

MCIB

Marine Casualty Investigation Board
Bord Imscrúdú Taisní Muirí



**REPORT OF THE
INVESTIGATION INTO
A FATAL INCIDENT ON BOARD
'MV EUROPEAN ENDEAVOUR'
AT DUBLIN PORT
22nd JUNE 2017**

**REPORT NO. MCIB/273
(No.5 OF 2018)**

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.



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

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(No.5 OF 2018)**



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1. SUMMARY

The '*MV European Endeavour*' is a combined Passenger and Freight Roll-on Roll-off vessel, operating a service between the ports of Liverpool and Dublin. On 22nd June 2017, the vessel arrived at Dublin. On arrival, the vessel discharged its cargo of vehicles, both accompanied and unaccompanied. Shortly before the incident occurred the vessel commenced loading the vehicular cargo for the next voyage, from Dublin to Liverpool. At approximately 13.25 hrs one of the crew, working on the upper exposed cargo deck (Deck five), was found at the rear of the trailer. The trailer was moved forward to give access to the casualty. He was given first aid treatment and was removed by ambulance to a nearby hospital where unsuccessful resuscitation attempts were made and stopped at 14.09 hrs, at which time he was declared dead.

Note all times are local time = UTC + 1

2. FACTUAL INFORMATION

2.1 The vessel

The vessel is described as a Passenger and Freight Roll-on and Roll-off ferry. The vessel has two cargo decks for the carriage of cars and commercial units. Access is via a stern ramp which leads directly to Deck three (Main Deck) and by two side ramps that lead directly to Deck five (Upper Deck). Deck five is open to the weather (see Appendix 7.1 Photograph No. 1). The passenger accommodation area is accessed on foot via Deck five or via internal staircases to port and starboard from Deck three. The predominant type of cargo carried comprises 40 foot articulated tractors and trailers or 40 foot trailers sent unaccompanied (i.e. no tractor with the trailer).

Note: Tractors and trailers travelling as a unit are considered road freight. Unaccompanied trailers are considered as cargo.

Principal Particulars

Name:	<i>'MV European Endeavour'</i> .
Flag:	Bahamas.
Port of Registry:	Nassau.
IMO:	9182206.
Type:	Passenger Roll-on/Roll-off Freight Ferry.
Length Overall:	180.00 metres (m).
Beam:	25.70 m.
Draught:	5.95 m (approximately).
Cargo area:	Decks 3 and 5.
Crew:	Various Nationalities.
Working Language:	English.

2.2 Voyage Particulars

The vessel operates a fixed route between the ports of Dublin and Liverpool, six days a week with a layover at the weekend. This is an international voyage. The normal schedule indicates an arrival time at Dublin of 09.30 hrs. On this occasion, due to engine problems, the vessel arrived at 11.32 hrs which was two hours behind schedule and was due to depart at 15.00 hrs.

At the time of the incident the vessel was alongside at Terminal three, Port of Dublin. It was berthed port side to, on the outer or riverside ramp. Cargo was being loaded over the stern ramp and moved up to the Deck five via the port side internal ramp.

2.3 Marine Casualty/Incident information

This was a very serious marine casualty, resulting in the loss of life of a crewmember.

The incident occurred at approximately 13.25 hrs on the 22nd June, 2017. At approximately 13.30 hrs the Chief Officer received a call from the Bosun requesting immediate medical assistance on Deck five.

The location of the incident was Lane two, aft end, starboard side, Deck five. Immediately at the end of Lane two there was a ventilator shaft for cargo ventilation purposes.

The tractor unit was a Terberg Ro-Ro four wheel drive unit, bearing the fleet number T105. It was manufactured in 2015.

The trailer was owned by an international haulage company. It was a 40 foot refrigerated unit, fully laden. The trailer was built in May, 2017 and had been in service for two weeks. The trailer had three axles and air suspension.

2.4 Shore Response

Once the alarm was raised the shore response took approximately 15 minutes.

This involved ambulance, paramedics, fire and rescue services and An Garda Síochána.

2.5 The Operation

The crew was engaged in cargo operations, discharging Dublin cargo and then loading Liverpool cargo. The trailer involved was the fifth unit to be loaded on Deck five.

The Chief Officer was in overall charge of the activity. The Second Officer (Duty Officer) was on deck at the time positioned at the stern ramp. The supervision of the upper deck was the responsibility of the Bosun. Deck crewmembers (Able Bodied Seafarers) were tasked with different duties. On this occasion the casualty was tasked with guiding the trailers into position on Deck five.

There were no witnesses to the incident.

2.6 Standards of training, certification and watchkeeping for seafarers (IMO STCW Convention¹).

The IMO STCW Convention Chapter VII requires each administration, for the purposes of preventing drug and alcohol abuse, to ensure that adequate measures are established in accordance with the provisions of section A-VIII/1 while taking into account the guidance given in Section B-VIII/1 of the STCW Code.

2.7 Consequences.

The Coroner's autopsy report states that death "was due to injuries sustained from a significant abdominal thoracic blunt force trauma." The autopsy report also shows a significant blood alcohol level. The results of toxicological analysis provided to the Marine Casualty Investigation Board (MCIB) are provisional at the time of publication. The determination of the death causation is a matter for the coroner's inquest.

1. STCW - International Convention on Standards of Training, Certification and Watchkeeping for Seafarers, 1978 and Manila Amendments 2010 ("IMO STCW Convention").

3. NARRATIVE

- 3.1 P&O have been operating roll-on/roll-off vessels for approximately 40 years. They have services from Dublin, Larne, Dover and other UK ports. Over the years the company, hereinafter referred to as 'The Company'² which is responsible for the safe operation of the ship has developed a system of operations in respect of loading and unloading both articulated loads and unaccompanied loads.
- 3.2 The normal routine on Ro-Ro freight ferries is for the crew to rotate on a fortnightly basis. Most crew serve on board the vessel on a regular basis. The casualty had gone on leave on the 7th June, 2017 and rejoined the vessel on 21st June, 2017. The casualty was engaged on board the vessel as an Able Bodied Seafarer (AB).
- 3.3 The Chief Officer was in overall charge of the activity but was returning to the accommodation area at the time. The Second Officer (Duty Officer) was on deck at the time, positioned at the stern ramp. The supervision of the upper deck was done by the Bosun. Deck crewmembers (ABs) were tasked with different duties such as guiding the roll-on/roll-off tractor units, placing the trailer in the correct position within lanes, placing support trestles in way of the trailer fifth wheel³ and lashing/securing the trailers when in position. The duties were rotated regularly so that all crew were familiar with each task. On this occasion the casualty was tasked with guiding the trailers into position.
- 3.4 In port the practice on board was that the Chief Officer took his lunch break and then relieved the Duty Officer on deck to facilitate that officer having his lunch. On this occasion this activity coincided with discharging operations. Once Deck three had been completely discharged the Chief Officer went ashore to discuss the loading of the Liverpool cargo with a member of the shore team. The loading plan was agreed and the Chief Officer returned on board at approximately 13.25 hrs and went towards his office.
- 3.5 The trailer involved in the incident was the fifth unit to be loaded on Deck five. The location of the incident was Lane two, aft end, starboard side, Deck five (see Appendix 7.1 Photograph No. 2). Immediately at the end of Lane two there was a ventilator shaft for cargo ventilation purposes (see Appendix 7.1 Photograph No. 3).
- 3.6 Nobody witnessed the incident. The nearest crewmember to the casualty was located towards the front end of the trailer, approximately ten metres forward of the scene, preparing a trestle for under the front end of the trailer. The best

2. IMO SOLAS Chapter IX: Management for the safe operation of ships: Regulation 1 Definitions:

Company means the owner of the ship or any other organization or person such as the manager, or the bareboat charterer, who has assumed the responsibility for operation of the ship from the owner of the ship and who on assuming such responsibility has agreed to take over all duties and responsibilities imposed by the International Safety Management Code.

3. The fifth-wheel is the link between a trailer and the towing vehicle.

information available indicates that the AB placing the trestle in position looked aft as the truck stopped. He saw the casualty's head leaning to one side. He instructed the Tugmaster driver to move forward and when this was done the casualty fell to the deck.

- 3.7 At approximately 13.30 hrs the Chief Officer heard the Bosun calling for immediate medical assistance over his hand held Very High Frequency (radio) (VHF). He immediately requested the first aid team to attend the scene. On arriving at the scene he found the casualty lying on deck in the recovery position. He then directed the loading master to call an ambulance.
- 3.8 All cargo operations were suspended to allow for the care of the casualty. An oxygen mask was placed on the casualty and Cardiopulmonary resuscitation (CPR) procedures were administered until the paramedics arrived on board.
- 3.9 The emergency services, ambulance, paramedics, fire and rescue services and An Garda Síochána arrived on board the vessel approximately 15 minutes after the time of the initial call. The casualty was removed to hospital where he was declared dead.
- 3.10 The location of the incident has been identified as position '9Y'. The area was examined and it was noted that the yellow lane markings were missing. It was reported that the crew had asked the tractor driver to pull the trailer forward, approximately 1.5 m to 2 m distance, to allow access to the casualty. The rear of the trailer was approximately 1,120 mm forward of the ventilator shaft. The normal parked position for transport is approximately 550 mm forward of the shaft.
- 3.11 The lower louvre at the front of the ventilator shaft was noted to be set in. This was examined and it was determined that the damage was old. The space between paint cracks was filled with dirt which was indicative of long term presence rather than fresh or recent damage.
- 3.12 The tractor and trailer were assessed and were declared safe for use with no defects noted. They were released back to the shipping line's shore operation.
- 3.13 The coroner's autopsy report provided to the MCIB states the cause of death was "due to injuries sustained from a significant abdominal thoracic blunt force trauma". The autopsy report shows that the casualty had a significant blood alcohol level. The results of toxicological analysis provided to the MCIB are provisional at the time of publication. The determination of the cause of death is a matter for the coroner's inquest.

4. ANALYSIS

Loading System and Operation

- 4.1 The activity being carried out at the time of the incident was loading unaccompanied trailers onto the vessel. This involved using a Terberg tractor unit (four wheel drive truck type) to pull 40 foot trailers onto the vessel and to place them in position for the voyage. They are then secured for transit. The Terberg tractor, often referred to as a Tugmaster, is a specialised piece of equipment where the driver can rotate his seat through 180° and move forwards or backwards facing the direction of travel.
- 4.2 The system on board was simple. Every crew on duty was assigned a task:
- Chief Officer: In overall charge of loading operations but moving about the vessel.
- Duty Officer: At the stern ramp in charge of actual operations.
- Bosun: Is the senior deck rating (foreman) on duty on the upper deck level, overseeing crew on duty at that location.
- AB 1: Assigned to guide trailers into the correct position in the lane.
- AB 2: Assigned to place a trestle at the fifth wheel pin to support the front of the trailer.
- AB 3 and 4: Assigned to place lashing chains in place on the trailers.
- All work systems on board the vessel were covered under the vessel's Safety Management System (SMS) Code.
- 4.3 The units were loaded on board using a one way system to access Deck five. The roll-on/roll-off tractor (Tugmaster) used the port side ramp from Deck three to Deck five. On Deck five, with a crew member guiding the driver, the load was reversed into position.
- 4.4 The casualty was assigned the task of guiding the trailer into position. The driver, when reversing the trailer into position, had restricted vision due to the size of the trailer. The guide used a whistle to signal to the tractor driver that the load was in position. The safety procedures called for the guide to position himself on the right hand side of the load, placing himself in the safety zone provided by the adjacent ventilator shaft.
- 4.5 The Tugmaster driver had to place his head out of the side window of the tractor to maximise his range of vision. His seat was rotated to face aft and he reported that he did not hear the whistle telling him to stop. There were no other factors identified that could have distracted the driver from his task of placing the trailer in position.
- 4.6 The vessel's ventilation system was examined. The vessel has multiple ventilation shafts. Groups two and three affect Deck five. Groups four to nine are on the Main

Deck. The instructions indicate that the 'in port fan mode' is for groups two and three to be on supply and groups four and five on exhaust. The fans at group eight are never used in port. This is the group of fans adjacent to the scene of the incident. Therefore, noise from the fan motors was not considered to be a contributory factor.

- 4.7 The areas used for placing trailers or cargo in position are referred to as 'lanes'. Normally they are well marked by yellow painted lines on the deck surface. In addition, there are 'elephant's feet', to which the lashing chains are attached at equal spacing along the limits of each lane. The absence of the yellow painted lines did not contribute to the incident.

Training, Certification and Safety Equipment

- 4.8 The vessel operated a training regime. All crew, in addition to their normal certificates of competency, underwent training provided by the company. In addition there were regular 'Toolbox Meetings'⁴ held at which safety issues were discussed. The following documentation was made available to the investigation:

Familiarisation record for the casualty which was dated between 24th and 26th October 2012.

Vehicle Deck Safety Precautions during Cargo Operations (04-08/02/2013, completed on 11th February, 2012 and 30th April, 2017).

Cargo Securing Training Certificate for the casualty, completed February, 2013.

Certificate of Proficiency in Passenger Safety, Cargo Safety and Hull Integrity on Ro-Ro Passenger Ships for the casualty, completed 9th May 2017.

Record of Deck Rating Training for the casualty shows the level of training undertaken in compliance with Standards of Training, Certification and Watchkeeping for sailors (STCW1) between 2012 and 2017.

Copy of the Efficient Deck Hand Certificate for the casualty, issued on 6th June, 1975.

Copy of STCW Able Seafarer Deck Certificate for the casualty, issued at Killybegs on 17th November, 2016.

Copy of the Seafarer Medical Certificate (ENG 11) for the casualty, dated 30th June, 2016 and valid until 30th June, 2018.

4. A Toolbox Talk is an informal safety meeting that focuses on safety topics related to the specific job, such as workplace hazards and safe work practices.

Copy of the pocket Safety Guide, published by the ship owner in 2014. The document was provided to all crew when they joined the ship.

- 4.9 The crew were all issued with Personal Protective Equipment by the 'The Company'. The equipment included high visibility boiler suits, safety helmets with ear muffs, steel toe capped boots and work gloves. An additional piece of equipment was a whistle (see Appendix 7.1 Photograph No. 4) to be used by the AB acting as guide to the tractor driver. There was no direct radio communication system in place between the crew and tractor drivers.
- 4.10 The Coroner's toxicology report provided to the MCIB states a finding of "Significant blood alcohol level. This may have contributed to loss of concentration or impaired judgement." The Coroner's autopsy report conclusions and the accompanying toxicology report are provisional at the time of publication of this report. It is the role of the Coroner's Office to determine the cause of death.
- 4.11 It is not possible to determine the effect of alcohol on the casualty. The IMO STCW Convention states "Drug and alcohol abuse directly affect the fitness and ability of a seafarer to perform watch keeping duties. Seafarers found to be under the influence of drugs or alcohol should not be permitted to perform watch keeping duties until they are no longer impaired in their ability to perform those duties". The standards set out in the IMO STCW Convention is a limit of not greater than 0.05% blood alcohol level (BAC) or 0.25 mg/l in the breath.
- 4.12 The inventory of the casualty's personal effects, prepared post incident, showed there were no alcoholic products in his cabin.

Other Considerations

- 4.13 Nobody witnessed the incident. The nearest crewmember to the casualty was located towards the front end of the trailer, approximately 10 meters forward of the scene, preparing a trestle for under the front end of the trailer. The best information available indicates that the AB placing the trestle in position looked aft as the truck stopped. He saw the casualty's head leaning to one side. He instructed the truck driver to move forward and when this was done the casualty fell to the deck. In order to assist the casualty the scene of the incident could not be kept exactly the same as at the time of the incident.

5. CONCLUSIONS

- 5.1 There were no witnesses to the event that caused the death of the casualty. Something caused the casualty, an experienced seafarer, to move behind the load he was directing into place. As a consequence the casualty was crushed and died from his injuries.
- 5.2 The Coroner's autopsy report stated that there was a significant level of ethanol (alcohol) in the casualty's blood. The level present in the toxicology report was in excess of the standard set out in the IMO STCW Convention as above. The Coroner's Post Mortem Report conclusions and the accompanying toxicology report are provisional at the time of publication of this report. It is the role of the Coroner's Office to determine the cause of death.
- 5.3 Under the system of loading unaccompanied trailer units, the driver of the tug cannot see the AB guiding him into position and the crew rely on whistles by the guide to alert drivers to any issue. During this incident the driver did not have sight of the guide and the whistle system was not effective, either because no whistle was heard or the guide was not in a position to blow the whistle.

6. SAFETY RECOMMENDATIONS

6.1 The Company should;

- review the system of work in relation to cargo operations for unaccompanied trailers.
- review the application and enforcement of its drug and alcohol policy to ensure that it is fit for purpose.

7. APPENDICES

PAGE

7.1 Photographs.

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APPENDIX 7.1

Appendix 7.1 Photographs.



Photograph No. 1: View of scene from above.



Photograph No. 2: Rear end of trailer.

Appendix 7.1 Photographs.



Photograph No. 3: Ventilator shaft.



Photograph No. 4: Whistle issued to crew.

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.

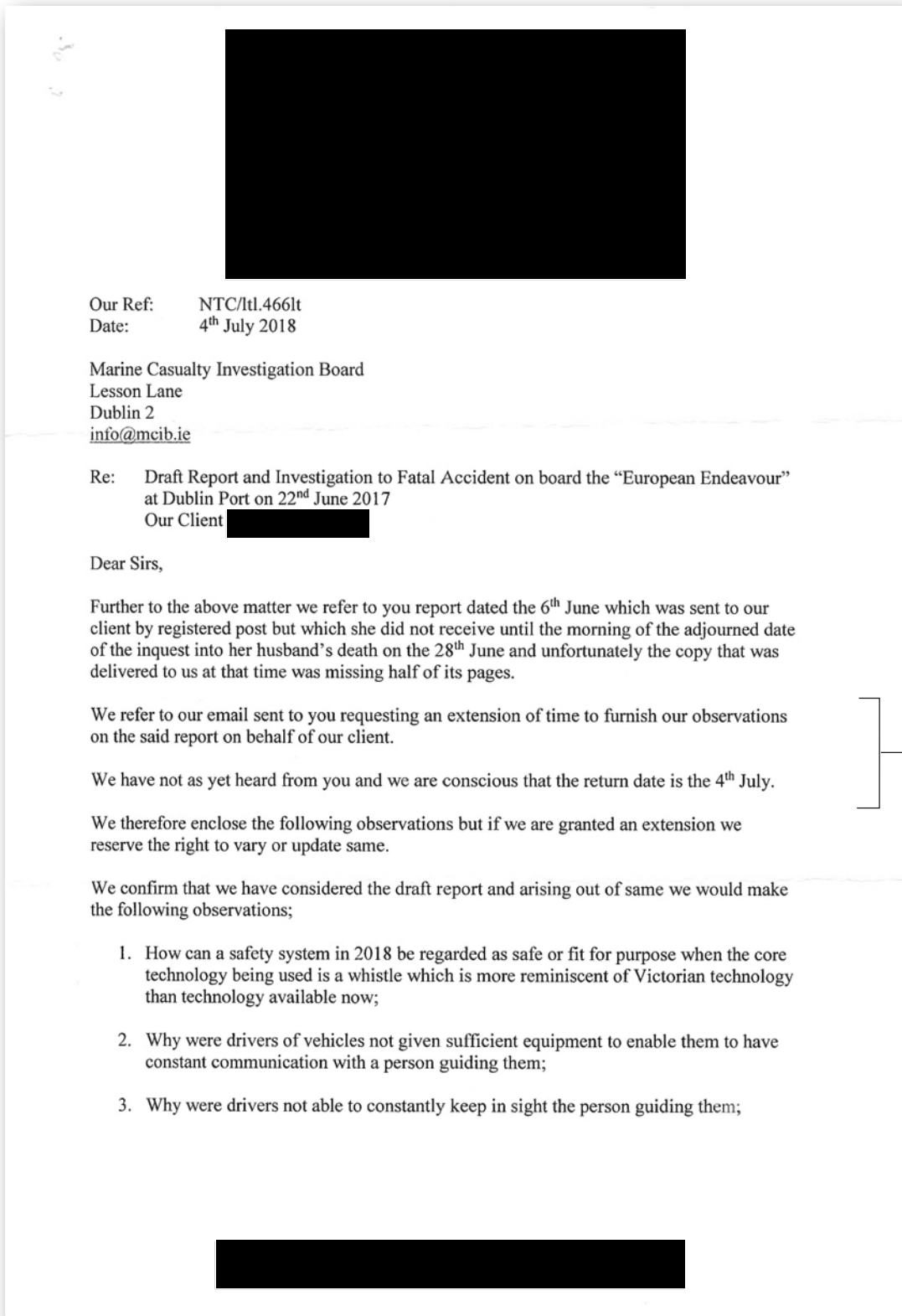
‘Noted’ does not mean that the Board either agrees or disagrees with the observation.

8. NATURAL JUSTICE - CORRESPONDENCE RECEIVED

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

Correspondence 8.1 Solicitor and MCIB response.



Our Ref: NTC/ltl.466lt
Date: 4th July 2018

Marine Casualty Investigation Board
Lesson Lane
Dublin 2
info@mcib.ie

Re: Draft Report and Investigation to Fatal Accident on board the “European Endeavour”
at Dublin Port on 22nd June 2017
Our Client [REDACTED]

Dear Sirs,

Further to the above matter we refer to your report dated the 6th June which was sent to our client by registered post but which she did not receive until the morning of the adjourned date of the inquest into her husband’s death on the 28th June and unfortunately the copy that was delivered to us at that time was missing half of its pages.

We refer to our email sent to you requesting an extension of time to furnish our observations on the said report on behalf of our client.

We have not as yet heard from you and we are conscious that the return date is the 4th July.

We therefore enclose the following observations but if we are granted an extension we reserve the right to vary or update same.

We confirm that we have considered the draft report and arising out of same we would make the following observations;

1. How can a safety system in 2018 be regarded as safe or fit for purpose when the core technology being used is a whistle which is more reminiscent of Victorian technology than technology available now;
2. Why were drivers of vehicles not given sufficient equipment to enable them to have constant communication with a person guiding them;
3. Why were drivers not able to constantly keep in sight the person guiding them;

MCIB RESPONSE:
The MCIB notes these points and wish to advise that an extension for return of comments was granted to all NJ receipts up until the 18th July,

Correspondence 8.1 Solicitor and MCIB response.

4. Why was it that a drivers default position was to move even though they could not see or hear the person that was supposed to be guiding them;
5. Why did the driver pass the elephants feet on the deck of the boat given that that is the point at which they were presumably trained to stop;
6. Arising out of same was training given to the staff and to the roll on and roll off drivers;
7. It is stated in the report that there were four able bodied seaman present on the deck. Where were the other two able bodied seaman at the time and why were there not sufficient seaman on deck at all times;
8. What is the protocol for a slip and fall in circumstances such as this where it is apparent that no one has sight of the victim in this case and the accident was only noticed after the event;
9. Please advise as to the exact alcohol level allegedly contained in the bloodstream of the victim as its exact level would have to be determined before any assessment can be made as to what impact if any it had upon him;
10. Please advise as to whether or not the stomach contents of the victim were analysed to determine whether there was any alcohol in his stomach so that we might better know how alcohol (assuming it did) got into his bloodstream;

MCIB RESPONSE:
The MCIB notes these points and considers they are covered in point 4.2 of the report.

MCIB RESPONSE:
The MCIB notes these points and considers they are covered in points 3.13, 4.10, 4.11 and 5.2 of the report.

It would appear (though it is not apparent from the report) that there was no video surveillance of the area in question.

As a general observation it seems to this writer that the work system that was in place is inherently dangerous.

No account of accidents occurring and the default position of drivers is to move rather than to stay still.

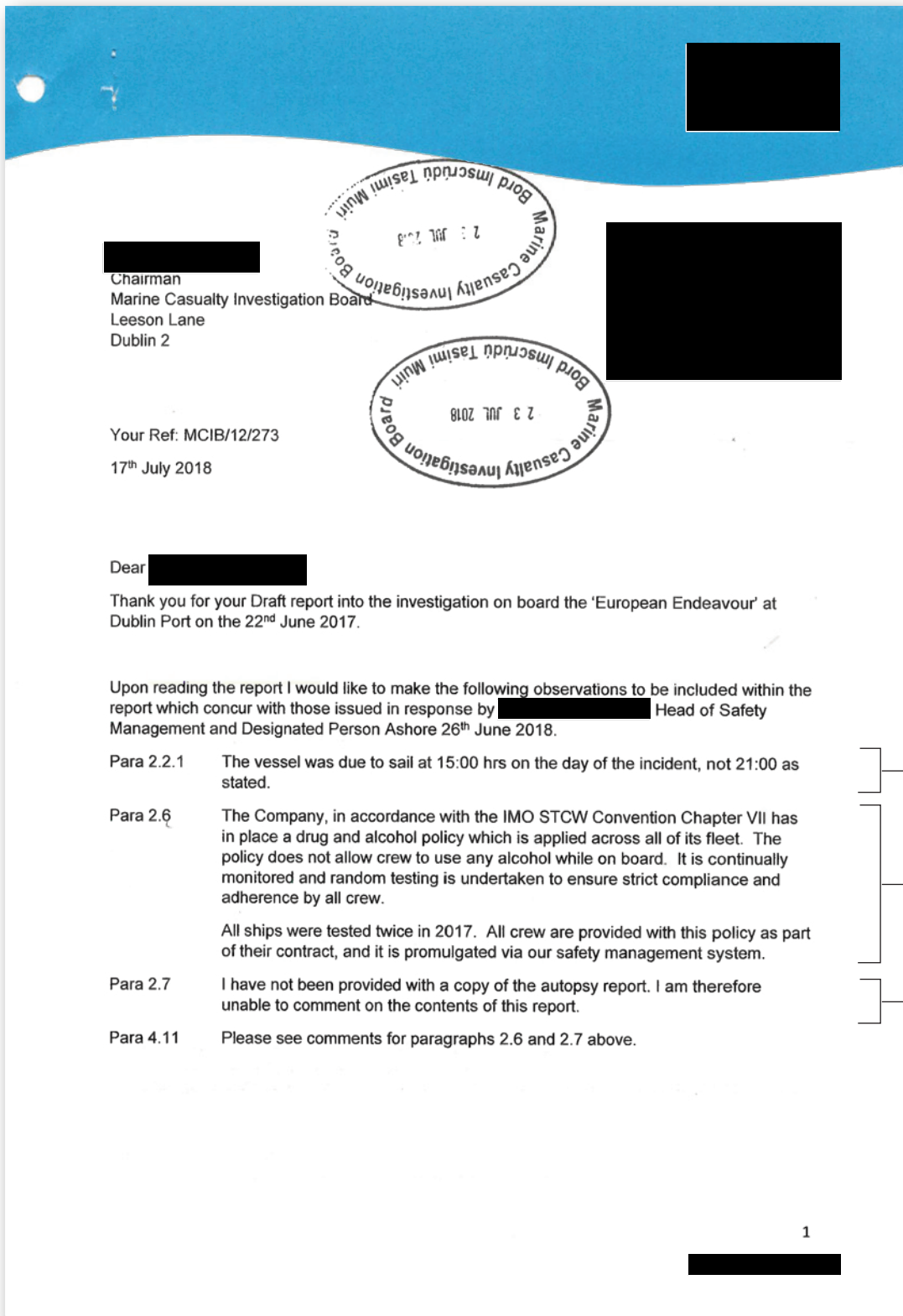
We reserve the right to make further observations.

Yours sincerely



CORRESPONDENCE 8.2

Correspondence 8.2 'The Company' (Fleet Operations Manager) and MCIB response.

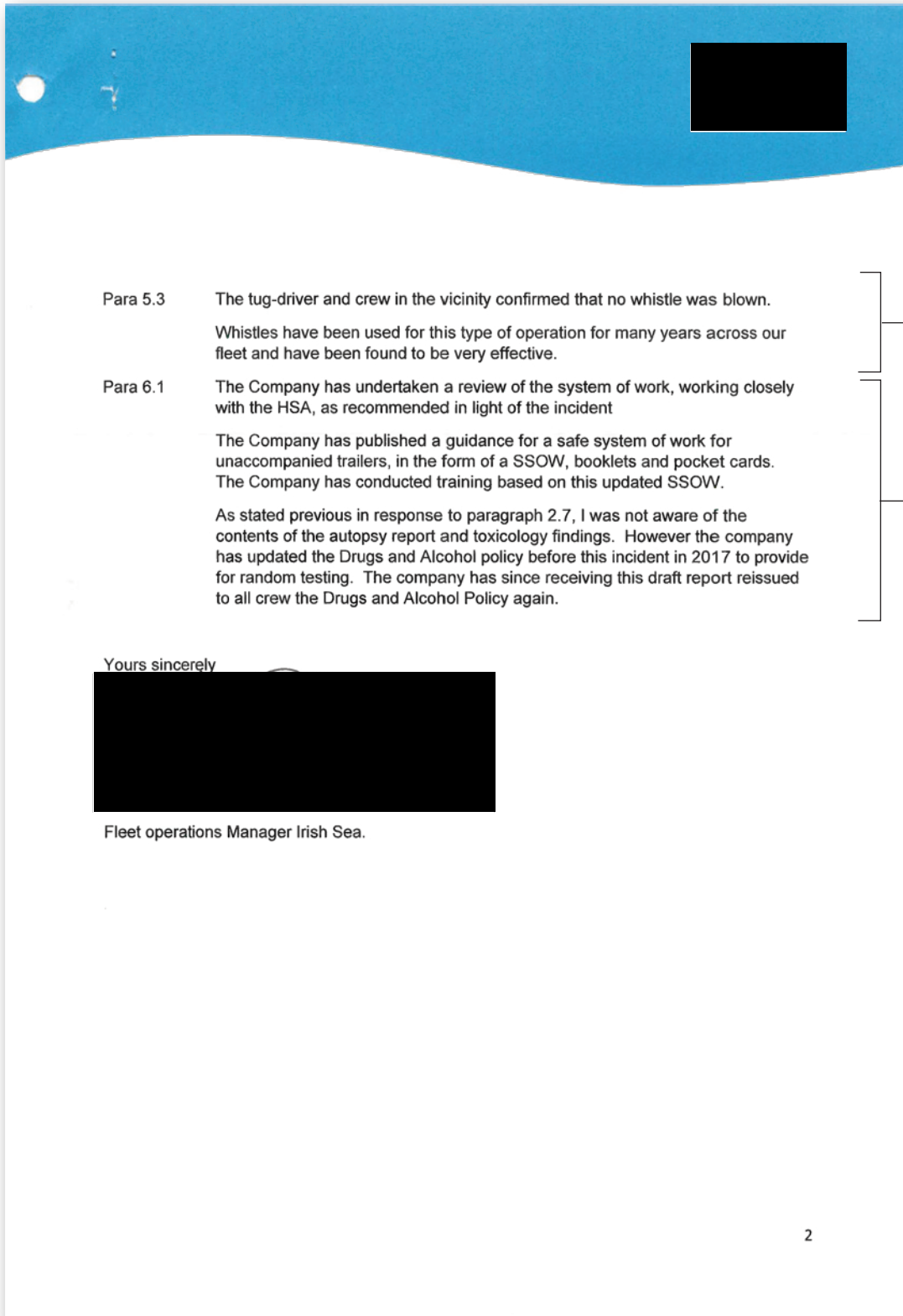


MCIB RESPONSE:
The MCIB notes this point and has made the necessary amendment.

MCIB RESPONSE:
The MCIB notes these points.

MCIB RESPONSE:
The MCIB notes this point. Please see Points 2.7, 3.13, 4.10, 4.11 and 5.2 of report.

Correspondence 8.2 'The Company' (Fleet Operations Manager) and MCIB response.



Para 5.3 The tug-driver and crew in the vicinity confirmed that no whistle was blown. Whistles have been used for this type of operation for many years across our fleet and have been found to be very effective.

Para 6.1 The Company has undertaken a review of the system of work, working closely with the HSA, as recommended in light of the incident

The Company has published a guidance for a safe system of work for unaccompanied trailers, in the form of a SSOW, booklets and pocket cards. The Company has conducted training based on this updated SSOW.

As stated previous in response to paragraph 2.7, I was not aware of the contents of the autopsy report and toxicology findings. However the company has updated the Drugs and Alcohol policy before this incident in 2017 to provide for random testing. The company has since receiving this draft report reissued to all crew the Drugs and Alcohol Policy again.

Yours sincerely

[Redacted signature]

Fleet operations Manager Irish Sea.

MCIB RESPONSE:
The MCIB notes this point.

MCIB RESPONSE:
The MCIB notes these points.

CORRESPONDENCE 8.3

Correspondence 8.3 'The Company' (Safety Management) and MCIB response.

[Redacted]

Chairman
Marine Casualty Investigation Board
Leeson Lane
Dublin 2

[Redacted]

Your Ref: MCIB/12/273
26th June 2018

Dear [Redacted]

Thank you for your Draft report into the investigation on board the 'European Endeavour' at Dublin Port on the 22nd June 2017.

We would like to make the following observations to be added to the report:

Para 2.2.1 The vessel was due to sail at 15:00 hrs on the day of the incident, not 21:00 as stated.

Para 2.6 The Company, in accordance with the IMO STCW Convention Chapter VII has in place a drug and alcohol policy which is applied across all of its fleet. The policy does not allow crew to use any alcohol while on board. It is continually monitored and random testing is undertaken to ensure strict compliance and adherence by all crew.

All ships were tested twice in 2017. All crew are provided with this policy as part of their contract, and it is promulgated via our safety management system.

Para 2.7 The Company has not been provided with a copy of the autopsy report despite requests for the same. The Company is therefore unable to comment on the contents of this report.

Para 4.11 Please see our comments on paragraphs 2.6 and 2.7 above.

1


[Redacted]

MCIB RESPONSE:
The MCIB notes this point and has made the necessary amendment.

MCIB RESPONSE:
The MCIB notes these points.

MCIB RESPONSE:
The MCIB notes this point. Please see points 2.7, 3.13, 4.10, 4.11 and 5.2 of report.

Correspondence 8.3 'The Company' (Safety Management) and MCIB response.



Para 5.3 The tug-driver and crew in the vicinity have confirmed that no whistle was blown.

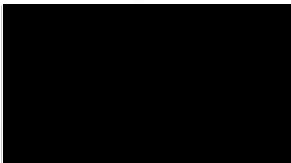
Whistles have been used for this type of operation for many years across many of our vessels and have been found to be very effective.

Para 6.1 The Company has undertaken a review of the system of work, working closely with the HSA, as recommended in light of the incident

The Company has published a guidance for a safe system of work for unaccompanied trailers, in the form of a SSOW, booklets and pocket cards. The Company has conducted training based on this updated SSOW.

The Company has not been made previously aware of the contents of the autopsy report and toxicology findings. However the company has updated the Drugs and Alcohol policy before this incident in 2017 to provide for random testing. The company has since receiving this draft report reissued to all crew the Drugs and Alcohol Policy again.

Yours sincerely



PP
Head of Safety Management and Designated Person Ashore

2

MCIB RESPONSE:
The MCIB notes this point.

MCIB RESPONSE:
The MCIB notes these points.


Correspondence 8.4 An Garda Síochána and MCIB response.

AN GARDA SÍOCHÁNA

Ard-Cheannfort
Réigiún Chathair Átha Cliath
Roinn Lár Thuáidh
An Garda Síochána
Sráid An Stórais
Baile Átha Cliath 1

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Bí linn/Join us  



Chief Superintendent,
Dublin Metropolitan Region
North Central Division
An Garda Síochána
Store Street
Dublin 1

Web site: www.garda.ie
E-Mail : Store_Street_DV@garda.ie

Please quote following ref no. SSDV-010-278475/18

**Secretariat
Marine Casualty Investigation Board
Leeson Lane
Dublin 2**

**RE: Correspondence From Marine Casualty Investigation Board RE: Fatal
Incident "European Endeavour" Dublin Port 22nd June 2017**

Dear [REDACTED]

With reference to the above, please be advised [REDACTED] of Store Street Garda Station, has examined the attached report as requested and would concur with the safety recommendations of the MCIB as set out in the report.

Yours sincerely,

[REDACTED]

11th July 2018

AN GARDA SÍOCHÁNA REGISTRY
NORTH CENTRAL DIVISION
OUTGOING

12 JUL 2018

DMNC
DUBLIN METROPOLITAN
REGION

CC: Assistant Commissioner, DMR

Seirbhísí gairmiúla póilíneachta agus slándála a sholáthar le hiontaobh, muinín agus tacaíocht na ndaoine ar a bhfreastalaímid
To deliver professional policing and security services with the trust, confidence and support of the people we serve

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



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

