not visible to the vessel's crew on the forecastle (See Appendix 7.3 Photograph No. 1).

3.1.7. The vessel's draft on arrival was, Forward 7.23 m and Aft 7.40 m. No cargo was worked on the Sunday 27th September and there were no draft observations at the 17.39 hrs low water.

3.2. The incident

3.2.1. On the 28th September between 05.30 hrs and 06.00 hrs the Chief Officer went on quay and took the draft readings. He noted that the drafts were Forward 6.49 m and Aft 8.0 m. As he had not changed ballast and no cargo had been discharged he concluded the vessel was aground Forward, potentially causing damage in way of frames 213 and 217. He informed the Master and then arranged for tank soundings to be taken and also a sounding around the vessel. A depth of water of 5.3 m was observed at the vessel's bow.

3.2.2. The forepeak ballast tank sounding was found to be 2.53 m, compared with the previous days sounding of 0.36 m. The tank was sounded hourly during the day and pumped occasionally. From these measurements the rate of ingress of water appeared to be about 17cm per hour.

3.2.3. The Master informed the Agent of the owners of the situation at 07.50 hrs who informed the Stevedoring Manager who checked the vessels position alongside the quay and noted that the bow of the vessel was nine meters beyond the limit mark on the quay. This limit mark was a yellow line painted on the quay (see Appendix 7.3 Photograph No. 1).

3.2.4. At 13.00 hrs the vessel was shifted astern to the correct position.

3.3. Events after the incident

3.3.1. Divers were engaged to examine the bottom and they reported damage about 2 m Aft of the stem. The hull plating was set up and there were splits in the shell plating either side of the keel bar (see Appendix 7.3 Photograph No. 2).

3.3.2. Inspection inside the forepeak tank found internal damage where the frames were distorted (see Appendix 7.3 Photograph Nos. 3 and 4). A Classification Society Surveyor from RINA attended and proposed temporary repairs which were commenced on the 30th September.

3.3.3. During the vessel's stay in port there were a number of communications between the Port Company and the vessel in respect of the vessels position on the berth. It appears the vessel had difficulty in maintaining position, and on one occasion during high winds on the 5th October a tug was called to assist the vessel (See Appendix 7.4 Timeline).

3.3.4. The discharge of the cargo was complete at 16.15 hrs on the 6th October. Temporary repairs were completed on the 9th October and the vessel sailed at 21.30 hrs.

4. ANALYSIS

4.1. The Contact with the bottom by the vessel on the 27th and 28th September.

4.1.1. The vessel was berthed at high water with the bow of the vessel about 9 m Forward of the limit of the deep water marked by a yellow line on the quay placing the Forward 6 m of the vessel over shallow water. On the next low tide at 17.30 hrs, the tidal height was 0.3 m and the depth of water would have been about 4.3 m. With a draft of 7.3 m Forward the bow section would have gently rested on the bottom as the tide receded. The damage was between frames 213 and 217, from 2.8 m from the bow to 6 m Aft of the bow (See Appendix 7.5 Elevation of Forward part of vessel).

4.1.2. The ingress of water into the forepeak tank observed by the Chief Officer's regular soundings after the incident was about 17 cm per hour in the 13 hours following the 17.34 hrs low water on the 27th September, about 2.21 m of water would have entered the tank at this rate. The sounding on the 28th September at 06.30 hrs was 2.53 m an increase of 2.17 m, indicating that the initial damage occurred on the first low water after berthing on the 27th September.

4.2. The causal factors which led to this incident were:

4.2.1. The Master is responsible for the safety of the vessel and it appears that the pre-arrival preparations for the vessel did not consider all aspects of the port. Prudence would dictate in a port such as Greenore that a master would be cautious in relation to the depth of water. It is noted that the vessel is 180 m in length and that the varying depths of the port would have been obvious to the Master. The charted depths vary between 3.8 m and 0.6 m.

4.2.2. In addition a voyage planned in accordance with the requirements of chapter VIII of the International Convention on Standards of Training, Certification and Watchkeeping for Seafarers would have ensured that the Master was aware of the limiting depths in the area.

4.2.3. The Pilot who boarded the vessel had no information about the limit of the vessels position on the berth. He was unaware of the yellow line on the quay showing this limit. Consequently the Master and crew were not informed of the possible danger to the vessel. The use of the vessel's Forward echo sounder would not have alerted the Master of the shallow water under the bow as the echo sounder was located between frames 207 and 208. From the vessel's plans this places the transducer 10 m Aft of the bow, too far Aft to detect the shallow water under the bow (see Appendix 7.5 Elevation of Forward part of vessel).

4.2.4. The Berthing Master, with the radio, failed to attend so there was no communication between the vessel and the shore team. The members of the shore team who attended did not know that the yellow line was the forward limit for large vessels.

4.2.5. The yellow line was obscured by dust.

4.2.6. When berthing the Pilot had no reference points on the shore which would assist him in determining the position of the vessel relative to the quay.

4.3. These factors indicate that there was a failure in the risk assessment and procedures for the berthing of large vessels. An inspection of Greenore Port Companies Safety Statement confirmed this.

4.4. The yellow limit line was covered with dust indicating a failure in up keep and maintenance of safety notices.

4.5. Greenore Port is an independent privately owned port which is not regulated by any legislative act and the port safety management system is not subject to any independent external audits.

4.6. At least one Irish Port has voluntarily become subject to the "Port Marine Safety Code" and is audited regularly.

4.7. The vessel experienced difficulty in maintaining the correct position on the berth throughout its time alongside. On the 5th October (eight days after arrival) the wind increased and one of forward spring lines broke and a tug was required to pull the vessel back into the safe position.

4.7.1. The causal factors for this incident were due to:

4.7.1.1. At Greenore Port large vessels cannot lie completely alongside the quay wall and they project beyond the end of the quay (see Appendix 7.2 Plan). This vessel projected 58 m beyond the quay (see Appendix 7.3 Photograph No. 5).

4.7.1.2. Only two mooring lines (the forward spring lines) out of the 12 deployed prevented movement forwards into the shallow water.

4.7.1.3. Initially the weather forecasts for the vessel's stay were relatively calm. However due to quantity of cargo the time to discharge was nine days, during which time the weather deteriorated causing the problems experienced on the 5th October.

4.7.2. Large vessels have berthed at this quay for a number of years. Since the dredging works the maintenance of position in deep water when alongside has become more critical for large vessels with deep draught. This is especially the case in light of the mooring arrangements available at the time.

4.7.3. These factors also indicate a failure to fully risk assess the berthing of large vessels in the Port, in particular the effect of adverse weather and tide condition in wintertime.

4.8. Actions Taken:

4.8.1. The management of Greenore Port immediately commenced an investigation into the incident and as a result instituted new procedures for berthing of vessels and began a training program for berthing teams. A new limit mark consisting of a red pole and line has been positioned to give five meters clearance of the shoal water at forward end of berth. All mooring crews have been informed of this limit. All vessels will be notified in writing of the limit of the deep-water berth prior to arrival and instructed to maintain the correct position on the berth.

4.9. The pilotage service has been made aware of the limits of the deep-water berth and the marking of the limits.

4.10. In order to improve the berth for large vessels, Greenore Port Management are seeking planning to deepen the forward end of the berth so vessels can berth further in along the quay wall and also place a mooring buoy off Greenore Point so the after mooring lines will lead in an astern direction thus preventing forward movement (see Appendix 7.3 Photograph No. 6).

5. CONCLUSIONS

5.1. The Master is responsible for the safety of the vessel and it appears that the pre-arrival preparations for the vessel did not consider all aspects of the port.

5.2. The incident occurred due to failings in the port's management of risk assessment and appropriate safety procedures and the safe management of the ship.

5.3. Greenore Port is a privately owned independent port and as such the safety and management procedures are not audited by an independent authority for best practice.

5.4. The management of Greenore Port have taken corrective actions to ensure vessels are berthed in the correct safe position.

6. SAFETY RECOMMENDATIONS

6.1. Greenore Port should implement a safety management system to ensure the safety of vessels using the port.

6.2. The shipping company should ensure that their passage planning and berthing procedures ensure that there is sufficient underkeel clearance at all times.

7. APPENDICES

Appendix 7.1 Met Éireann Weather Report.

MET ÉIREANN
The Irish Meteorological Service

Glasnevin Hill,
Dublin 9, Ireland.

Cnoc Ghlas Naíon
Baile Átha Cliath 9, Éire.
www.met.ie

Tel: +353-1-806 4200
Fax: +353-1-806 4247
E-mail: met.eireann@met.ie

7/10/2015

Our Ref. **WS3018/2_16028**
Your Ref. **MCIB/12/250**

Estimate of weather conditions in the Greenore Port, Co Lough sea area, on the 27th September 2015, between 00 and 6 hours

General Situation
A large anticyclone was slow moving over the Irish Sea, Ireland and the UK.

Details:
00-6 hours

Winds: Light, Force 2 to 3, from variable directions mainly the south-east.

Weather: Dry and mostly cloudy. There was widespread fog inland and some may have drifted into the area.

Visibility: Moderate to Poor

Seastate: Calm to Smooth.

[redacted]
Met Éireann

Appendix 7.1 Met Éireann Weather Report.

MET ÉIREANN
The Irish Meteorological Service

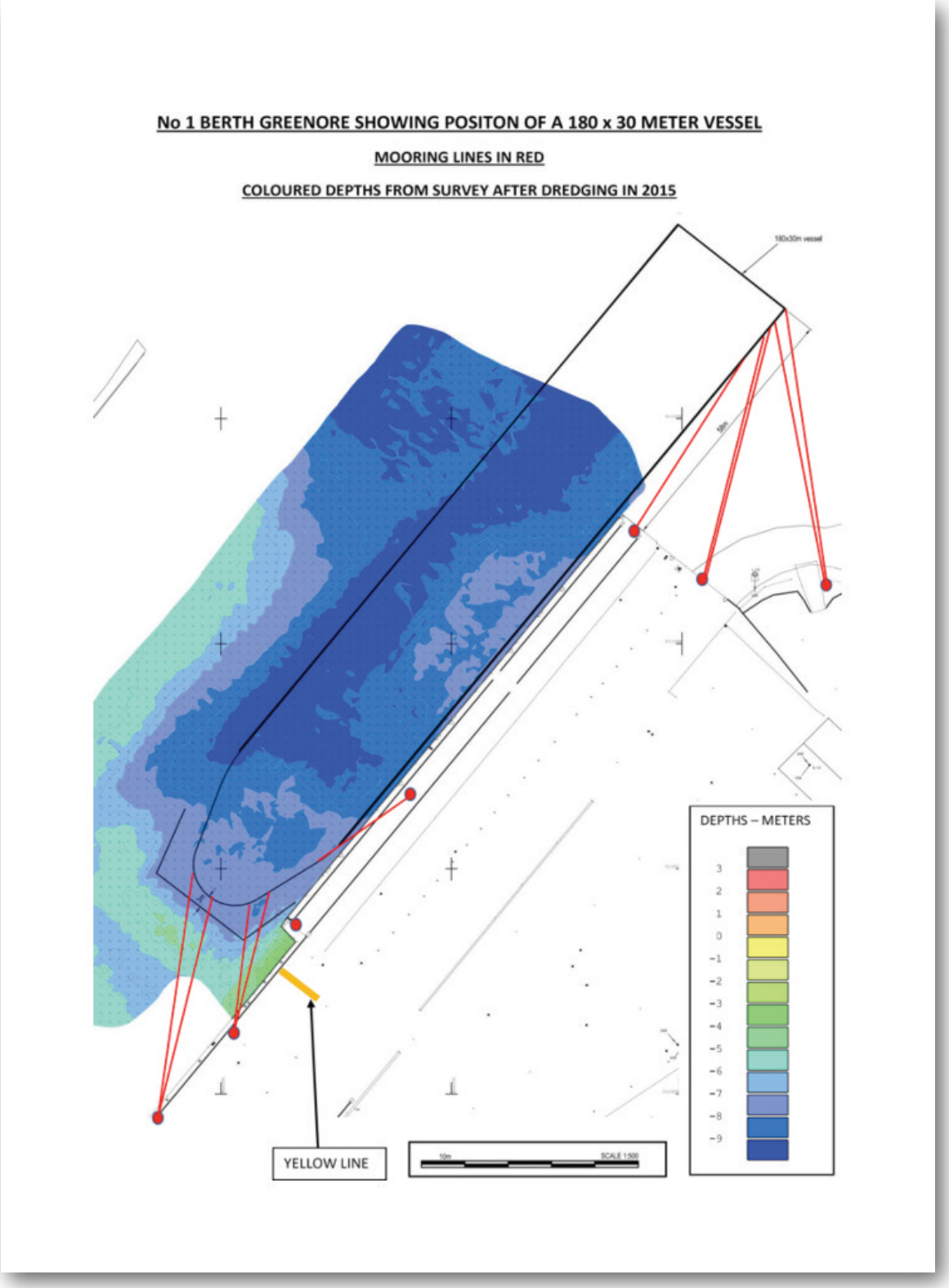
Glasnevin Hill,
Dublin 9, Ireland.

Cnoc Ghlas Naíon
Baile Átha Cliath 9, Éire.
www.met.ie

Tel: +353-1-806 4200
Fax: +353-1-806 4247
E-mail: met.eireann@met.ie

Buoy M2 (station number)	Date and time	Wind speed (knots)	Wind direction (degrees from North)	Wind gust (knots)	Air temperature (°C)	Significant wave height (m)
62091	27-sep-2015 00:00:00	4.6	160	5.8	14.3	0.2
62091	27-sep-2015 01:00:00	3.3	149.8	4.4	14.2	0.2
62091	27-sep-2015 02:00:00	7.3	141.7	9.5	14.3	0.2
62091	27-sep-2015 03:00:00	8.7	150.1	11.2	14.2	0.2
62091	27-sep-2015 04:00:00	9.4	160	11.5	14.3	0.2
62091	27-sep-2015 05:00:00	8.4	169.5	11.1	14.2	0.4
62091	27-sep-2015 06:00:00	9.8	154.7	12.2	14.1	0.4

Appendix 7.2 Plan of No. 1 Berth.



Note - Only one forward spring line and one back spring are shown for clarity, there were two of each.

Appendix 7.3 Photographs.

Photograph No. 1: View taken on 28th September at 12.55 hrs just before the move astern at 13.00 hrs. The yellow line has been brushed free of debris.

Photograph No. 2: External damage showing one of the splits in shell plating.

Appendix 7.3 Photographs.

Photograph No. 3: Internal damage, distortion of internal frames.

Photograph No. 4: Internal damage, distortion of internal frames.

Appendix 7.3 Photographs.

Photograph No. 5: View of after mooring lines – note all 4 lead in a forward direction.

Photograph No. 6: Proposed large vessel mooring Buoy – this will be located Aft of the vessel so the after mooring lines will lead in an astern direction.

Appendix 7.4 Timeline.

26th September 2015

20:54 The vessel arrived off Carlingford Lough and anchored

27th September 2015

10:28 Pilot On board

12:00 Vessel secure alongside

28th September 2015

06:00 Vessel observed aground by Chief Officer

08:15 Agent informs Master vessel was 9 m beyond the assigned mark forward.

08:50 Discharge commenced

13:00 Vessel moved 9 m astern on berth.

29th September 2015

13:00 Vessel observed to be 5 m beyond assigned mark and asked to shift astern.

30th September 2015

16:04 e-mail from Agent to vessel advising that vessel was 2 m ahead of assigned position, and importance of maintaining position on the berth.

5th October 2015

05:00 Master of vessel calls Agent to arrange for a tug after spring rope parts in high winds. Tug assists vessel back into position on berth.

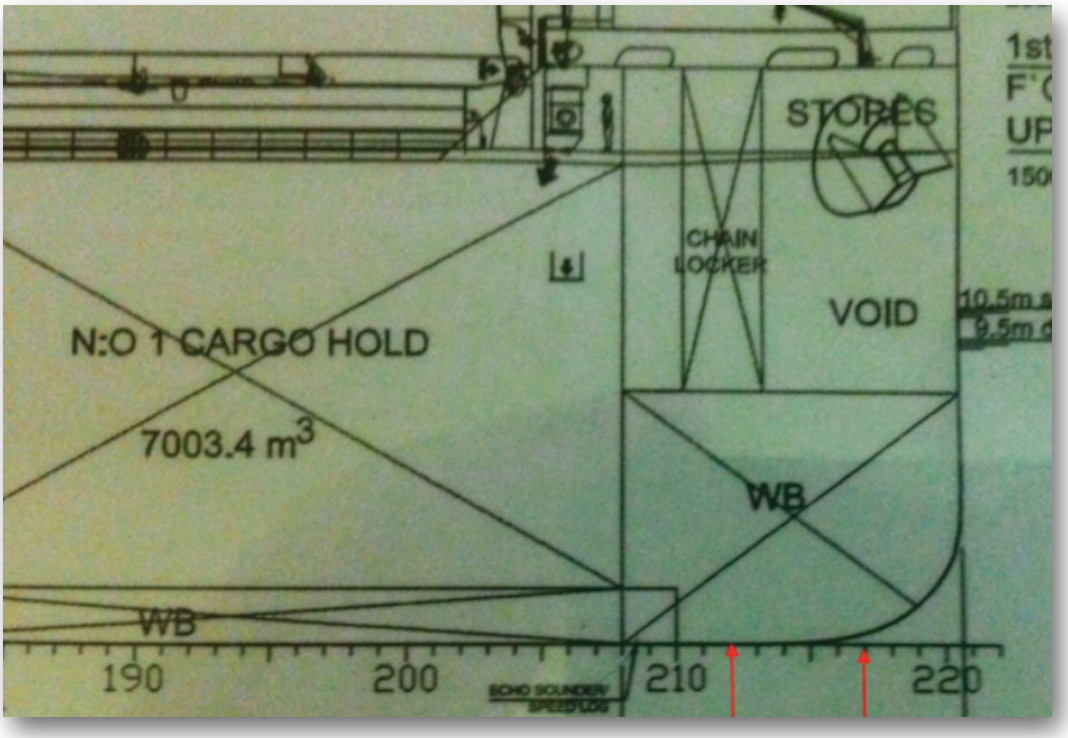
6th October 2015

16:15 Cargo discharge completed

9th October 2015

21:30 Vessel sailed.

Appendix 7.5 Elevation of Forward part of vessel.



Frame spacing was at 800mm
Damage occurred between frames 212 and 217.

NATURAL JUSTICE - CORRESPONDENCE RECEIVED

Section 36 of the Merchant Shipping (Investigation of Marine Casualties) Act, 2000 requires that:

"36 (1) Before publishing a report, the Board shall send a draft of the report or sections of the draft report to any person who, in its opinion, is likely to be adversely affected by the publishing of the report or sections or, if that person be deceased, then such person as appears to the Board best to represent that person's interest.

(2) A person to whom the Board sends a draft in accordance with subsection (1) may, within a period of 28 days commencing on the date on which the draft is sent to the person, or such further period not exceeding 28 days, as the Board in its absolute discretion thinks fit, submit to the Board in writing his or her observations on the draft.

(3) A person to whom a draft has been sent in accordance with subsection (1) may apply to the Board for an extension, in accordance with subsection (2), of the period in which to submit his or her observations on the draft.

(4) Observations submitted to the Board in accordance with subsection (2) shall be included in an appendix to the published report, unless the person submitting the observations requests in writing that the observations be not published.

(5) Where observations are submitted to the Board in accordance with subsection (2), the Board may, at its discretion -

(a) alter the draft before publication or decide not to do so, or

(b) include in the published report such comments on the observations as it thinks fit."

The Board reviews and considers all observations received whether published or not published in the final report. When the Board considers an observation requires amendments to the report that is stated beside the relevant observation. When the Board is satisfied that the report has adequately addressed the issue in the observation, then the observation is 'Noted' without comment or amendment. The Board may make further amendments or observations in light of the responses from the Natural Justice process.

'Noted' does not mean that the Board either agrees or disagrees with the observation.

8. NATURAL JUSTICE - CORRESPONDENCE RECEIVED

Note: The names and contact details of the individual respondents have been obscured for privacy reasons.

Correspondence 8.1 RINA and MCIB response.

[redacted]

From: [redacted]
Sent: 12 August 2016 15:01
To: Marine Casualty Investigation Board
Subject: Draft report into the grounding of the vessel "Cielo Di MOnaco" Greenore Port, Co Louth on the 27th September 2015

Dear [redacted]

reference is made your letter MCIB/12/250 dated 28th July 2016.

We have reviewed the captioned draft report and we have no comments.

Thanks for submitting it to our attention before release.
Yours sincerely,

RINA SERVICES

[redacted]
General Manager, Northern & Western Europe, Central & Eastern Europe

RINA Services S.p.A.
[redacted]
RINA website: www.rina.org

The information contained in this e-mail is intended only for the individual or entity to whom it is addressed. Its contents (including any attachments) are confidential and privileged: if you are not an intended recipient you must not use, disclose, disseminate, copy or print its contents. If you have received this email by mistake please notify us by emailing the sender, and then delete and/or destroy the e-mail and any copies from your system

1

MCIB RESPONSE:
The MCIB notes the contents of this correspondence.

Correspondence 8.2 Marine Safety Investigation Unit, Malta and MCIB response.

[redacted]

From: [redacted]
Sent: 08 August 2016 08:59
To: Marine Casualty Investigation Board
Subject: MV Cielo di Monaco IMO # 9638147 Draft Safety Investigation Report

Importance: High

Kind Attention: [redacted]
Secretariat
Marine Casualty Investigation Board, Ireland

Dear [redacted]

Good morning.

Reference is made to your draft report into the grounding of the captioned vessel, which happened on 27 September 2015.

We find the draft report very well written, clear and to the point. Whilst we thank you for sharing it with us, please note that we only have editorial comments as follows:

Para 3.1.3: Last sentence – suggest amending "Under the vessels ISM Code..." to "Under the vessel's safety management system...";

Para 3.2.1: Third sentence – suggest amending "...and no cargo been discharged he concluded the vessel was aground forward causing damage between frames 213 and 217" to "...and no cargo been discharged he concluded the vessel was aground forward, potentially causing damage in way of frames 213 and 217." (The reason behind this amendment is to take into consideration that at the time, the chief officer may have not been aware as to where exactly the damage was);

Para 3.3.3: First sentence – suggest amending "During the vessels stay in port..." to "During the vessel's stay in port...";

Para 4.4.2: First sentence – suggest amending "Large vessels have been berthed at this quay..." to "Large vessels have berthed at this quay...".

Thank you for your time into the matter.

Regards

[redacted]
Head of Marine Safety Investigation
Marine Safety Investigation Unit

Malta Transport Centre
Marsa MRS 1917
Malta

Marine Casualty Investigation Board
08 AUG 2016
Bord Imscrúdú Tasimi Muirí

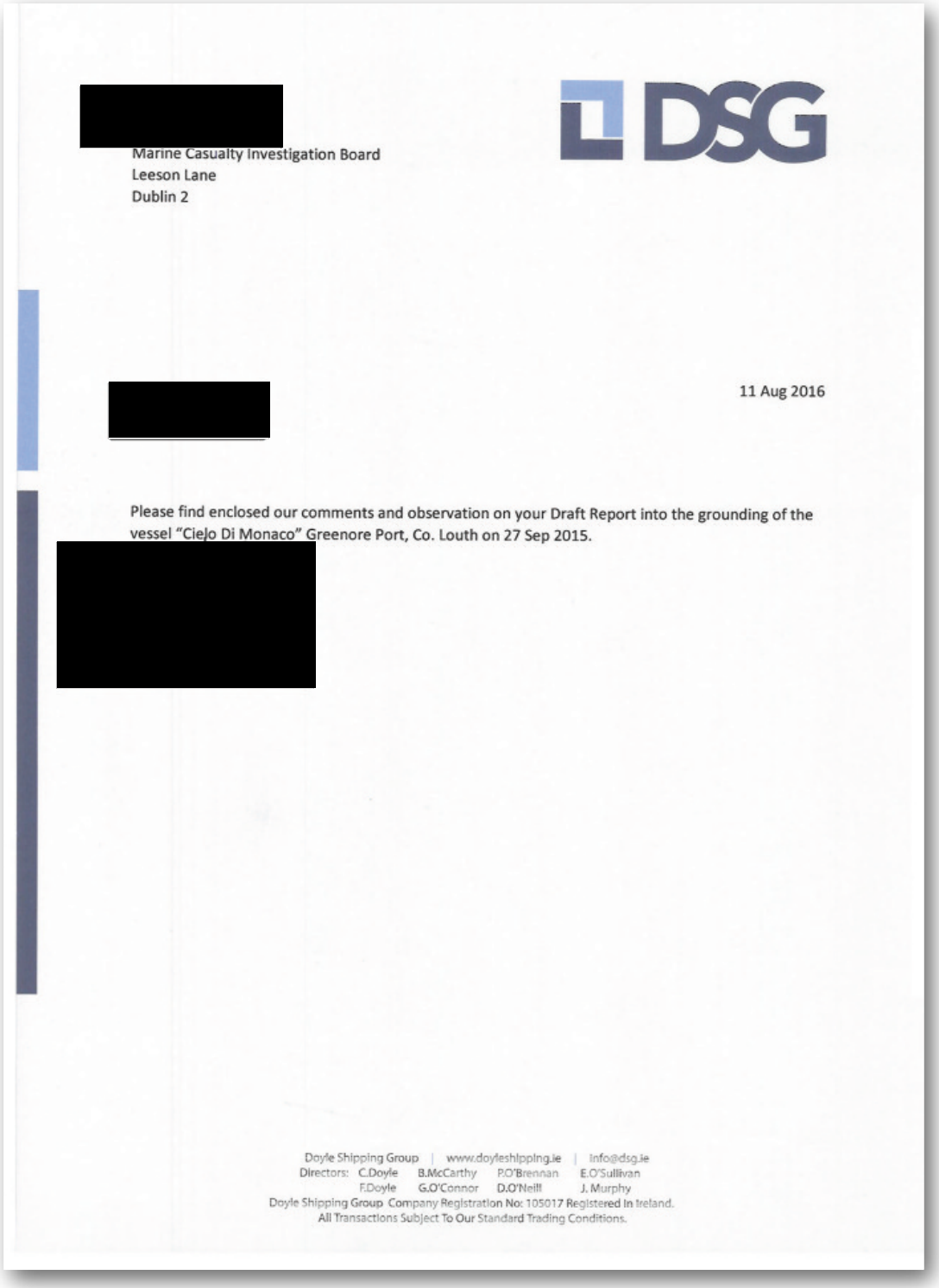
Think green before you print

CONFIDENTIALITY NOTICE:
This e-mail message (including any attachments thereto) is privileged and confidential to the addressee and is intended only for the use of the addressee or his authorised agent.
If you are not the named addressee:
(i) you are hereby notified that any distribution or copying of this message is strictly prohibited;

1

MCIB RESPONSE:
The MCIB notes the contents of this correspondence and has made the necessary amendments.

Correspondence 8.3 Doyle Shipping Group and MCIB response.



[redacted]

Marine Casualty Investigation Board
Leeson Lane
Dublin 2

DSG

[redacted]

11 Aug 2016

Please find enclosed our comments and observation on your Draft Report into the grounding of the vessel "Cielo Di Monaco" Greenore Port, Co. Louth on 27 Sep 2015.

[redacted]

Doyle Shipping Group | www.doyleshipping.ie | info@dsg.ie
Directors: C.Doyle B.McCarthy P.O'Brennan E.O'Sullivan
F.Doyle G.O'Connor D.O'Neill J. Murphy
Doyle Shipping Group Company Registration No: 105017 Registered in Ireland.
All Transactions Subject To Our Standard Trading Conditions.

Correspondence 8.3 Doyle Shipping Group and MCIB response.

DSG

[redacted]
Marine Casualty Investigation Board
Leeson Lane
Dublin 2

August 22nd 2016

Draft report into the grounding of the vessel "Cielo Di Monaco" Greenore Port, Co. Louth on 27 September 2015

[redacted]

Thank you for your letter of 28 July 2016 enclosing a copy of your Draft Report in relation to the above incident and inviting our observations on same in accordance with the provisions of Section 36 of the Merchant Shipping (Investigation of Marine Casualties) Act, 2000. We are pleased to be afforded this opportunity to provide our observations as we feel a number of factors are not included within the Draft Report and which had a critical and causative effect.

We set out our observations below with reference to the section numbers adopted by you in your Draft Report.

Section 3.1.1

At section 3.1.1 of the Draft Report, and throughout the remainder of the report, great significance is attached to the dredging of the berth in May 2015 and the subsequent painting of a yellow line on the quay wall to show the extent of the dredging. It is critical to note that the dredging and the painting of the yellow line did not change in any respect the berthing limitations on the berth. The importance therefore attached to and the relevance therefore of the yellow line to the berthing position has been misconstrued.

It is also important to note that vessels both the size and of greater draft of the mv Cielo Di Monaco had berthed at the berth prior to the dredging works and without any incident.

Section 3.1.2

At Section 3.1.2 of the Draft Report we note the MCIB state that at the time of the incident the Port Company had a health and safety statement and an emergency plan but this Safety Statement only related to occupational safety aspects in the Port referable to the Safety, Health and Welfare at Work Act 2005. The Draft Report goes further to state that there were no risk assessments or operating procedures in place for the docking and management of vessels alongside, particularly large vessels that extended beyond the quay.

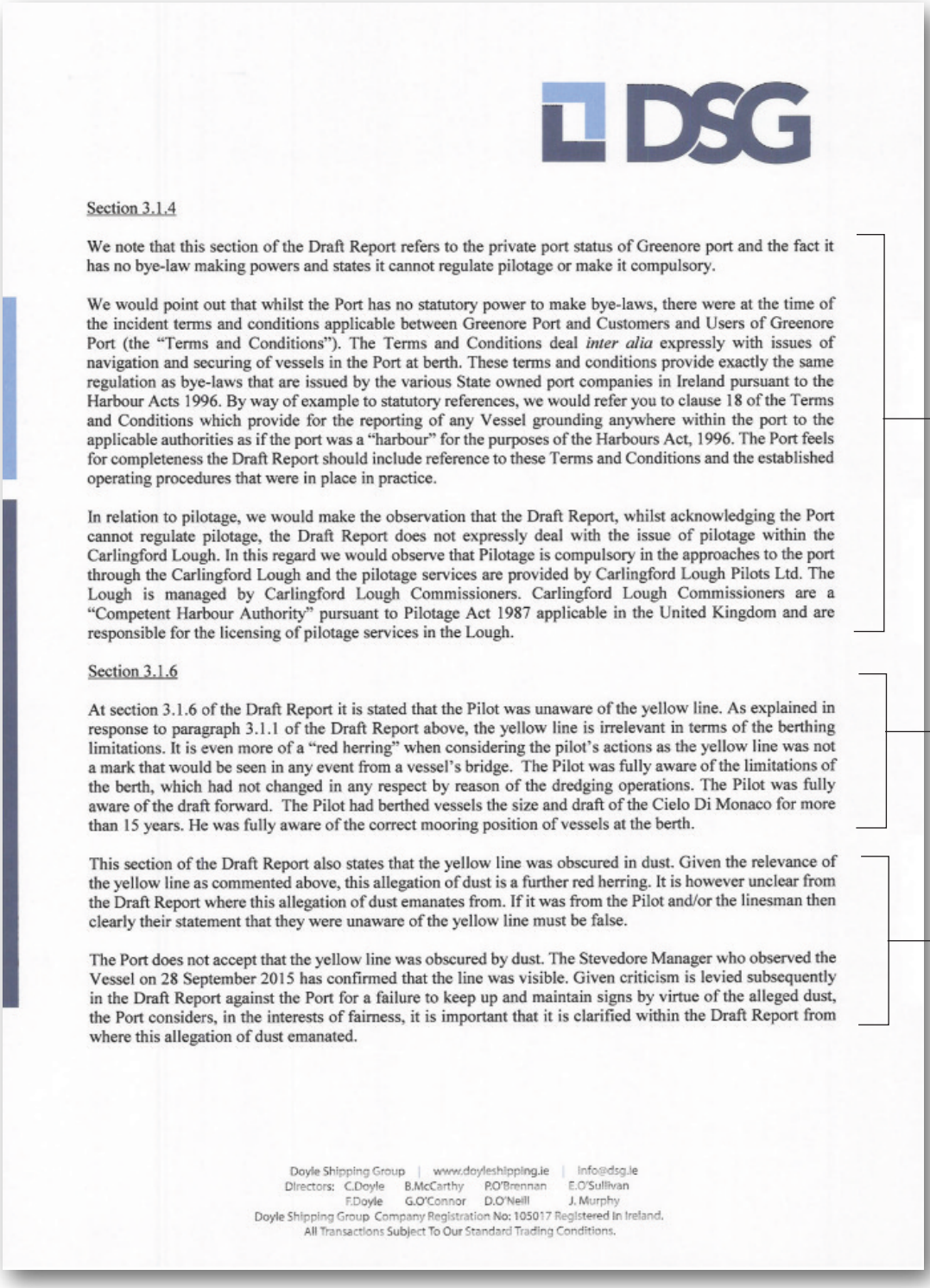
The Port acknowledges that at the time of the incident there was no separate written risk assessment of the procedures for the docking and management of vessels alongside. A written separate document has now been executed. There were however well established operating practices in place at the time of the incident and which had been in place for over 15 years. The responsibility for the berthing of all vessels at Greenore port in terms of manoeuvring of the vessel lies with the Master and the Pilot. The Pilot would, in conjunction with communication with the stevedore manager and linesman, moor all vessels.

Doyle Shipping Group | www.doyleshipping.ie | info@dsg.ie
Directors: C.Doyle B.McCarthy P.O'Brennan E.O'Sullivan
F.Doyle G.O'Connor D.O'Neill J. Murphy
Doyle Shipping Group Company Registration No: 105017 Registered In Ireland.

MCIB RESPONSE: The MCIB notes the contents of this observation. The yellow line was the only visible reference to the limit of the deep water.

MCIB RESPONSE: The MCIB notes the contents of this observation.

Correspondence 8.3 Doyle Shipping Group and MCIB response.



DSG

Section 3.1.4

We note that this section of the Draft Report refers to the private port status of Greenore port and the fact it has no bye-law making powers and states it cannot regulate pilotage or make it compulsory.

We would point out that whilst the Port has no statutory power to make bye-laws, there were at the time of the incident terms and conditions applicable between Greenore Port and Customers and Users of Greenore Port (the "Terms and Conditions"). The Terms and Conditions deal *inter alia* expressly with issues of navigation and securing of vessels in the Port at berth. These terms and conditions provide exactly the same regulation as bye-laws that are issued by the various State owned port companies in Ireland pursuant to the Harbour Acts 1996. By way of example to statutory references, we would refer you to clause 18 of the Terms and Conditions which provide for the reporting of any Vessel grounding anywhere within the port to the applicable authorities as if the port was a "harbour" for the purposes of the Harbours Act, 1996. The Port feels for completeness the Draft Report should include reference to these Terms and Conditions and the established operating procedures that were in place in practice.

In relation to pilotage, we would make the observation that the Draft Report, whilst acknowledging the Port cannot regulate pilotage, the Draft Report does not expressly deal with the issue of pilotage within the Carlingford Lough. In this regard we would observe that Pilotage is compulsory in the approaches to the port through the Carlingford Lough and the pilotage services are provided by Carlingford Lough Pilots Ltd. The Lough is managed by Carlingford Lough Commissioners. Carlingford Lough Commissioners are a "Competent Harbour Authority" pursuant to Pilotage Act 1987 applicable in the United Kingdom and are responsible for the licensing of pilotage services in the Lough.

Section 3.1.6

At section 3.1.6 of the Draft Report it is stated that the Pilot was unaware of the yellow line. As explained in response to paragraph 3.1.1 of the Draft Report above, the yellow line is irrelevant in terms of the berthing limitations. It is even more of a "red herring" when considering the pilot's actions as the yellow line was not a mark that would be seen in any event from a vessel's bridge. The Pilot was fully aware of the limitations of the berth, which had not changed in any respect by reason of the dredging operations. The Pilot was fully aware of the draft forward. The Pilot had berthed vessels the size and draft of the Cielo Di Monaco for more than 15 years. He was fully aware of the correct mooring position of vessels at the berth.

This section of the Draft Report also states that the yellow line was obscured in dust. Given the relevance of the yellow line as commented above, this allegation of dust is a further red herring. It is however unclear from the Draft Report where this allegation of dust emanates from. If it was from the Pilot and/or the linesman then clearly their statement that they were unaware of the yellow line must be false.

The Port does not accept that the yellow line was obscured by dust. The Stevedore Manager who observed the Vessel on 28 September 2015 has confirmed that the line was visible. Given criticism is levied subsequently in the Draft Report against the Port for a failure to keep up and maintain signs by virtue of the alleged dust, the Port considers, in the interests of fairness, it is important that it is clarified within the Draft Report from where this allegation of dust emanated.

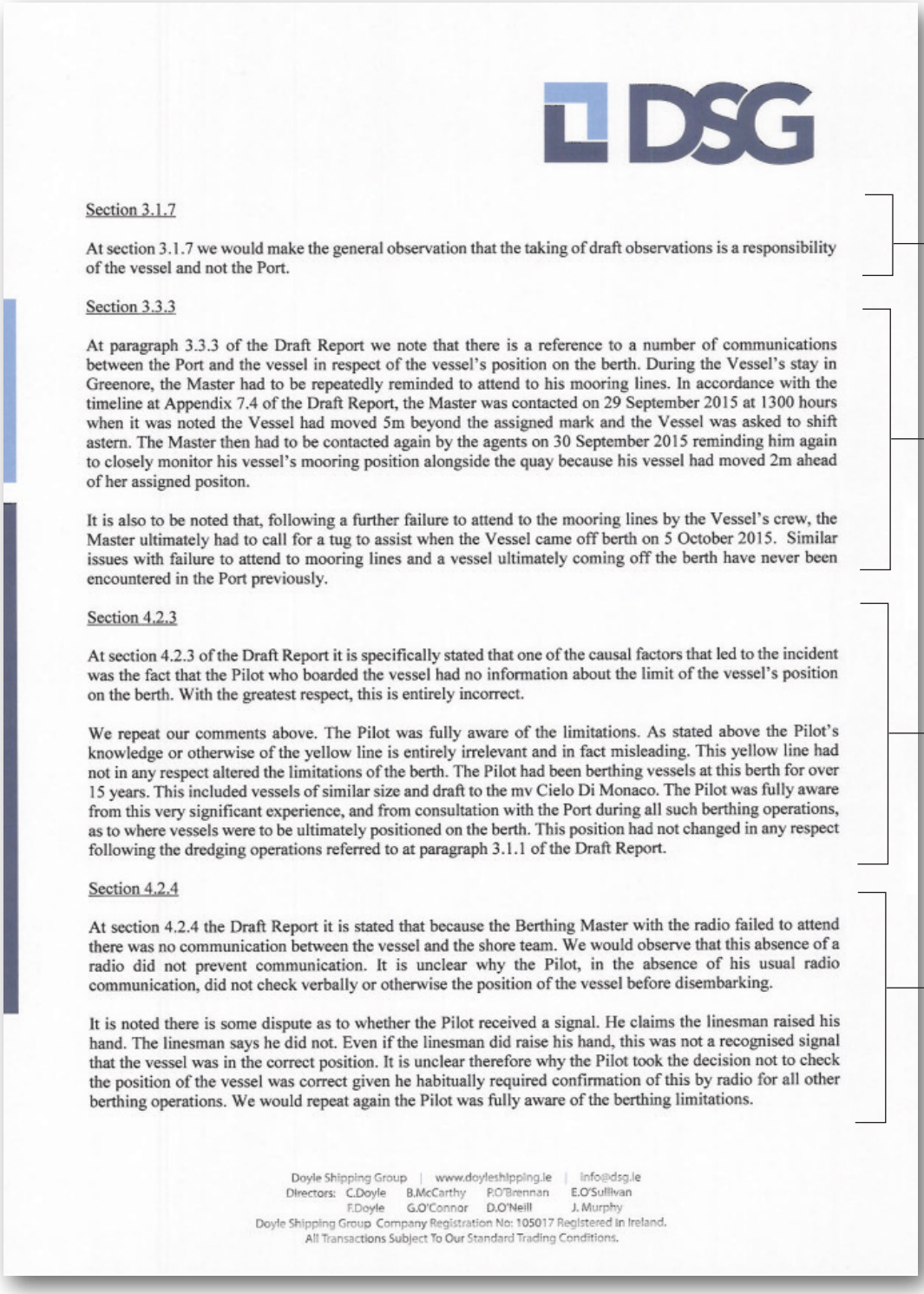
Doyle Shipping Group | www.doyleshipping.ie | info@dsg.ie
Directors: C.Doyle B.McCarthy P.O'Brennan E.O'Sullivan
F.Doyle G.O'Connor D.O'Neill J. Murphy
Doyle Shipping Group Company Registration No: 105017 Registered in Ireland.
All Transactions Subject To Our Standard Trading Conditions.

MCIB RESPONSE: The MCIB notes the contents of this observation.

MCIB RESPONSE: Please see response at 3.1.1 above.

MCIB RESPONSE: This information came from witness evidence. See Appendix 7.3 Photograph No. 1.

Correspondence 8.3 Doyle Shipping Group and MCIB response.



DSG

Section 3.1.7

At section 3.1.7 we would make the general observation that the taking of draft observations is a responsibility of the vessel and not the Port.

Section 3.3.3

At paragraph 3.3.3 of the Draft Report we note that there is a reference to a number of communications between the Port and the vessel in respect of the vessel's position on the berth. During the Vessel's stay in Greenore, the Master had to be repeatedly reminded to attend to his mooring lines. In accordance with the timeline at Appendix 7.4 of the Draft Report, the Master was contacted on 29 September 2015 at 1300 hours when it was noted the Vessel had moved 5m beyond the assigned mark and the Vessel was asked to shift astern. The Master then had to be contacted again by the agents on 30 September 2015 reminding him again to closely monitor his vessel's mooring position alongside the quay because his vessel had moved 2m ahead of her assigned positon.

It is also to be noted that, following a further failure to attend to the mooring lines by the Vessel's crew, the Master ultimately had to call for a tug to assist when the Vessel came off berth on 5 October 2015. Similar issues with failure to attend to mooring lines and a vessel ultimately coming off the berth have never been encountered in the Port previously.

Section 4.2.3

At section 4.2.3 of the Draft Report it is specifically stated that one of the causal factors that led to the incident was the fact that the Pilot who boarded the vessel had no information about the limit of the vessel's position on the berth. With the greatest respect, this is entirely incorrect.

We repeat our comments above. The Pilot was fully aware of the limitations. As stated above the Pilot's knowledge or otherwise of the yellow line is entirely irrelevant and in fact misleading. This yellow line had not in any respect altered the limitations of the berth. The Pilot had been berthing vessels at this berth for over 15 years. This included vessels of similar size and draft to the mv Cielo Di Monaco. The Pilot was fully aware from this very significant experience, and from consultation with the Port during all such berthing operations, as to where vessels were to be ultimately positioned on the berth. This position had not changed in any respect following the dredging operations referred to at paragraph 3.1.1 of the Draft Report.

Section 4.2.4

At section 4.2.4 the Draft Report it is stated that because the Berthing Master with the radio failed to attend there was no communication between the vessel and the shore team. We would observe that this absence of a radio did not prevent communication. It is unclear why the Pilot, in the absence of his usual radio communication, did not check verbally or otherwise the position of the vessel before disembarking.

It is noted there is some dispute as to whether the Pilot received a signal. He claims the linesman raised his hand. The linesman says he did not. Even if the linesman did raise his hand, this was not a recognised signal that the vessel was in the correct position. It is unclear therefore why the Pilot took the decision not to check the position of the vessel was correct given he habitually required confirmation of this by radio for all other berthing operations. We would repeat again the Pilot was fully aware of the berthing limitations.

Doyle Shipping Group | www.doyleshipping.ie | info@dsg.ie
Directors: C.Doyle B.McCarthy P.O'Brennan E.O'Sullivan
F.Doyle G.O'Connor D.O'Neill J. Murphy
Doyle Shipping Group Company Registration No: 105017 Registered in Ireland.
All Transactions Subject To Our Standard Trading Conditions.

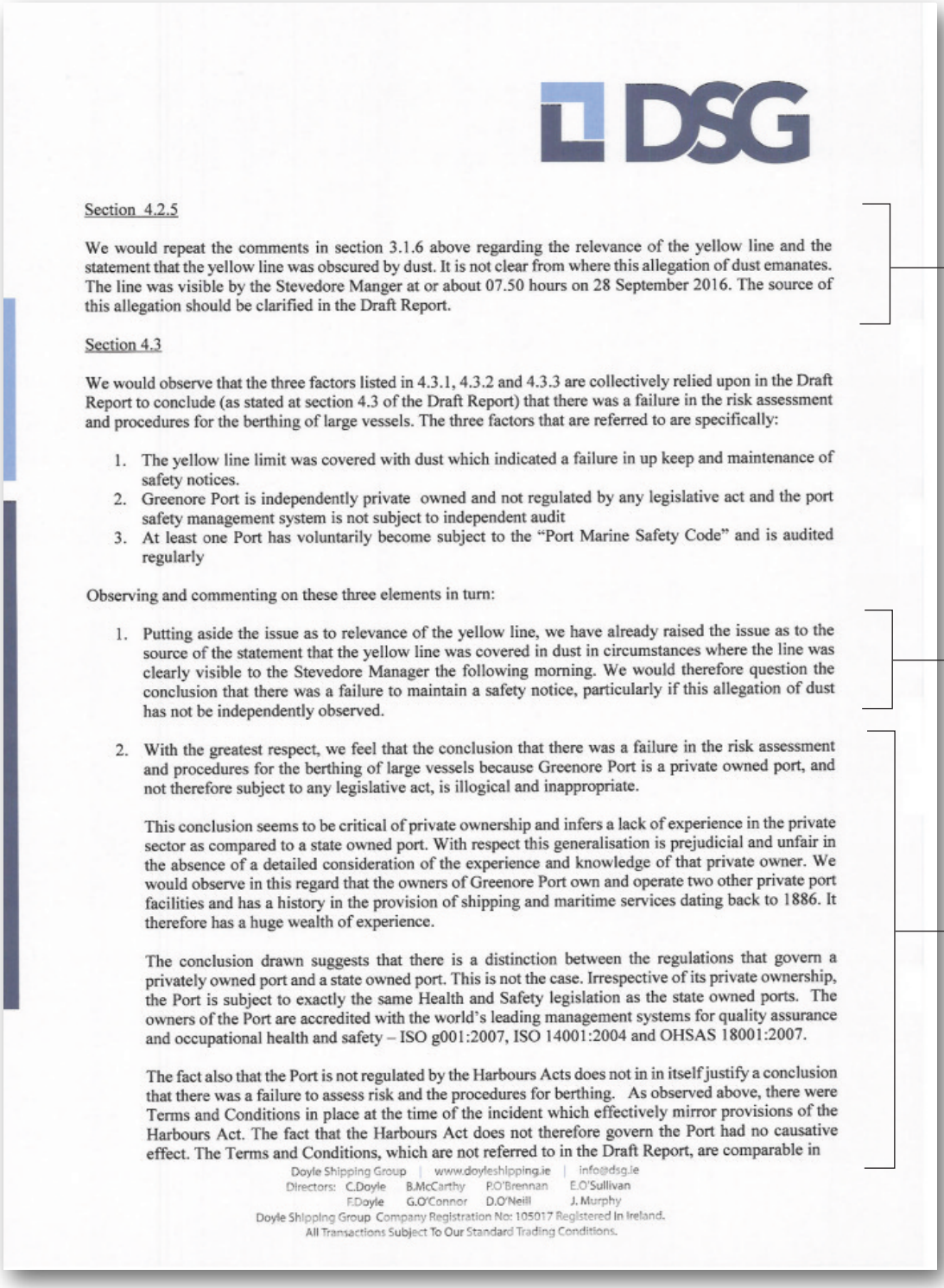
MCIB RESPONSE: The MCIB notes the contents of this observation.

MCIB RESPONSE: The MCIB notes the contents of this observation.

MCIB RESPONSE: Please see response at 3.1.1 above.

MCIB RESPONSE: Please see response at 3.1.1 above.

Correspondence 8.3 Doyle Shipping Group and MCIB response.



DSG

Section 4.2.5

We would repeat the comments in section 3.1.6 above regarding the relevance of the yellow line and the statement that the yellow line was obscured by dust. It is not clear from where this allegation of dust emanates. The line was visible by the Stevedore Manger at or about 07.50 hours on 28 September 2016. The source of this allegation should be clarified in the Draft Report.

Section 4.3

We would observe that the three factors listed in 4.3.1, 4.3.2 and 4.3.3 are collectively relied upon in the Draft Report to conclude (as stated at section 4.3 of the Draft Report) that there was a failure in the risk assessment and procedures for the berthing of large vessels. The three factors that are referred to are specifically:

1. The yellow line limit was covered with dust which indicated a failure in up keep and maintenance of safety notices.
2. Greenore Port is independently private owned and not regulated by any legislative act and the port safety management system is not subject to independent audit
3. At least one Port has voluntarily become subject to the "Port Marine Safety Code" and is audited regularly

Observing and commenting on these three elements in turn:

1. Putting aside the issue as to relevance of the yellow line, we have already raised the issue as to the source of the statement that the yellow line was covered in dust in circumstances where the line was clearly visible to the Stevedore Manager the following morning. We would therefore question the conclusion that there was a failure to maintain a safety notice, particularly if this allegation of dust has not be independently observed.

2. With the greatest respect, we feel that the conclusion that there was a failure in the risk assessment and procedures for the berthing of large vessels because Greenore Port is a private owned port, and not therefore subject to any legislative act, is illogical and inappropriate.

   This conclusion seems to be critical of private ownership and infers a lack of experience in the private sector as compared to a state owned port. With respect this generalisation is prejudicial and unfair in the absence of a detailed consideration of the experience and knowledge of that private owner. We would observe in this regard that the owners of Greenore Port own and operate two other private port facilities and has a history in the provision of shipping and maritime services dating back to 1886. It therefore has a huge wealth of experience.

   The conclusion drawn suggests that there is a distinction between the regulations that govern a privately owned port and a state owned port. This is not the case. Irrespective of its private ownership, the Port is subject to exactly the same Health and Safety legislation as the state owned ports. The owners of the Port are accredited with the world's leading management systems for quality assurance and occupational health and safety – ISO g001:2007, ISO 14001:2004 and OHSAS 18001:2007.

   The fact also that the Port is not regulated by the Harbours Acts does not in in itself justify a conclusion that there was a failure to assess risk and the procedures for berthing. As observed above, there were Terms and Conditions in place at the time of the incident which effectively mirror provisions of the Harbours Act. The fact that the Harbours Act does not therefore govern the Port had no causative effect. The Terms and Conditions, which are not referred to in the Draft Report, are comparable in

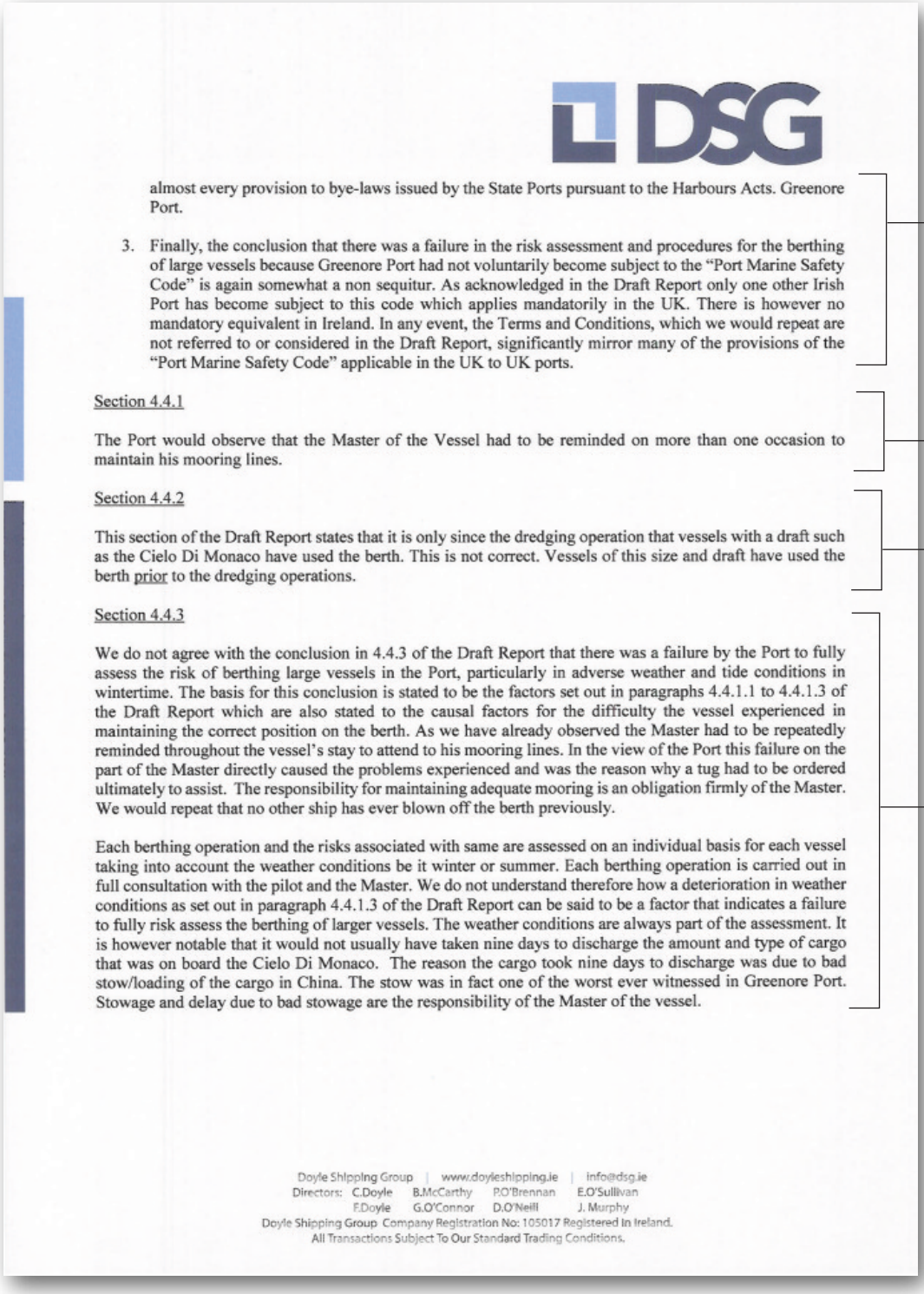
Doyle Shipping Group | www.doyleshipping.ie | info@dsg.ie
Directors: C.Doyle B.McCarthy P.O'Brennan E.O'Sullivan
F.Doyle G.O'Connor D.O'Neill J. Murphy
Doyle Shipping Group Company Registration No: 105017 Registered In Ireland.
All Transactions Subject To Our Standard Trading Conditions.

MCIB RESPONSE: Please see response at 3.1.1 above.

MCIB RESPONSE: Please see response at 3.1.1 above.

MCIB RESPONSE: The MCIB notes the contents of this observation.

Correspondence 8.3 Doyle Shipping Group and MCIB response.



almost every provision to bye-laws issued by the State Ports pursuant to the Harbours Acts. Greenore Port.

3. Finally, the conclusion that there was a failure in the risk assessment and procedures for the berthing of large vessels because Greenore Port had not voluntarily become subject to the "Port Marine Safety Code" is again somewhat a non sequitur. As acknowledged in the Draft Report only one other Irish Port has become subject to this code which applies mandatorily in the UK. There is however no mandatory equivalent in Ireland. In any event, the Terms and Conditions, which we would repeat are not referred to or considered in the Draft Report, significantly mirror many of the provisions of the "Port Marine Safety Code" applicable in the UK to UK ports.

Section 4.4.1

The Port would observe that the Master of the Vessel had to be reminded on more than one occasion to maintain his mooring lines.

Section 4.4.2

This section of the Draft Report states that it is only since the dredging operation that vessels with a draft such as the Cielo Di Monaco have used the berth. This is not correct. Vessels of this size and draft have used the berth prior to the dredging operations.

Section 4.4.3

We do not agree with the conclusion in 4.4.3 of the Draft Report that there was a failure by the Port to fully assess the risk of berthing large vessels in the Port, particularly in adverse weather and tide conditions in wintertime. The basis for this conclusion is stated to be the factors set out in paragraphs 4.4.1.1 to 4.4.1.3 of the Draft Report which are also stated to the causal factors for the difficulty the vessel experienced in maintaining the correct position on the berth. As we have already observed the Master had to be repeatedly reminded throughout the vessel's stay to attend to his mooring lines. In the view of the Port this failure on the part of the Master directly caused the problems experienced and was the reason why a tug had to be ordered ultimately to assist. The responsibility for maintaining adequate mooring is an obligation firmly of the Master. We would repeat that no other ship has ever blown off the berth previously.

Each berthing operation and the risks associated with same are assessed on an individual basis for each vessel taking into account the weather conditions be it winter or summer. Each berthing operation is carried out in full consultation with the pilot and the Master. We do not understand therefore how a deterioration in weather conditions as set out in paragraph 4.4.1.3 of the Draft Report can be said to be a factor that indicates a failure to fully risk assess the berthing of larger vessels. The weather conditions are always part of the assessment. It is however notable that it would not usually have taken nine days to discharge the amount and type of cargo that was on board the Cielo Di Monaco. The reason the cargo took nine days to discharge was due to bad stow/loading of the cargo in China. The stow was in fact one of the worst ever witnessed in Greenore Port. Stowage and delay due to bad stowage are the responsibility of the Master of the vessel.

Doyle Shipping Group | www.doyleshipping.ie | info@dsg.ie
Directors: C.Doyle B.McCarthy P.O'Brennan E.O'Sullivan
F.Doyle G.O'Connor D.O'Neill J. Murphy
Doyle Shipping Group Company Registration No: 105017 Registered in Ireland.
All Transactions Subject To Our Standard Trading Conditions.

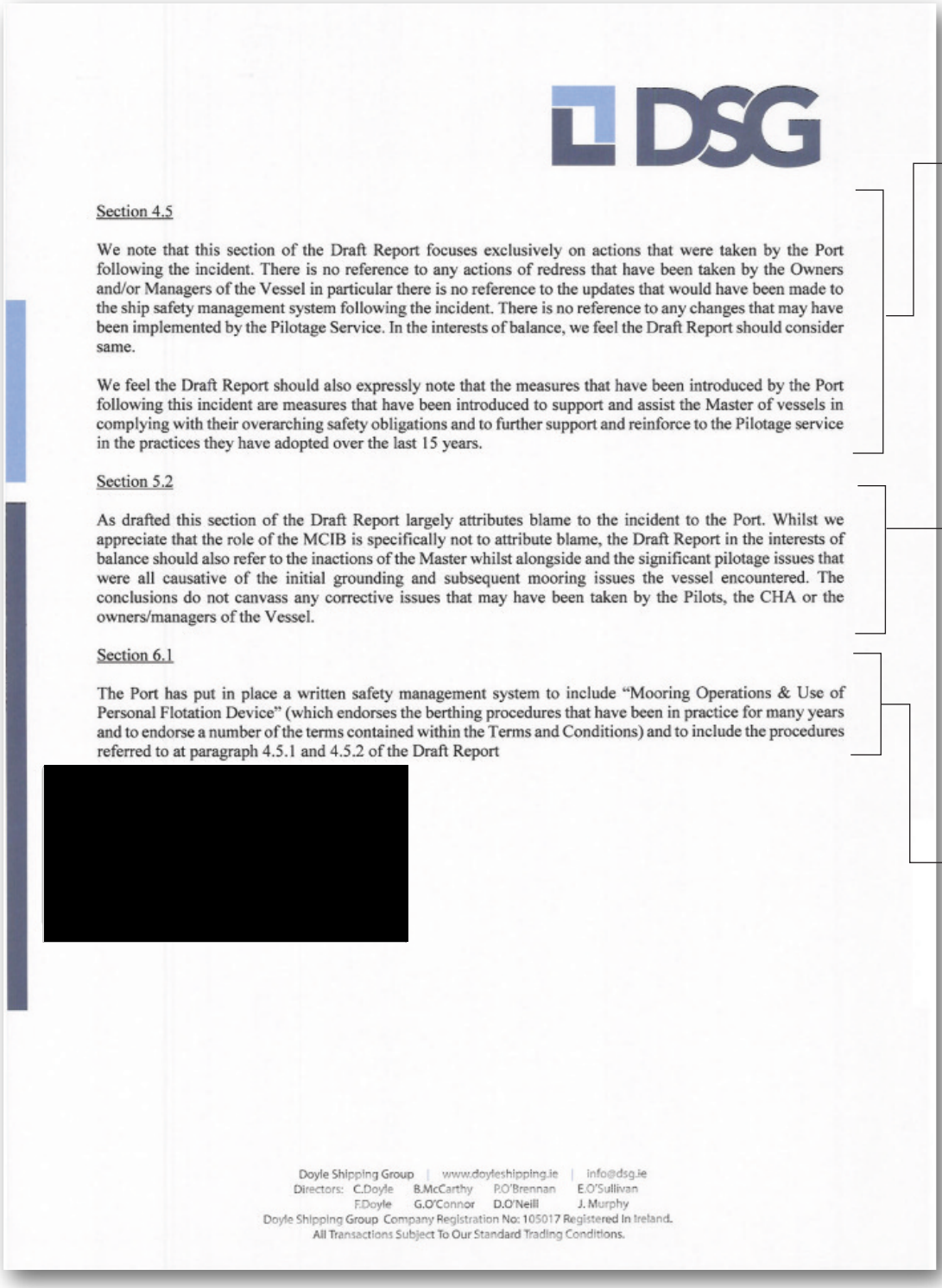
MCIB RESPONSE: The MCIB notes the contents of this observation.

MCIB RESPONSE: The MCIB notes the contents of this observation.

MCIB RESPONSE: Please see response at 3.1.1 above.

MCIB RESPONSE: Please see response at 3.1.1 above.

Correspondence 8.3 Doyle Shipping Group and MCIB response.



DSG

Section 4.5

We note that this section of the Draft Report focuses exclusively on actions that were taken by the Port following the incident. There is no reference to any actions of redress that have been taken by the Owners and/or Managers of the Vessel in particular there is no reference to the updates that would have been made to the ship safety management system following the incident. There is no reference to any changes that may have been implemented by the Pilotage Service. In the interests of balance, we feel the Draft Report should consider same.

We feel the Draft Report should also expressly note that the measures that have been introduced by the Port following this incident are measures that have been introduced to support and assist the Master of vessels in complying with their overarching safety obligations and to further support and reinforce to the Pilotage service in the practices they have adopted over the last 15 years.

Section 5.2

As drafted this section of the Draft Report largely attributes blame to the incident to the Port. Whilst we appreciate that the role of the MCIB is specifically not to attribute blame, the Draft Report in the interests of balance should also refer to the inactions of the Master whilst alongside and the significant pilotage issues that were all causative of the initial grounding and subsequent mooring issues the vessel encountered. The conclusions do not canvass any corrective issues that may have been taken by the Pilots, the CHA or the owners/managers of the Vessel.

Section 6.1

The Port has put in place a written safety management system to include "Mooring Operations & Use of Personal Flotation Device" (which endorses the berthing procedures that have been in practice for many years and to endorse a number of the terms contained within the Terms and Conditions) and to include the procedures referred to at paragraph 4.5.1 and 4.5.2 of the Draft Report

[redacted]

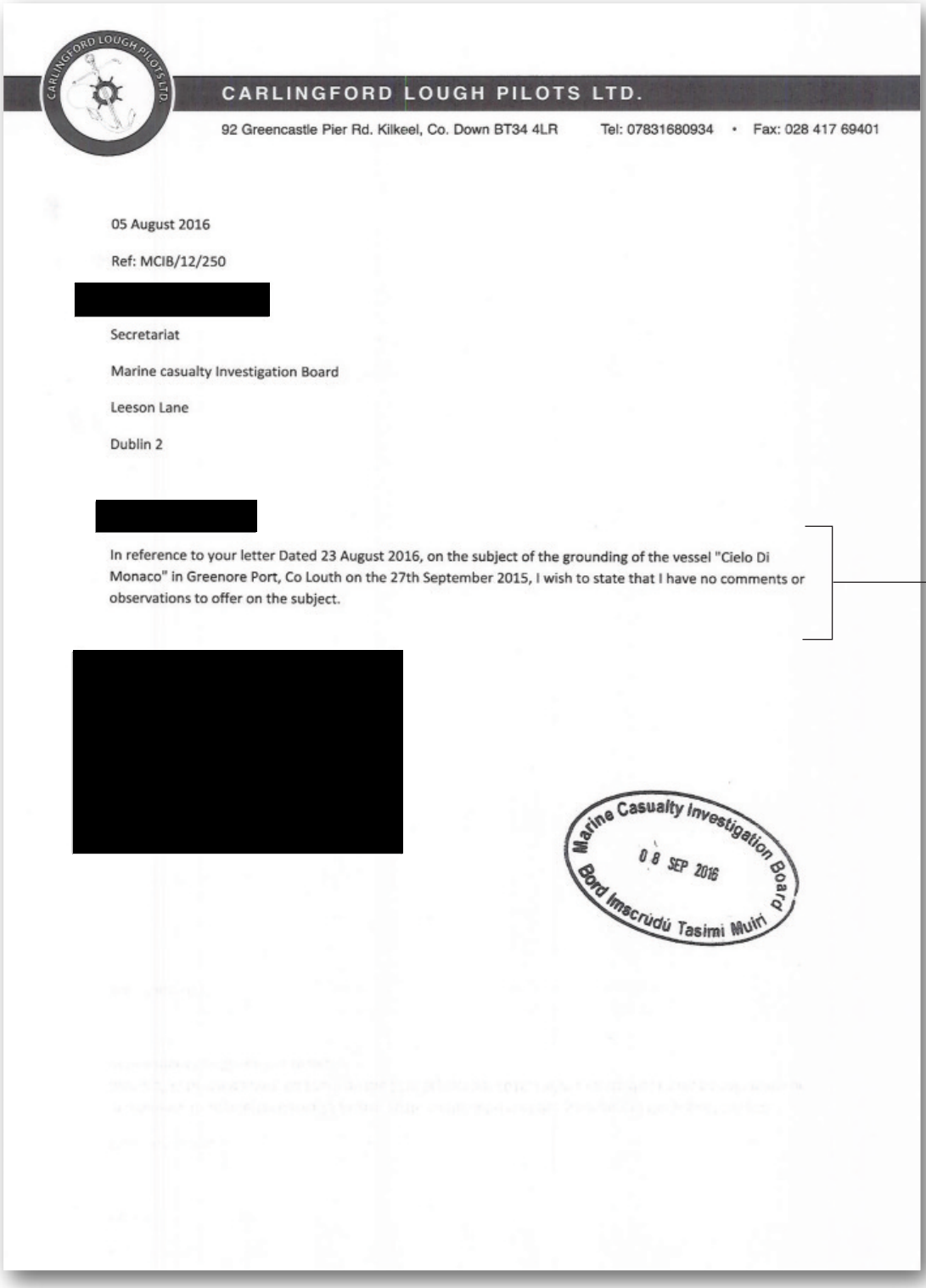
Doyle Shipping Group | www.doyleshipping.ie | info@dsg.ie
Directors: C.Doyle B.McCarthy P.O'Brennan E.O'Sullivan
F.Doyle G.O'Connor D.O'Neill J. Murphy
Doyle Shipping Group Company Registration No: 105017 Registered In Ireland.
All Transactions Subject To Our Standard Trading Conditions.

MCIB RESPONSE:
The MCIB notes the contents of this observation.

MCIB RESPONSE:
The purpose of an investigation by the MCIB is to establish the cause or causes of a marine casualty with a view to making recommendations for the avoidance of similar marine casualties. It is not the purpose of an investigation to attribute blame or fault.

MCIB RESPONSE:
The MCIB notes the contents of this observation.

Correspondence 8.4 Carlingford Lough Pilots Ltd and MCIB response.



CARLINGFORD LOUGH PILOTS LTD.

92 Greencastle Pier Rd. Kilkeel, Co. Down BT34 4LR Tel: 07831680934 • Fax: 028 417 69401

05 August 2016

Ref: MCIB/12/250

[redacted]

Secretariat

Marine casualty Investigation Board

Leeson Lane

Dublin 2

[redacted]

In reference to your letter Dated 23 August 2016, on the subject of the grounding of the vessel "Cielo Di Monaco" in Greenore Port, Co Louth on the 27th September 2015, I wish to state that I have no comments or observations to offer on the subject.

[redacted]

Marine Casualty Investigation Board
0 8 SEP 2016
Bord Imscrúdú Tasimi Muiri

MCIB RESPONSE:
The MCIB notes the contents of this observation.

Leeson Lane, Dublin 2.
Telephone: 01-678 3485/86.
Fax: 01-678 3493.
email: info@mcib.ie
www.mcib.ie