Annex A

EMU Marine Circular 22 April 2010 - Safety Measures on Elevator Maintenance

MARINE CIRCULAR

EVERGREEN MARINE (UK) LIMITED

TO: **Master, C/E & all crews**
各輪船長、輪機長及全體船員

FM: EMU-LDN MAR

DATE: 22 / APR / 2010

REF. NO.: MAR-2010-009

SUBJECT: 檢修電梯時應注意事項

Safety Measures on Elevator Maintenance

To avoid the accident happen again on elevator maintenance; hereunder, the reminders for you to follow up:

電梯檢修前

Preparation before maintenance commence

1. Risk assessment 和電梯說明書:進入電梯檢修前務必先做Risk assessment確實了解風險之存在和避免
2. 電梯說明書:預先詳讀說明書其中有很多檢修和操作注意要項都需了解
3. 懸掛警示牌:修理前每層電梯門口務必掛修理中的明顯之警告標語,以避免外人誤觸發生危險
4. 個人的安全鞋、安全帽和足夠的照明，如工作燈、手電筒等必須備齊
5. 施工人數最少需三人一組並攜帶無線電對講機.建議在保養時,在Machine room保持一個人備便，而另兩人則在現場互相照應做檢查維修工作.

1. Risk assessment and elevator maintenance instruction:
   Does the risk assessment prior to commence the maintenance work to fully understand the existing risk and to avoid.
2. Study the instruction manual in details to know the cautious/attention point on maintenance.
3. Place the warning sign of UNDER MAINTENANCE at the elevator door of each floor, to avoid the others for accessing the elevator.
4. Should wear the personal safety equipment, such as safety helmet, working shoes and prepare enough illumination facilities, such as torch, working light.
5. To be at least 3 person as a team and prepare good communication equipment, such as walkie-talkie. While carry out maintenance work, suggested one person to be stand-by in the machine room and the two others (leader and assistant) work on-site.

開始要進入電梯檢修或一般加潤滑油例行檢查時:

Before commence of the maintenance work

1. 先確定目前電梯停在那一樓層.
2. 總電源先關閉:請Machine room的人先將總開關 Power-off
3. 可用電梯專用Key將門打開並經由電梯箱頂上的工作門進入手動控制盤位置.
4. 手動選擇開關之切換:先將Cage上的Operating panel之開關由 AUT 切換到 MAN 位置，同時也需將Safety 的選擇開關轉到Stop位置.
5. 人員就定位後應注意周遭環境避免跌倒或摔落危險

1. Confirm the cage stopping floor.
2. Order the person in machine to switch-off the main power.
3. Use special key to open the elevator door for entering the cage then through cage hatch to the place of manual operated control panel positioned.
4. Switch-over the selection switch:
   a. Switch over the control mode selection switch on control panel from AUT to MAN.
   b. Switch over the safety selection switch on control panel from NORMAL to STOP.
5. Beware of vicinity environment all the time while working, to avoid oneself and working mate from any possible falling, slipping or hitting by protruding matter.

在進入電梯Cage 就定位後:

After on-site person (leader and assistance) in place on the cage:

1. 請Machine room 的人打開電源。
2. 另一人(助手)則將Safety 選擇開關撥回Normal 的位置，但助手的一隻手最好不要離開該Safety開關位置，可在緊急時可馬上轉回 Stop (這就有如同按壓 Emergency Stop 使電梯停止)。
3. 電梯在 Cage 內以手動操控:帶領者先將 Door Close ，此時因先前已由 AUT 放到 MAN 位置則可按壓UP 或 DOWN 以寸動方式控制電梯上或下以作常規性檢查動作(兩人同時進入電梯可互相照應，增加安全)

1. Order the person in machine room to switch-on the main power.
2. Switch over the safety selection switch on control panel from STOP to NORMAL. The assistant should always keep an eye to the surrounding condition and stop the cage operation by switch over the safety selector to stop mode if necessary.
3. Now the cage can be inch operated by push the button UP or DOWN, while the hand off the push button the cage movement will be stopped, the leader can start the routine maintenance or inspection.

檢修完畢要離開電梯Cage 時:

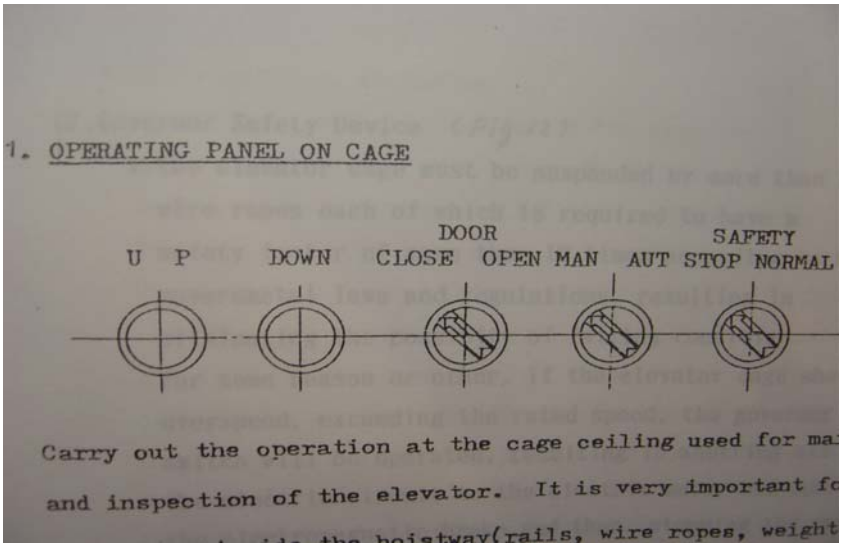
Completed the maintenance to leave the cage:

1. 將電梯在開回先前進入的位置，聯絡 Machine room的人將總電源 Power-off 後，再將 MAN 轉到 AUT 位置和將Safety 轉到Normal位置。
2. 經由電梯箱上工作門回到電梯箱內將工作門以手動關閉後，呼叫Machine room 的人將電源再重新開啟，恢復正常使用。

1. Return the cage to the position at the beginning and order the person in machine to switch-off the main power, then restore the manual control panel by a. Switch over the control mode selection switch on control panel from MAN to AUT.
   b. Ensure the safety selection switch on control panel at NORMAL mode.
2. On-site person can through the hatch on the cage back inside the cage, then close the hatch cover firmly and inform the person in the machine room to switch on the main power and recover the elevator into normal operation.

以下為E-Type 在Cage 上的 Operating Panel 簡圖.

Below the sketch of E-type manual operating panel on the cage



Safety selection switch on control panel

At NORMAL, means safety device in working.

At STOP, means elevator operation will be stop for both MAN and AUT control mode.

You attention and good cooperation would be highly appreciated and anticipated.

您的充份注意與良好配合，是我們衷心的期盼，謝謝！

Bon Voyage.

順頌　航安！

Annex B

EMU Marine Circular 23 February 2009 - “Vessel General Permit” implementation for EMU fleet

MARINE CIRCULAR

EVERGREEN MARINE (UK) LIMITED

TO: Master, C/E and all Crew

FM: EMU-LDN
MAR- MAT

DATE: 23 / FEB / 2009
REF. NO.: MAR-2009-008

SUBJECT: "Vessel General Permit" implementation for EMU fleet

本公司船隊實施"船舶一般排放"通知

MESSAGE:

As per previous Marine Circular MAR-2009-004 noted, since February 06, 2009 vessels entering into U.S. territory waters (3 miles limit) will be automatically covered by the "Vessel General Permit" and must have a Compliance Program or Company Policy in place to ensure compliance with the VGP regulation and requirements that includes the implementation, monitoring and documentation of best management practices for the 26 discharges covered by the permit that are applicable for each vessel.
根據先前發佈之 MAR-2009-004 通告所述，自 2009 年 2 月 6 日起，凡是進入美國領海(3 海浬範圍)之船舶將自動適用"船舶一般排放"之規定，並且必須符合公司相關之環保政策及計劃，確實遵照 VGP 之規定與要求，包括對此許可所列管的 26 項船舶排放之最佳管理實務的執行、監控與書面記錄等。

A copy of the VGP document and associated enclosures should be kept in the Company office and onboard each vessel. Therefore, the Company plans to send via e-mail or to burn the document and associated enclosures into a CD disk and distribute to our fleet in the near future for shipboard implementation.
VGP 文件及相關附件等必須存放在公司及各屬輪上，因此公司計劃在近期內將有關文件以 E-MAIL 及燒錄成光碟方式陸續分送各船執行。

For the vessels will recently be enter into U.S. territory waters, please follow the enclosed "The Best Management Practices" and "Vessel Discharge Inspection Checklist" to comply with the VGP regulation and requirements as well. During the period of vessel in U.S. territory waters, the vessel must conduct the inspection of discharge once per week and before the formal inspection checklist is available to our fleet, the inspection should be carried out according to the enclosed "Vessel Discharge Inspection Checklist" then record the result into Deck/Engine Logbook. For the detail of the VGP implementation and regulation, please refer to the enclosed "VGP Compliance Document".
對於近期內將進入美國領海水域的船舶，請先根據本通告附件"最佳管理實務"及"船舶排放檢查表"遵照執行。當船舶航行於美國領海水域時，在正式的檢查表格尚未送船前，船上必須按照附件"船舶排放檢查表"每週實施船舶排放檢查並將檢查結果記錄於甲板/機艙日誌中；有關船舶一般排放的執行細節及規定，請參照附件"VGP 符合文件"之內容。

Since the VGP regulation is only covered in U.S. territory waters. The Master should keep the VGP CD disk onboard in case for service route changing in the future.
由於"船舶一般排放"規定僅適用於美國領海水域，對於不進入美國領海水域的船舶並不需要遵照

	[APPROVED]	[CHECKED]	[WRITER]
[CATEGORY]	[redacted] FEB 23 2009 DSVP	[redacted] FEB 23 2009 M	*Port C/Engineer* [redacted]

該排放之規定，但當船長收到VGP光碟時，仍須將該光碟妥善保管並列入移交，以備未來航線更改時使用。

Bon Voyage

順頌 航安

Annex C

VGP Annual Inspection Notice

VGP ANNUAL INSPECTION NOTICE

Notice Date: 2010/04/20

To the Master of	Ever Excel	Ref No.	
Date of Inspection:	21/Apr/2010	Place of Inspection:	KSG
Inspectors:	[redacted]		

Time	Scope of Inspection	Remark
0845 ~ 0900	Open meeting	Key man
0900 ~ 0930	OWS overboard valve open-up inspection	C/Engineer
0930 ~ 1200	Sludge tank, bilge tank, void space sounding / pipe duct inspection / steering Gear room void space checking / bow thruster room visual inspection / elevator pit, air conditioner visual inspection, etc	Officers / Engineers
1200 ~ 1300	Lunch Break	
1300 ~ 1530	Document checking (VGP checklist, deck logbook, engine logbook, oil record book, Garbage record book, LSA/FFE logbook)	Officers / Engineers
1530 ~ 1600	Close meeting	Key man

Note: The above inspection program is subject to adjust by actual ship schedule

Issued by: EMU Taiwan Office

Annex D

Lift Operation Manual (extract)

PLAN RECORD	-F	Prepared for finished p an

NAME OF MAKER	SCHINDLER ELEVATOR K.K

A4
A3
Sum sheets with cover

CON-FERRED

SHIP & MARINE DEPARTMENT
HULL & MACH. OUTFIT DESIGN. SECT.

HATSU ETHIC

APPROVED [redacted] CLASS ABS

CHECKED [redacted]

DRAWN [redacted]

OPERATION MANUAL FOR ELEVATOR

SCALE

ORDER ITEM DRAWING NO

S1255

F-042

MITSUBISHI HEAVY INDUSTRIES,LTD.
KOBE SHIPYARD & MACHINERY WORKS

DRAWN ISSUED

8. Maintenance & Inspection of Machines on A Top of Cage

Make sure to satisfy the following requirements before taking any action.

1. Needs at least two men working together. (Communicate by use of transceivers during the work.)
2. Wear a safety cap.
3. Close both the landing door and cage door completely.
4. Pay attention to the surrounding apparatus and standing area.

Name of machine	Item	Details	Remarks
1. Operating panel on the cage	Operatin test	1. One worker climbs through the emergency exit to the cage ceiling and turn on the inspection lamp. The other one goes to the machine room to change over the snap switch, "BS". (NOTE: Be sure to turn off the main breaker (attached on the controller door) before opening the doors.) 2. The worker standing on the cage ceiling switches over the "AUTO-MAN" switch to the "MAN" position and closes the emergency exit door. Now, call the worker in machine room to turn off the main breaker and changes over the "RESET" switch to the "RESET" position such that the "UNDER ESCAPE" lamp lights off.)	

		3. Control the cage up and down by use of the "UP" and "DOWN" buttons. 4. Switch over the "SAFETY" switch from the "NORMAL" to "STOP" position and perform appropriate maintenance work on switches inside the operating panel. Then, check if wiring and contacts conditions are normal. Also check if all bolts are securely tightened. √ The "SAFETY" switch is provided to avoid the automatic operation during the maintenance. The function of this switch protects the person on the cage ceiling if he/she forgets to switch over the "AUT-MAN" switch to the "MAN". √ The "BS" switch is provided such that it prevents the cage operation in the case which someone in any floors presses a call button. This function protects worker(s) on the cage ceiling to exit safely after he returns all switches to their initial positions to complete his work. √ The "RESET" switch attached on the controller door is provided to prevent the cage operation by pressing "CALL" buttons in any floors. This function protects passengers in emergency case which they try to escape through the hoistway.	
2. Limit switch cam	Inspection	1. Loosening of fitting condition 2. Fitting condition of cam If the landing error is specially large in any of floors, make adjustment by moving up and down the limit switch in the trunk or limit switch cam on the cage.	Error in level between landing floor level and cage floor one.

9. MAINTENANCE AND INSPECTION INSIDE PIT

Operate the cage and open the cage and landing doors at the lowermost floor. One worker must shortcircuit the door switch for doorway at landing with another worker remained inside the cage. Then, ascend the cage approx. 1.5 m. For shortcircuiting operation, push the door switch with hand. And, the worker remained inside cage must close the cage door and push UP BUTTON (2F button will do.) When the cage goes up approx. 1.5 m, the worker who has short-circuited it at landing must release door switch. Thus, the cage stops and the worker inside the cage must push the emergency stop switch for assuring safety. Hereafter, the operations are to be carried out inside pit.

Annex E

EMU Vessel Discharge Inspection Guideline

U.S. ENVIRONMENTAL PROTECTION AGENCY

NATIONAL POLLUTION DISCHARGE ELIMINATION SYSTEM GENERAL PERMIT FOR SHIPS

EMU VESSEL DISCHARGE INSPECTION GUIDELINE

Reference	Description of Discharge	Practice
1.2.2.1	Deck runoff and above water line hull cleaning 甲板沖洗、溢流及水線以上的船體清潔污水	進美國水域管制區前，須先清洗甲板，可用消防水沖洗，順便排放消防系統內之鏽水，並記錄於“檢查表“ 及 “甲板日誌“。 Prior to entering the VGP covered waters shall clean wash the upper deck. It may use firemain system in convenient to drive out rusty water inside of firemain piping, then record into “Check List Form” and “Deck Log Book”.
1.2.2.2	Bilge water / Oily water separator effluent 艙底水／油水分離器排放	請依照“油料記錄簿“規定確實執行，並記錄於該記錄簿。 Please follow the “Oil Record Book” related regulations and record into it.
1.2.2.3	Ballast Water 壓艙水	請依照壓艙水管理手冊操作及記錄。 Please follow the “Ballast Water Management Plan” to operate and record.
1.2.2.4	Anti-fouling leachate from Anti-fouling hull coatings / Hull coating leachate 船體防污漆／船體塗料剝落	船體塗料須符合美國環保署規定並有檢查報告及證明文件。入塢時須請船廠簽署“Dry-dock Inspection Certification Report“。 The coating applied for ship’s hull must conform to U.S. EPA’s requirements with inspection reports and certification documents. Whilst in dry dock, a “Dry-dock Inspection Certification Report” must be issued by shipyard.
1.2.2.5	Aqueous Film Forming Foam (AFFF) 泡沫滅火器所產生的泡沫	泡沫滅火器一律由岸上廠商更換並附證明文件。3/O負責日常目視檢查並記載於“甲板日誌“ 及 “安全裝備保養記錄“。任何泡沫滅火操作、排放皆須記錄於 “檢查表“。 Foam extinguishers must be maintained and renewed by shore base service provider with certification documents. The 3/O is in charge for routine visual inspection and record the result into “Deck Log Book” and “Safety Equipment Maintenance Records”. Any operational foam extinguisher discharges must be recorded into “Check List Form”.
1.2.2.6	Boiler / Economizer blowdown 鍋爐/節熱器吹放	爐水化驗月報表上須加註吹放日期、時間(開始、停止)及船位，並記載於“機艙日誌“ 及 “檢查表“。 The “Boiler water analysis monthly report” needs to note blowdown date, time (start, complete), position, then record into “Engine Log Book” and “Check List Form”.
1.2.2.7	Cathodic protection 陰極防蝕保護	請確實填寫陰極防蝕裝備記錄表。入塢時，請船廠簽署 “Dry-dock Inspection Certification Report“。 Please enter into ICCP or CAPAC Log with truly and correctly. When in dry dock, a “Dry-dock Inspection Certification Report” must be issued by shipyard.
1.2.2.8	Chain locker effluent 錨鏈艙流出物	進塢時須檢查及清洗錨鏈艙(應記錄於 “甲板日誌“)，並請船廠簽署 “Dry-dock Inspection Certification Report“。錨鏈艙艙底水排海必須離岸50海浬以外。起錨、下錨及錨鏈艙艙底水排海操作皆須記錄於 “檢查表“ 及 “甲板日誌“。 When in dry dock, the chain locker will be checked and cleaned, and a “Dry-dock

		Inspection Certification Report" will be issued by shipyard. The discharge of chain locker bilge must exceed 50 nautical miles from any shore. The operation of anchorages and discharges of chain locker bilge must be recorded into "Check List Form" and "Deck Log Book".
1.2.2.9	Controllable pitch propeller hydraulic fluid and other oil sea interface including lubrication discharges from paddle wheel propulsion, stern tubes, thruster bearing, stabilizers, and propulsion pod lubrication可 可變螺距俥葉及艏俥液壓油及其他油水界面包括俥葉推進器滑油排放、艉軸、推進器軸承、穩定器、舵軸、橫向推進器、艉軸管潤滑油。	遵循規定，確實執行，並記錄於FM-FLT-1001-5 "Records of S/T L.O. condition" 。 Please record into FM-FLT-1001-5 "Records of S/T L.O. condition" with truly and correctly.
1.2.2.10	Distillation and reverse osmosis brine 蒸餾及逆滲透鹵水	請確實記載於"造水機日誌"。 The fresh waster generator has a "Daily Log Book", it should be noted with truly and correctly.
1.2.2.11	Elevator pit effluent 升降機井槽流出物	定期(每週)巡視清潔整理，並記於"檢查表"及"機艙日誌"。 Periodically (weekly) inspect and maintain in good housekeeping, then record in "Check List Form" and "Engine Log Book".
1.2.2.12	Firemain systems 消防系統	此項併入1.2.2.1清洗作業，順便排放滅火管路積水並記錄於"檢查表"及"甲板日誌"。 This item is merged into 1.2.2.1 operation to drive out residue water inside of firemain piping system, then record into "Check List Form" and "Deck Log Book".
1.2.2.13	Freshwater layup 淡水消毒添加物	本項僅適用於S型船，須記錄於"檢查表"及"甲板日誌" 。 This item is available for S type vessels only. It should be recorded into "Check List Form" and "Deck Log Book".
1.2.2.14	Gas turbine wash water 渦輪增壓機水洗	本公司船隊除少數非MET Type主機仍用水清洗外，目前大都用米沖洗(MET Type主機)，清洗之污水請排入污油櫃並記錄於"油料記錄簿"、"機艙日誌"及"檢查表"。 Except of minority vessels not equipped with MET type main engine still needs to wash the gas turbine by water. Most of our fleet vessels are equipped with MET type main engine which use rice to clean the gas turbine. The gas turbine wash water should be discharged into S.B.O.T. the record into ORB and "Engine Log Book" and "Check List Form".
1.2.2.15	Graywater 灰水	在港時,應儘量減少灰水的產量。有灰水儲存櫃之船舶(S型船)必須在航行中且離岸1海浬以上方可排放。如果要在許可管制區排放的灰水必須儘可能清除過多的食物與油渣。 1. Minimize the production and discharge of graywater. 2. If the vessel has sufficient storage capacity, store graywater and discharge at least 1 nm from shore while the vessel is underway. 3. Soaps and detergents used in graywater must be non-toxic and phosphate-free. 4. Soaps and detergents should be biodegradable where possible unless there is evidence they would not be harmful to the marine environment.
1.2.2.16	Motor gasoline and compensating discharge 注入汽油櫃之海水排放	本項排放不適用於本公司船隊。 This discharge is not available for our fleet vessels.

1.2.2.17	Non-oily machinery wastewater 機艙不含油廢水	此項目如同1.2.2.2 艙底水/油水分離器排放之處理方式。 The handling of this item is same as item 1.2.2.2 Bilge water / Oily water separator effluent.
1.2.2.18	Refrigeration and Air Condensate discharge 冰機及空調冷凝水排放	每日巡視、觀察冷凝水是否乾淨，不能含油或有毒物質，如發現異常應馬上處理並於“檢查表”及“機艙日誌”記錄。 Daily check and observe the condensate whether clean or not. Should not contain oil or hazardous substances, if any abnormal was found should eliminate the problem immediately then record into “Check List Form” and “Engine Log Book”.
1.2.2.19	Seawater cooling overboard discharge (including non-contact engine cooling water; hydraulic system cooling water, refrigeration cooling water) 冷卻海水排放（包括間接式主機冷卻水、液壓系統冷卻水、冰機冷卻水）	每周目視檢查冷卻器出口端海水，每季取樣化驗，以上皆須記錄於“檢查表”及“機艙日誌”。靠港期間需經常檢視船邊海面狀況，是否有油花、垃圾等。 Visual inspection of Cooler water discharging gate by weekly. Sample test by quarterly. All of above mentioned inspection and test must be recorded into “Check List Form” and “Engine Log Book”. During the berthing period, visual check the surface of water around the ship from time to time to verify whether have sheen or garbage etc. or not.
1.2.2.20	Seawater piping biofouling prevention 海水管路防止海生物衍生裝置	請確實填寫"防止海生物衍生裝置記錄表"，並依說明書保養。 This item should be recorded in MGPS Log and maintenance according to the maker's instruction.
1.2.2.21	Small boat engine wet exhaust 小艇引擎濕式廢氣排放	根據SOLAS公約規定所做的小艇操演、目視檢查、保養、測試皆須記錄於“安全裝備保養紀錄”、“甲板日誌”、“機艙日誌”及“檢查表”。 According to SOLAS convention regulated. Any boat drill, visual inspection, maintenance, testing needs to record into “S.E. Maintenance Log”, “Deck & Engine Log Books” and “Check List Form”.
1.2.2.22	Sonar dome discharge 聲納導流罩水排放	本項排放不適用於本公司船隊。 This discharge is not available for our fleet vessels.
1.2.2.23	Underwater ship husbandry 水下船體管理	每次水下清潔、檢查、修理，須記錄於“檢查表”、“甲板日誌”及“機艙日誌”中，且須有檢查報告及/或完工簽收單。 Every under water cleaning, inspection, repairing need to be record into “Check List Form” and “Engine Log Book”, and with inspection report and/or acknowledgement of repairing.
1.2.2.24	Welldeck discharges 浮塢平台污水排放	本項排放不適用於本公司船隊。 This discharge is not available for our fleet vessels.
1.2.2.25	Graywater Mixed with sewage from Vessels 混雜穢水的灰水	如有此項操作須記錄於“檢查表”、“甲板日誌”及“機艙日誌”中。 If the operation has carried out, it should be recorded into “Check List Form”, “Deck & Engine Log Books”.
1.2.2.26	Exhaust gas scrubber washwater discharge 煙道廢氣清洗水排放	清洗節熱器之污水應先存於煙灰櫃，再轉駁至污油櫃存放，並記錄於“油料記錄簿”、“檢查表”及“機艙日誌”。 The waste water from economizer washing should be stored into Soot Tank first, then transferred into S.B.O.T. The operation should be recorded into ORB, “Check List Form” and “Engine Log Book”.

Annex F

Lift Manual Extract - Escaping Method in Emergency

5. ESCAPING METHOD IN EMERGENCY

If the elevator should be stop suddenly while operating with passenger in the cage, for some reason or other, he must be calm and take the following countermeasures.

(1) If the elevator should stop suddenly with cage within ±200mm from floor level of the landing, he can open the doors and escape from it vary easily.

(2) If the elevator should stop suddenly in other positions than that shown in the aforementioned item (1) , PUSH THE "EMERGENCY STOP" push button switch and "ALARM" button. Upon making communication with outside sources, he must behave himself accordingly.

(3) If he fails in communicating with outside sources, he must escape by himself. in this case, take the following procedure and cautions to the fokkowing points :

1) Check whether or not the "EMERGENCY STOP" push button switch on the operating panel in the cage has been pushed.

2) Pus up the emergency exit cover at ceiling on the cage.

3) Climb the escaping ladder from the ceiling of the cage and escape to the outside from the hoistway top. In this case, as there are many machines and apparatuses on the cage, he must behave himself with utmost care. When he climbs the gangway ladder, there is no possibility of operation of the cage and he must climb it step by step with care.

4) In other cases than emergency escape, do not try to escape from the cage.

(4) Once emergency door is opened, merely closing it can,t restore the elevator to the original operative state.

In order to be restored, operate the "RESET BUTTON" in the controller.

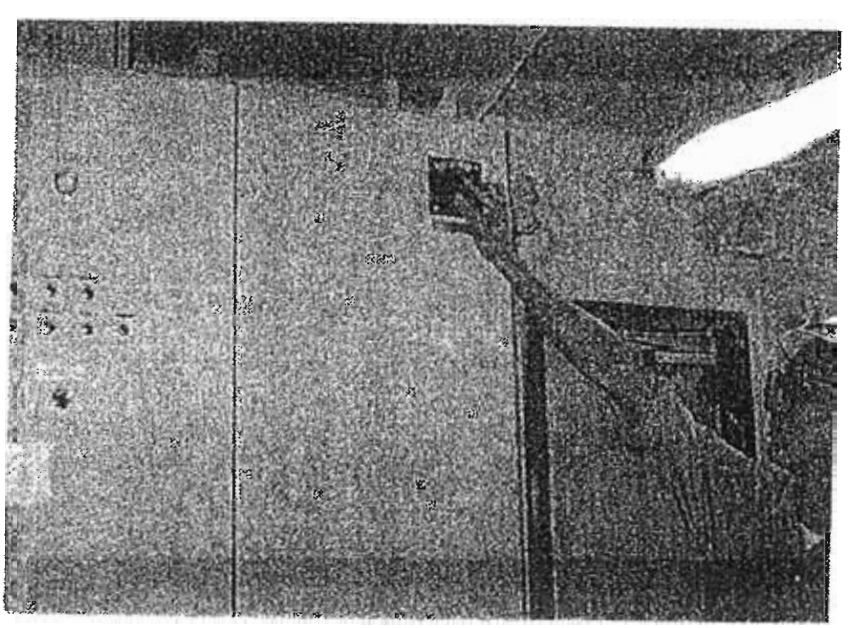
Special attention should be taken before operating of "RESET BUTTON".

6. RESCUE METHOD AND CAUTIONS IN EMERGENCY

(1) The staff-member in charge who has come in contact with the passenger in the case by emergency bell goes to the elevator machine room immediately.

(2) The number of staff-members in charge who go to the elevator machine room must be more than 2 and they must carry an electric torch.

(3) Turn off the main power switch for control panel installed at machine room. (PHOTO 1)



(PHOTO 1)

(4) Open the hatch for rescue and confirm the position where the cage is stopped.

(5) Open the door at the floor above the position where the cage has stopped. In this case, be sure to use the key for emergency use provided at machine room.

(6) The Emergency Key Hole is located on upper side of floor door panel. To open the door, insert the key horizontally into the hole, move your key-holding hand toward the center of door, and then push the door in opening direction. (See Photo2)

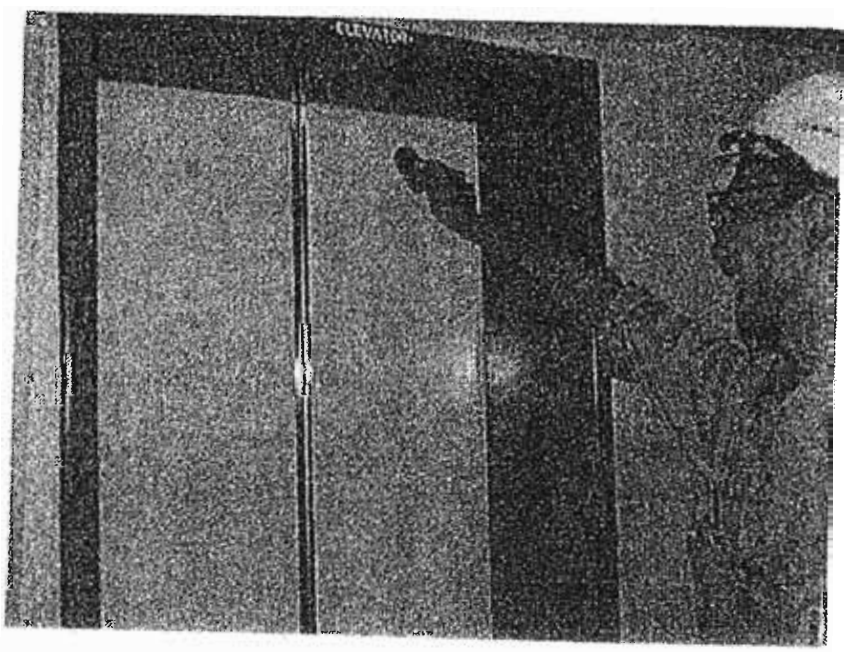
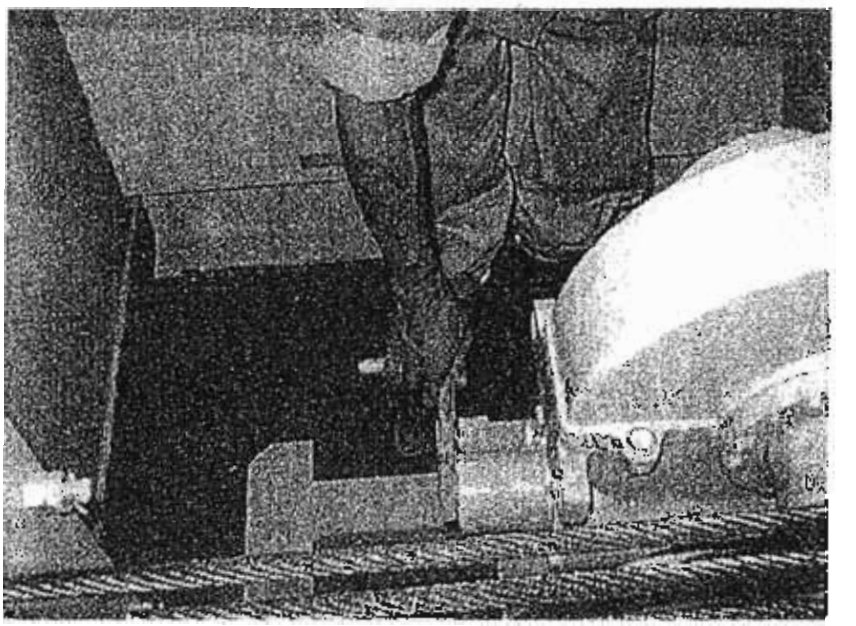


Photo2

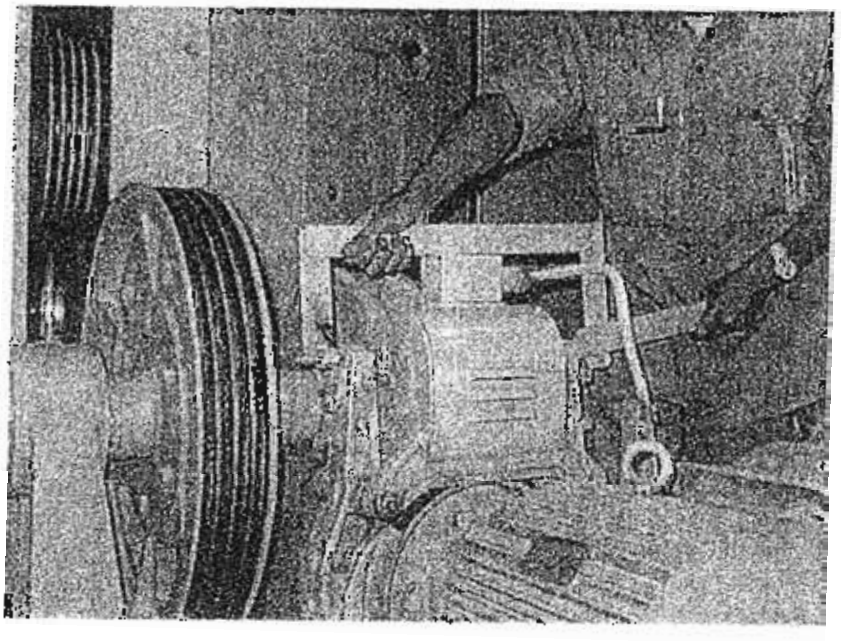
(7) Take full care for preventing dropping after the door has been opened and measure visually the distance (m) of the cage from the floor level of the landing.

(8) Insert the turning handle provided at machine room to the electric motor for hoist (PHOTO 5).



(PHOTO 5)

(9) Release the brake mechanism by means of the handle for releasing of the brake provided at the machine room. (PHOTOS 3 and 4)



(PHOTO 4)

In this case, simultaneously with releasing the brake, the motor shaft will be rotated two times due to the unbalancing of the cage and counterweight. Accordingly, one or 2 staff-members in charge must hold the running handle which has been inserted in the electric motor. (PHOTO 5)

(10) Turn the running handle by the volume measured manually in item (7) and let the cage go up.

(11) After going-up operation of the cage, remove the handle for releasing of brake and then, operate the brake mechanism.

(12) Rescue the passenger at the floor of which landing door has been opened.

(13) At the condition of (12), the distance between cage floor level and landing floor one is desired to be within ±200mm. When passengers are rescued, ±500mm approx. will be enough.

(14) After rescuing passengers, the distance between cage floor level and landing floor is within ±200mm.

(15) Besides the rescue method of which procedure is as mentioned in the above items (1) - (14), there is the following rescue method. That is, you can get down inside the hoistway from the hatch for rescuing purpose of the machine room through the escaping ladder and open the escape exit cover at the ceiling of the cage. Then, you can guide the passengers and rescue them.

In this case, pay attention to the following points:
That is, behave yourself, taking into consideration the machines and apparatuses existed in the hoistway and unstability of scaffold on the cage. There is a strong possibility that passengers might touch the machines and apparatuses inside hoistway, resulting in developing a dropping accidents. Accordingly, it is desired to rescue passengers by means of the procedures mentioned in items (1) - (13) in other cases than emergency (breakout of fire of ship).

(16) When there is a telephone between cage and elevator machine room, make the best use of the telephone. You can get a grip on the situation inside the cage by exchanging conversation with passengers inside the cage by telephone. Thus, you can control the ascending quantity of the cage according to the instruction of passengers inside the cage . (PHOTO 5)

(PHOTO 5)

Annex G

MCA's Code of Safe Working Practices section 20.12 - Personnel Lifts and Lift Machinery

20.12 Personnel Lifts and Lift Machinery

20.12.1 Before a lift is put into normal service it must be tested and examined by a competent person and a certificate or report issued.

20.12.2 Regular examination must be carried out by a competent person at intervals not exceeding six months and a certificate or report issued. More detailed examination and testing of parts of the lift installation must be carried out at periodic intervals.

20.12.3 A person chosen to act as a competent person must be over 18 and have such practical and theoretical knowledge and actual experience of the type of lift which they have to examine, as will enable them to detect defects or weaknesses and to assess their importance in relation to the safety of the lift.

BS 5655:1986 Lifts and service lifts (or an alternative equivalent Standard).

20.12.4 Details of the tests and examinations required for the issue of a certificate are given in BS 5655:1986 and equivalent Standards. Guidance is also contained in Guidance Note PM 7 from the Health and Safety Executive - Lifts: Thorough Examination and Testing.

20.12.5 An initial risk assessment must be made to identify hazards associated with work on each lift installation, including work requiring access to the lift trunk. Safe working procedures must be drawn up for each lift installation. Persons who are to be authorised to carry out work on or inspection of the lift installation must comply with these procedures.

20.12.6 The specific areas that the risk assessment should address should include, as appropriate:

(a) whether there are safe clearances above and below the car at the extent of its travel;

(b) whether a car top control station is fitted and its means of operation;

(c) the working conditions in the machine and pulley rooms.

20.12.7 Based on the findings of the risk assessment, it is recommended that a permit-to-work system, as described in Chapter 16, is adopted when it is necessary for personnel to enter the lift trunk or to override the control

safety systems. It is strongly recommended that no person should work alone on lifts.

20.12.8 Any work carried out on lifts must only be performed by authorised persons familiar with the work and the appropriate safe working procedures. These procedures must include provision for both the safety of persons working on the lift and others who may also be at risk such as intending passengers.

20.12.9 Appropriate safety signs must be prominently displayed in the area and also on control equipment such as call lift buttons. Barriers must be used when it is necessary for lift landing doors to remain open to the lift trunk.

20.12.10 Experience indicates that the most important single factor in minimising risk of accidents is the avoidance of misunderstandings between personnel. A means of communication to the authorising officer and between those involved in working on the lift must be established and maintained at all times. This might be by telephone, portable-hand held radio or a person-to-person chain. Whatever the arrangement, action should only be taken as a result of the positive receipt of confirmation that the message is understood.

20.12.11 Before attempting to gain access to the trunk, whenever possible the mains switch should be locked in the OFF position (or alternatively the fuses should be withdrawn and retained in a safe place) and an appropriate safety sign must be positioned at the point of such isolation. This should include both main and emergency supplies. In addition, the landing doors should not be allowed to remain open longer than necessary; the machine room should be protected against unauthorised entry and after completion of work a check must be made to ensure that all equipment used in the operation has been cleared from the well.

BS 2655: (10 parts) Specification for lifts, escalators, passenger conveyors and paternosters (or an alternative equivalent standard).

20.12.12 When it is necessary for personnel to travel on top of a car, safety can be enhanced considerably by the use of the car top control station (comprising a stopping device and an inspection switch/control device) required by BS 2655 or an equivalent Standard. Account should be taken of the arrangement and location of the control station ie whether the stopping device can be operated before stepping on to the car top. Persons must not travel on the top of the lift car if no stopping device is fitted.

Annex H

EMU - Health and Safety Policy

Health and Safety Policy

The principle aim of our policy is to encourage the development and the maintenance of a sound safety and effective occupational health culture of the highest level amongst all employees within Evergreen Marine (UK) Ltd. To achieve this, we have established an Integrated Management System (OH&S) for our container Carriers and Company's shore-based personnel.

We are committed to maintain and operate our ships safely and efficiently by providing a safe and healthy working environment following these principles:

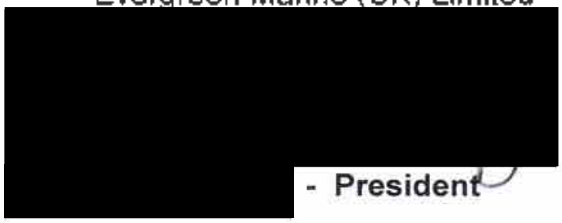
1. Making Health and Safety our first priority.
2. Promoting a culture of Health and Safety responsibility and awareness through the implementation of training and familiarisation.
3. Complying with all relevant Health and Safety legislation, and where possible, improving on these requirements.
4. Conducting Health and Safety practices in ship operation.
5. Establishing all reasonably practicable control measures to reduce identifiable risks associated with the Company's operations.
6. Investigating all incidents and accidents to identify root causes and prevent recurrence of human injury or loss of life.
7. Demonstrating a high degree of Leadership and Management commitment.

Evergreen Marine (UK) Ltd. is certified according to the rules of the ISM code and has obtained a full term Document of Compliance (DOC) and committed to fully comply with OHSAS: 18001-1999 standard.

I will be fully responsible for implementing the Health and Safety policy of the company. I hereby designate the Head of the Marine Department to monitor Occupational Health and Safety Management System implementation and authorize him as Designated Person (DP) to provide a link between the Company and ship.

Date: 20/Jan/2010

Evergreen Marine (UK) Limited



- President

EVERGREEN MARINE UK		POLICY			
Issued by:	Top Management	Number:	Policy-01	Revision:	1
Title:	Health and Safety Policy			Page:	1/1

Revision History

Revision	Date	Description
0	01/May/2007	Initial issue
1	20/Jan/2010	Signatory change

President	Designated Person	Quality Management Representative	Environmental Management Representative	Issued Division / Department / Section
[redacted] JAN 20 2010 P	[redacted] JAN 20 2010 DJVP	[redacted] JAN 20 2010 DM		

Annex I

EMU Marine Circular 22 February 2005 - Working safety instruction to the involved crew prior to carrying out a particular task or operation

HATSU MARINE LIMITED
MARINE CIRCULAR

TO: Master, C/E and all crew

FM: HML-LDN MAR

DATE: Feb / 22 / 2005

REF. NO.: MAR-2005-008

SUBJECT: To provide a briefing of working/safety instruction to the involved crew prior to carrying out a particular task or operation.
執行特殊操作或重大維修時，應實施勤前工作指導及安全講習。

MESSAGE:

In order to develop, establish and maintain a "Safety Culture" and to achieve the high standards of safety in the Company, it is desirable that all personnel are to be careful examination of what action or operations could cause an incident. Read the manufacturer's instruction manuals and related Marine Circular/Maintenance Circular prior to carrying out a task. So that precautions can be taken to prevent harm or personal injury. The aim is to minimise accidents on board ship.
為了發展、建立及維持公司一向重視之"安全文化"；及達成高標準之安全作業程序。希望全體同仁在執行重要維修工作或作業前詳讀廠家說明書、公司發出之相關程序書及海技／維修通告。作業前應對施工流程全面且詳細評估，對可能發生之傷害或風險應事先防止，以達成降低事故之目標。

Reviewed the accidents had occurred in Group's fleet vessels and found that the root cause of these accidents mostly was due to human negligence. And the majority of the accidents were wrong and careless operation. A useful preliminary briefing of working/safety instruction prior to carrying out a particular task or operation to the involved crew by the person in charge will help to eliminate the risk for each individual work activity, including, but not limited to, main/generator engine overhaul, elevator repair or maintenance, drills, bunkering operation or transfer, hot work, working aloft/outboard, entry into enclosed space, electrical equipment repair and moving heavy object etc.
檢討公司過去所發生之意外事故，其根本原因有大部份為人員疏忽所造成，其中又以操作錯誤或施工不慎佔多數。為消除前述之根本原因，最為有效且簡單之方法為主管人員應事前作充分的準備；並於開工或操演前指導參與同仁，實施勤前講習提示標準作業流程、安全須知、分配工作等。以下為重要之船上特殊操作或保養工作，事前主管人員應確實執行勤前講習，如：主機或發電機吊缸、電梯保養維修、操演、加油及駁油作業、電焊或氣焊之熱工作業、高空或舷外作業、進入密閉艙間缺氧防止、維修電氣設備及搬運重物等。

During the safety/working briefing, the person in charge shall clearly give the working instructions or procedures, the usage of special tools to the workers in accordance with the MCA's Code of Safe Working Practices for Merchant Seamen or Manufacturer's instruction manuals. In the meantime, assign duties to each individual worker and always monitor any possible unsafe acts that may cause

	[APPROVED]	[CHECKED]	[WRITER]
[CATEGORY]	[redacted]	[redacted]	[redacted]

potential risks of hazards during the operations or maintenance. Furthermore, a risk assessment should be made to identify the hazards and to take suitable measures.
實施勤前安全作業講習時，需針對工作之需求及特性，必要時主管人員應依據安全工作準則，廠家說明書規定之施工程序、工具之使用及作業準則給予參與之同仁清楚指導；同時分派工作並注意現場有無施工失誤或不安全之因素以防止損害，並進行危險評估指出可能之危險，並採取適當之措施。

The following are examples of the consequences regarding safety, which may occur on board the ship: 以下之事故，常在保養及操作期間發生，例如：

1. Hydraulic tools were not properly used while overhauling the main engine or generator engine and caused the nuts slackening. 在主機及發電機保養時不當使用油壓締緊工具，造成螺絲帽鬆脫。

2. Maker's instructions were not followed while repairing the defective bearing of main engine or generator engine and caused serious damage. Any finding of a damaged bearing should report to the Company immediately prior to repairing by ship hands.
主機及發電機軸承故障時，未依照廠家說明書之規定處理，造成更大之傷害；今後如有類似事故時，應在修理前向公司報告並依照公司指示辦理。
3. Carrying out a drill without a safety briefing or assigning duties, particularly, on the drill of launching lifeboat may cause serious damage and human injury.
船上實施各項操演時，未在集合地點執行勤前講習。尤其對救生艇或救難艇之施放及回收未詳加解說；且未確實分派工作，以致現場操作毫無章法，造成人員傷亡及損壞。

4. Maintenance of the elevator or crane without collaborative work or giving safety instructions prior to doing the task may cause possible risk.
船上電梯及吊車維修時，須團隊間默契良好；且事前應有詳細規劃以降低維修風險。

Please kindly be advised that all crews shall read this safety instruction and establish a "Safety Culture" in the Company and be sure that proper measures are taken to ensure an improvement in safety as well.
請船上同仁詳細閱讀本通告；並確實建立本公司高標準之"安全文化"；以改進及防止意外事故之發生。

Bon voyage !
順頌　航安！

Annex J

Shipboard Safety Committees and safety and health meeting minutes - 5 December 2009

SHIPBOARD MINUTES OF MEETING

Ship name: HATSU EXCL Voyage number: 0478-073 W

Subject	Shipboard Safety Committees and safety and health meeting		
Date	DEC/05/2009	Time	1030-1200
Attendance	MS: [redacted] C/E [redacted] BUN.: [redacted] CO(S.O.): [redacted] 2/E(E.S.R): [redacted] A.B.(0-4): [redacted] 2/O(D.S.R): [redacted] 3/E [redacted] A.B.(R.S.R.)(4-8): [redacted] 3/O: [redacted] 4/E: [redacted] A.B.(8-12): [redacted] A.B.(DECK): [redacted] C/C: [redacted] GPC [redacted] FITTER: [redacted] M/M: [redacted]		

Agenda:

1. Review the previous meeting and follow up actions:

All crewmembers should keep the measure of the instruction as, (1) COSWP chapter 15.2 issued by UK MCA and CK-FLT-0706-3, (2) COSWP chapter 16 & 17 issued by UK MCA and CK-FLT-0706-2, in daily routine work to prevent the fatal casualty happened.

2. Review the deficiencies of audits or port state control inspections. Corrected the deficiencies of onboard inspection and closed the case on NOV/23/2009.

3. Review the accident or incidents happened. No case was happened at this period.

4. Review the near miss or minor-incidents happened. NIL

5. Review the shipboard discipline, health and safety condition: (a) Strictly to measure all crew members' body temperature. (b) Strictly to comply with the safety measures of operation of tugs lines. (c) To conduct the training course: recognizing " Snap-back zone " in mooring and towing operations. (d) Strictly to execute shipboard food preparation and handling as per HSQE WORKING MANUAL WM-FLT-0606.

6. Review the critical machinery failure case. NIL

7. Review the environmental targets achievement: Container overboard: until now quantity of containers overboard is zero.

8. To conduct the training course: Shipboard food preparation and handling.

9. Any other business and date time of the next meeting

next meeting will JAN/16/2009

Conclusion:

1. All crewmembers should keep the measure of the instruction as, (1) COSWP chapter 25 issued by UK MCA (2) COSWP chapter 14, MGN-61, issued by UK MCA and HSQE PL-04, WORKING MANUAL WM-FLT-0606, CK-FLT-0605-2, in daily routine work to prevent the harmful casualty happened.
2. All crewmembers should keep all shipboard operations to comply with the HSQE, other relevant regulations and rules.

Approved by MASTER	Prepared by
[redacted]	[redacted]

Annex K

EMU Marine Circular 13 January 2010 - Encourage and promote the reporting of near misses

MARINE CIRCULAR

EVERGREEN MARINE (UK) LIMITED

TO: **Master, C/E & all crews**
各輪船長、輪機長及全體船員

FM: EMU-LDN
MAR-MATG

DATE: 13 / JAN / 2010
REF. NO.: MAR-2010-002

SUBJECT: Encourage and promote the reporting of near misses

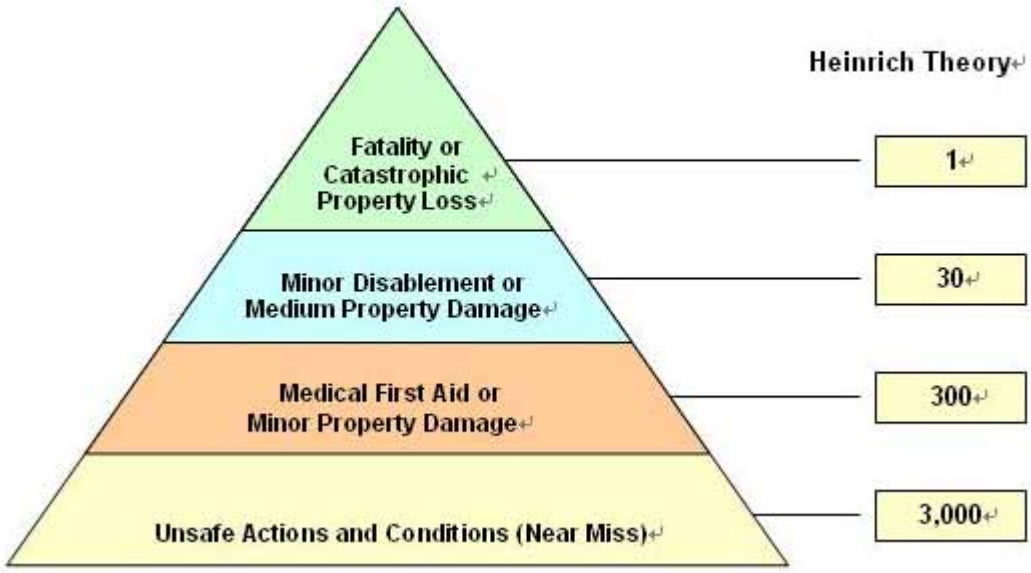
鼓勵“幾乎發生的事故”案件之通報。

MESSAGE:

A near miss is an unplanned event that did not result in injury, illness, or damage - but had the potential to do so. Only a fortunate break in the chain of events prevented an injury, fatality or damage. Other familiar terms for these events is a "close call", or in the case of moving objects, "near collision".

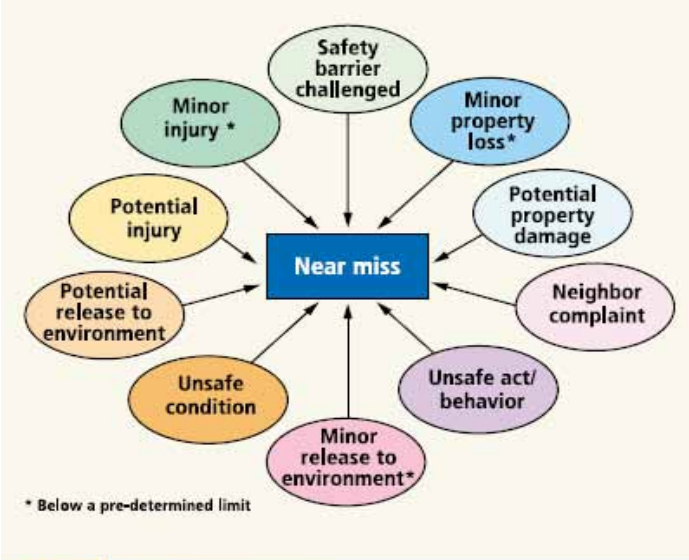
一個“幾乎發生的事故”是一樁意外事件未導致人員受傷、生病或財產損失－但有潛在的可能會發生。只有幸運的打破連串的事故鍊才可能防止人員受傷、死亡或財產損失。其他稱呼這些事故熟悉的名詞為“千鈞一髮”；或對移動物體的事故，稱為“幾乎碰撞”。

Figure 1: Accident Triangle



The interpretation of the revised Heinrick accident triangle shows the relationship between accidents and their identified related hazard. For every 3,000 hazards (including near miss), 300 will result in a first-aid or minor property damage case. Of the 300 first-aid or minor property damage cases, 30 minor disablement or medium property damage cases will result. From the 30 minor disablement or medium property damage cases, one fatality or catastrophic property loss is expected. Therefore, the more information of near misses we acquire from the bottom of the triangle, the more lessons we can learn and develop the countermeasures to prevent the similar event from happening again.

上列經修改過的漢尼克意外事故三角形顯示了意外與其有關的危險。據統計，每 3 千樁危險（包括“幾乎發生的事故”）會產生 300 個醫療急救或較小的財產損失案件。每 300 個醫療急救或較小的財產損失案件會肇致 30 樁較小的殘障或中度財產損失事故。這 30 樁較小的殘障事故或中度財產損失可能導致一樁死亡意外或災難性的財產損失。因此，我們從三角形底部獲得的資訊越多，我們越能學到更多的教訓從而發展出對策以防止類似意外事故的再度發生。



FG 3 Possible near misses.

Left is the category of near miss includes unsafe condition/act; potential injury/property damage/release to environment; neighbour complaint; safety barrier challenge; minor injury/property loss/release to environment below a pre-determined limit.

左圖是可能發生的 near miss 種類：包括不安全的工作情況及行為；潛在的人員受傷、財產的損害或環境污染；鄰居的抱怨；挑戰安全護欄；容許範圍內極小的人員受傷、財產損失或環境污染（必須合乎環保公約管制）。

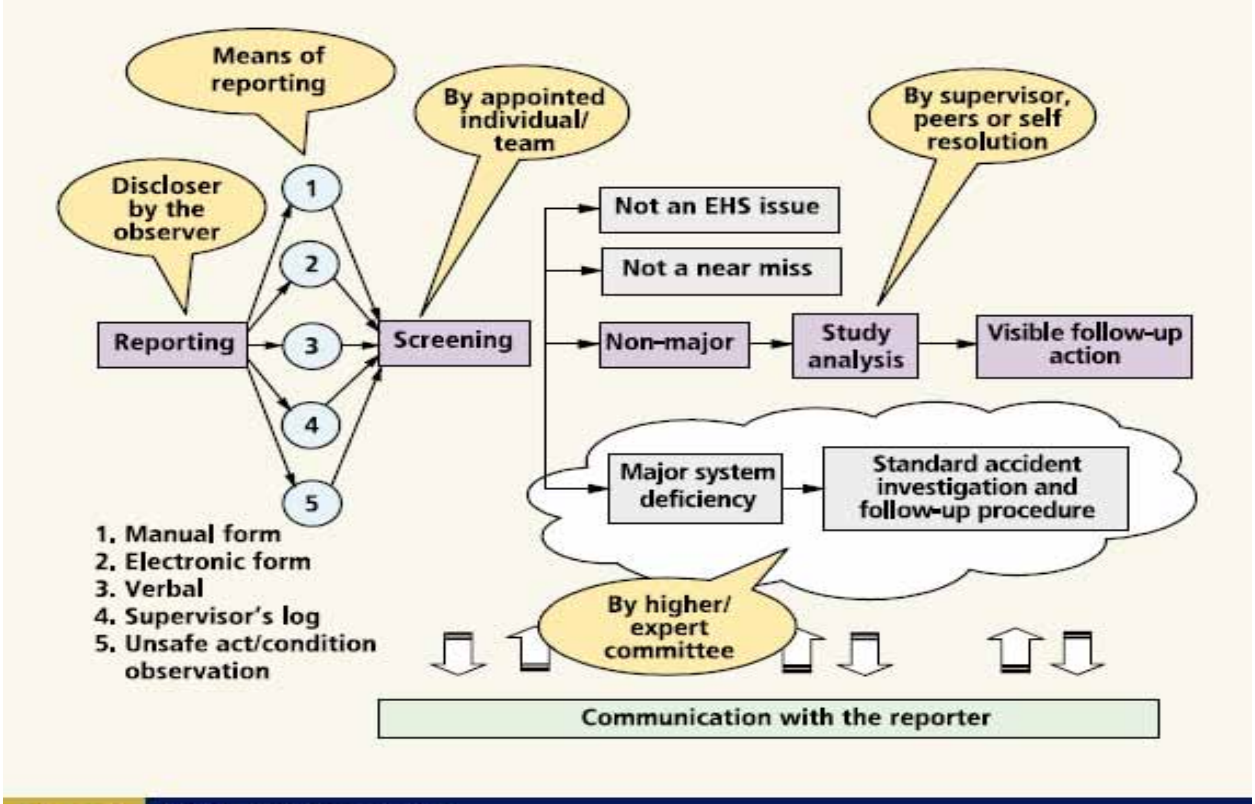
Near miss is a cheaper learning tool than learning from actual injury or property loss accident. Moreover they are numerous. Since they are smaller in scale, relatively simpler to analyze the root cause and easier to resolve the problem. Thus capturing near misses not only provides an inexpensive means of learning it has some equally beneficial spin offs; which highlights the significance of encouragement and promotion of the reporting of “near miss” by the fleet, so that we can share the lesson and devise the plan and strategy to prevent the “real event” from happening. Take “Ever Smile” man-overboard case as a example, after the event many captains reflected the similar situation whereas narrowly escaped the danger. Supposed they report the near miss in advance, the accident on Ever Smile should have been avoided.

比起真實發生的人員受傷或財產損失，“幾乎發生的事故”是一個極廉價的學習工具；而且數量龐大。由於其規模較小，相對的易於分析其根本原因及解決問題。因此，獲得“幾乎發生的事故”案例不但提供廉價的學習工具，且有若干附帶的受益價值。這益加突顯鼓勵及推廣船隊通報“幾乎發生的事故”的重要性，如此我們才能分享其教訓而制定計劃及策略以防真實事故的發生。以“長怡輪”人員落海為例，事故後許多船長反映了類似的情況卻幸運的逃離險境；如果他們能及早將這些“幾乎發生的事故”匯報，“長怡輪”的意外應該就可以避免了。

Therefore your are highly encouraged and appreciated to report “Near Miss” cases if any, some guidelines below are for your reference:

因此我們高度感激且鼓勵您們儘量通報“幾乎發生的事故”，下列通報的一些指南供您參考：

1. Shipboard shall establish an awareness program for detecting “Near Miss” at all times, keep the topic high in the everyday agenda, using meetings, other gatherings and coaching opportunities to capture further near-miss reporting.
   船上應制定一個隨時偵測“幾乎發生的事故”的機制，可以將此議題當作日常工作事項，利用會議、其他集會或輔導訓練的機會，以獲取更多的“幾乎發生的事故”通報。
2. Keep the reporting form simple with less text.
   報告應簡化，內容應精簡。
3. Use FM-FLT-0902-1 via E-mail or fax to send the message. People should know how to report near misses as well as they know how to press the fire alarm.
   以 FM-FLT-0902-1 經電子文件、傳真發送通報。熟悉通報“幾乎發生的事故”就像熟悉如何按火警警報按鈕一樣。



FG 4 Simple near-miss model.

4. It is the company’s policy to encourage and promote the reporting of near misses, thereby the reporter will not be blamed/punished, but highly praised/protected.
   鼓勵及推廣通報“幾乎發生的事故”是公司的政策，因此通報者不但不會受到責難／處罰，相反的將被高度讚揚／保護。
5. Prior to send the reporting, self-evaluation shall be carried out to review and analyze the root cause and lesson from “near miss”, so that the countermeasures can be developed to prevent the repetition.
   發通報前，應先自我評鑑，檢討及分析“幾乎發生的事故”的根本原因及教訓，從而制定對策以防止其再次發生。

6. The Master is obligated to report “near miss”, but everyone onboard is highly encouraged and requested to report if he finds any abnormity of potential injury or property loss.
   除了船長有義務要通報“幾乎發生的事故”之外，我們也高度鼓勵及要求船上其他人通報發現到有潛在人員受傷或財產受損失的任何異常狀況。
7. Kindly collect and send your good ship’s “near miss” report at least once every season, certainly the more, the better.請收集及寄送貴輪的“幾乎發生的事故”案例至少每季一次，當然越多越好。

“Near Miss” reporting is part of ship’s safety culture, and most importantly, it affects everybody’s safety onboard. Nobody makes mistakes on purpose. They are always the result of bad leadership, lack of training and education, lack of experience, poor technical solutions, assumptions, habits, attitudes, culture, silent acceptance, shortcuts, etc.
“幾乎發生的事故”通報是船上安全文化的一環，而且更重要是：它攸關每個人的安全。沒有人會故意犯錯。錯誤皆是拙劣的領導、缺乏教育與訓練、無經驗、不良的技術、假設、習慣、態度、文化及抄捷徑所導致。

Take action on the near-misses that occur - because you will simply not accept accidents aboard and you know that Accidents are Preventable. The better we are at sharing our knowledge about how things go wrong, the fewer industrial accidents - and accidents at sea - will happen.
對任何“幾乎發生的事故”必須採取行動－因為你不僅不接受船上發生意外事故，而且知道意外是可以預防的；我們愈能分享發生意外的原因、工安事故及海上意外即愈不容易發生。

We need to get away from finger pointing and a blame culture and move towards the question of "Why it happened" and "What can we learn from that." We need to get to a point where crew are actually appreciated and acknowledged for reporting errors to a near-miss system. Everyone aboard needs to feel comfortable about reporting a near-miss event to the company. Because we can see that safety gets better and better and because people start to talk about safety issues in a very different way. It suddenly all makes sense.
我們必須揚棄指責及歸咎的文化，而將焦點移向“這事如何發生？”及“我們從而得到什麼教訓？”。我們必須努力達到船上每一個人都欣賞且承認通報失誤至一個“幾乎發生的事故”的系統。船上的每一個人都必須感到通報“幾乎發生的事故”給公司是好事。因為我們可以看到船上安全越來越改善而且每人都開始以不同的方式談論安全的議題。突然之間一切都變得合情合理了！

Thank you for your full cooperation.
感謝您的充分合作！

Bon Voyage.
順頌　航安！

Annex L

EMU 2009-10 Fleet Management Review Meeting Minutes (extract)

EMU 2009-10 Fleet Management Review Meeting Minute

The chairman of meeting welcome all of you to participate in this meeting of fleet management Review and reminded attending members to verify all the necessary documents and records in preparation for the external audit of ISM **Code, ISO 9001:2000 and ISO14001:2004**, which will be scheduled on **19. April 2010**.

Topic_1 Review safety management meeting in last year resolution and its result.

- **Regarding Internal and External Audit:**

The EMU-MAT is ongoing review and revises our HSQE manual to become more users friendly and through visiting ship and internal audit to enhance documents control and safety concept.

- **PSC inspection in 2009:**

Enhance the onboard training and port Captain with port C/E onboard inspection to reduce the PSC deficiency.

- **fleet accident/incident and near miss cases:**

There were 2 fatal accidents during last 3 month period, although we found main reason were personal lack of safety awareness, but how to enhance our crew safety awareness will be our task of coming year.

- 090910-ELITE- Crew overboard and dead;
- 091119-SMILE-Crew Overboard;

Topic_2 Overview company HSQE Policy and targets setting

Company's Safety, Quality and Environmental Policy had no change last year and has been reviewed by DP and found all policy is still suitable for next year and decides to keep it.

The Quality targets for the 2010-2011 Marine Department are change to reviewing fleet "Oil Record Book" record entry every 6 month (**March and September**) compare the deficiencies raise in first and second half year to achive **10 % recudtion** of count of deficiencises.

The 2010-2011 fleet quality targets remain the same

1.) Reduction 1% TEU of container overboard (compare with last year).

Topic_3 Overview Internal and External Audit

A.) Main deficiencies of **Internal Audits** for fleet

No.	Deficiency	Type
01	Fire damper in steering gear room was found stuck. It needs to be maintained for ensuring smooth operation.	NC
02	The safety sign and mark were completed all areas of the vessel except the areas of forward windlass and fresh water chlorination device in 2nd passage.	OBS
03	The ship was not aware of the risk of falling hazard caused by movable door mat while getting wet.	OBS
04	The vessel had never removed the tarpaulin of the liferaft boarding ladder for maintenance and ensuring the condition for immediate use.	OBS
05	Regular cleaning of the oil filter was not properly conducted to prevent fire accident and food contamination.	OBS
06	Shipboard failed to start up the engine of the port side lifeboat during the boat drill in the audit.	NC
07	Drill and rescue from dangerous space should be carried out every two months as required by COSWP 10.5.1. However, no evidence of drill scenario for simulating the rescue of an incapacitated person from dangerous space was found in the past two months drill record.	OBS
08	"Enclosed Space Work Permit" record of "M/E Scav. Air chamber inner clean" date of Apr07, 2009 was found that the PIC did not define the reporting interval of time (minutes) as section 2.4 requirements.	OBS
09	The sill edges of the lighting-hole aperture at Bay01 forward did not paint with Hi-Viz color to accentuate their respective position in the designated walkway. Trip hazards.	OBS
10	Suspension wire of davit of port side accommodation ladder was found squeezed in the sheave. The wire needs to be renewed for the safety of operation.	NC
11	Cleanliness of the oil filter (fat trapper) in the gallery was not acceptable as the surface of the filter was covered by oil drips and the oil drainage in 2 steel cans seemed having been kept for a long time.	OBS
12	Bulldogs used at the ends of the lifeboat fall were not rigged properly.	OBS
13	No evidence of simulating the rescue of an incapacitated person from a dangerous space which carried out on Oct07, 2009 for drill of entering enclosed spaces.	NC

Summarize the non-conformities above and analysis, we have conclusion as below:

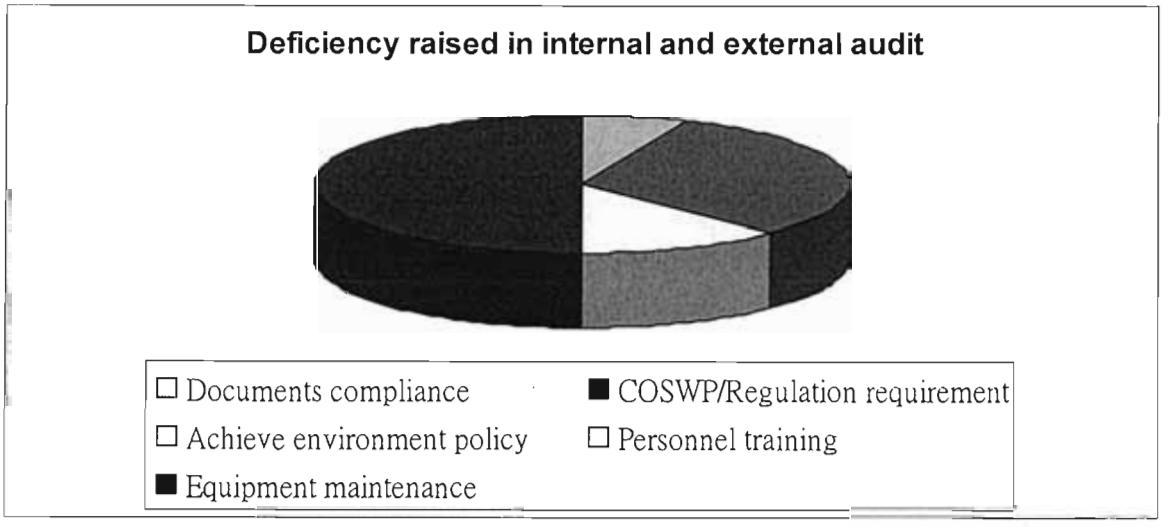
In year of 2009, we have totally 11 vessel internal audits activities conducted by Taiwan office/London office inspectors; 2 vessels have external audits by MCA.

Base on internal audit records total 13 non-conformities or observations had completely corrected by shipboard and closed out.

Regarding with external audit, there are 2 observation and 1 deficiency of general inspection had been raised by auditors and been closed out by ship.

To make a comprehensive survey of total 16 defects, 50% of defects are related to Equipment maintenance, 31% of defects are related to COSWP or Regulation requirement, 13% are related to Personnel training and no defect is failed to achieve environment policy.

Category	defects	Percentage
Documents compliance	1	6%
COSWP/Regulation requirement	5	31%
Achieve environment policy	0	0%
Personnel training	2	13%
Equipment maintenance	8	50%



The most deficiencies (4 of 8) of "Equipment Maintenance" category were S/E-related including fire damper, lifeboat engine, remote control wire and bulldog grips on lifeboat fall etc. Two deficiencies of maintenance of galley oil filter (fat trapper) were found not properly conducted.

Deficiencies in "COSWP/Regulation Requirement" reflects some safety officers lack completed concept of safety requirement in COSWP as well as mandatory regulations. The majority of deficiencies in this category are safety sign/mark and slipping hazard.

Category "Document Compliance" is no more the lead as last three years which means the document users onboard have better understanding on the HSQE documents.

All "Personnel Training" deficiencies are with regard to drill of entering enclosed space which is required by COSWP 10.5.1 to carry out every two months. And this means the

annual drill and exercise program is not carefully checked by Ship Master and Company as well at beginning of each year.

There is no deficiency in the category "Achieve environment policy" which continually improved since from last year showing shipboard personnel have been well educated for environmental issues.

Action to be taken and improvement in 2010:

1. Enhance maintenance inspection including relevant document review e.g. risk assessment/checklist, cross check the time and place of carrying out, verify the understanding of PIC for precaution and maintenance details during the internal audit or routine onboard inspection.

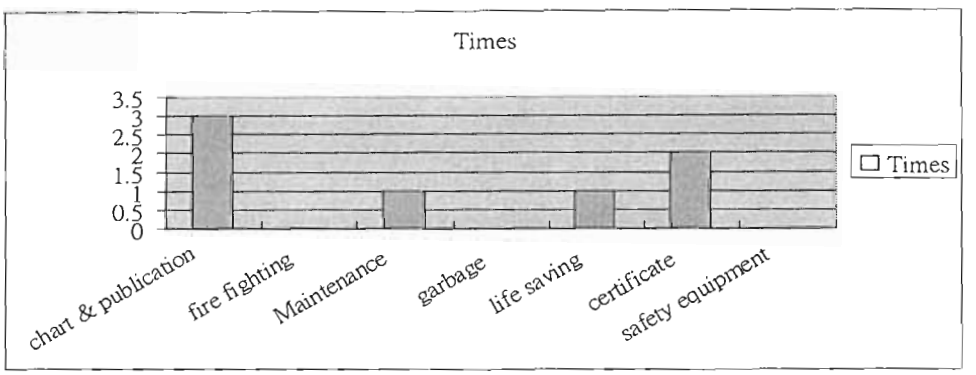
2. Besides simulation exercise, MAR-MAT should verify fleet annual drill program to ensure complying with regulations.

3. Increase visiting ship frequency to make a close communication between shipboard and Company and impress key staff for all safety aspects in order to develop safety culture onboard.

4. Review effectiveness of shipboard training by interviewing crew and document inspection in audit or onboard inspection

Topic_4 Overview fleet PSC inspection in 2009-2010

Port	LAX	HBG	ZEE	OKL	YYT	HKG	SHG	TYO	TCM	TRA	TOTAL
Vessel	8	5	4	3	2	1	1	1	1	1	27
N/C	0	3	0	2	2	1	0	0	0	1	9



Summary of deficiency by PSC inspection:

Port	Ship name	Deficiency item
HBG	ELITE	• Charts not up to date by lack of NtM for 4 weeks and all charts for the intended voyage have to be corrected to latest NtM 5/2009. **(chart & publication)** • The International Code of Signals is expired. Should be ed.2005.

		(chart & publication) • The Spare Magnetic Compass has a big air bubble. **(Maintenance)**
YYT	SMILE	• MOB smoking signal light un-light. **(life saving equipment)** •Some certificate of competency for seafarers have no holder signature. **(certificate)**
TRA	SMART	•The entry of LRIT in form E of SE Certificate did not update. **(certificate)**
OKL	ELITE (Gangway accident)	• US Coast Guard found severely damaged port embarkation gangway • An external audit is recommended to be conducted by the flag state or recognized security organization.
HKG	SMILE	• found not updated ITU publications. **(chart & publication)**

Review and analysis PSC inspection deficiencies:

(1) Total 27 times PSC inspections to EMU fleet vessel and 22 without deficiency, and except "Ever Elite" case other 4 vessels arose 7 minor deficiencies by PSCO.

(2) All deficiencies were rectified by the shipboard Master, and the corrected reports had submitted to PSCO to close out.

(3) The main faulty errors are "chart & publication" and "certificate".

Action Take:

Port Captain and Port C/Engineer will enhance the inspection on the listed NC while conducting visiting ship and/or internal audit to prevent recurrence.

Topic_5 Overview the fleet accident, incident and near-miss cases

A. Accident and incident cases:

1. Encountering heavy weather and resulting in damage to Hull: Date: 7/Mar/2009

Ship's name	MV HATSU ENVOY	Voyage No.	0316-068W
Ship's position	LAT 53-18N/LONG 174-47E TO LAT 53-15N/LONG 168-55E	Master:	[redacted]

HATSU ENVOY encountered heavy weather in her voyage from Oakland, U.S.A. to Xingang, P.R.O.C. on Mar 07, 2009. There are following Hull areas damage reported due to heavy weather:

1. THE BULWARK OF STARBOARD BOW BETWEEN FRAME 320~316 AND FRAME 310~307 WERE SLIGHTLY DISTORTED AND SWORN UP ON THE TOP PLATE.
2. THE ANCHOR LIGHT ON THE FORE MAST WAS BROKEN AND FALLEN DOWN.

The anchor light was repaired immediately since there is spare part set on board. Regarding to the damages of Bulwark, it has been arranged to be repaired in her next dry-docking.

2. Crew injury: Date: 30/Apr/2009

Ship's name	MV HATSU ENVOY	Voyage No.	0331-070E
Ship's position	LAT40-08'8N/LONG 168-09'6W	Master:	[redacted]

M/M MAMARION, [redacted] was cut by dropped angle grinder while HATSU ENVOY was sailing from Ningbo, P.R.O.C. to Los Angeles, U.S.A. The wound was around 5-7cm wide and 0.5cm deep. It was 5 days to the next calling port and second officer decided to suture the wound after consulting with Evergreen Group clinic doctor [redacted] The vital signs of life were kept monitoring and report to company day by day and found all in normal condition.

The patient was sent to hospital once HATSU ENVOY called at Los Angeles for further medical treatment. It is confirmed by doctor that the patient is fit for duty so he was sent back to ship for recovering and continuing his service.

3. Touch bottom: Date: 09/Jul/2009

Ship's name	EVER SMART	Voyage No.	0021-025E
Ship position	Colombo	Master:	[redacted]

At 1351 of Jul 09, 2009, EVER SMART was suspected to touch bottom in south entrance of breakwater. EMU arranged diver to carry out bottom survey to confirm if there is any serious damage to ship's hull once the EVER SMART safely berthed at Colombo, also ship's hands were requested to sound all tanks and make sure if there is seawater ingress.

According to diver's report, there are only 3 minor dents to propeller blades. After consulting with pilot, it is understood that the entrance of breakwater is silted up with sands. Therefore we deliver a complain letter to Colombo port authority to raise our complain.

Ship hands are requested to keep monitoring tanks sounding, void spaces, vessel vibration, propelling condition and if there is any further seawater ingress, and found everything works normally.

4. Crew death case: Date: 10/Sep/2009

Ship's name	EVER ELITE	Voyage No.	0474-067W

Ship position	Oakland, U.S.A.	Master: [redacted]

At 0505 of Sep/10/2009, AB/[redacted] rigged p'side accommodation ladder for berthing preparation with AB/[redacted]. During the time AB [redacted] was lifting up handrails, Lower part accommodation ladder and AB [redacted] fell into the sea accidentally. AB [redacted]'s body was subsequently found but died.

EMU carry out a study to the reason lower part accommodation ladder fell and to other securing measures to prevent from similar case occurred again. Another reason SB [redacted] sacrificed is he didn't wear working vest as per company's requests, and EMU emphasize again the importance of wearing proper equipment in difference circumstances.

This case has been investigated by MAIB and MCA, and EMU also prepared detailed report to this case.

5. Touch bottom: Date: 13/Nov/2009

Ship's name	EVER SMART	Voyage No.	0101-027E
Ship position	Suez Canal Channel	Master:	[redacted]

At 1440 of Nov 13, 2009, EVER SMART was suspected to touch bottom in fairway channel of Suez Canal. All tanks sounding, void spaces, vessel vibration, propelling condition are observed and found all in good order. Hence diver was arranged in Kaohsiung for bottom survey. According to diver report, there are only minor paint scratches in the bottom.

6. Crew death case: Date: 19/Nov/2009

Ship's name	EVER SMILE	Voyage No.	0108-028W
Ship position	Taipei, R.O.C.	Master:	[redacted]

EVER SMILE was scheduled to call at Taipei Harbour on Nov 19, 2009. Aft Tug "Sky 501" attended to the aft to make fast the tug's line around 2055. Due to the rough sea condition, GPC [redacted]'s leg was twisted by Tug's heaving line and pulled him overboard and missing. At 0959 of Nov 23, 2009, GPC [redacted]'s body was found on the beach of Taoyuan, where locates in the south of Taipei.

EMU have a meeting with Taipei port authority and tug company, both are agrees to improve their procedure to make fast tug's line safely.

B. Near-miss cases:

Ship's name	Date	Location	Category	Near Miss
SHINE	08/JAN/2009	At Sea	Unsafe Equipment	Cooling water tube to pressure switch of C/R unit cooler broken
SMILE	27/JAN/2009	PTP	Unsafe act	Paint falling down from pallet

				while it was lifted.
PRIDE	07/MAR/2009	At sea	Unsafe use of Equipment	Water ingresses into Bridge wing console caused alarm continuously sounding
EXCEL	16/JUN/2009	At sea	Unsafe Condition	Containers in cargo hold were found leaking oil
SMART	24/AUG/2009	Ushant TSS	Unsafe act	Close quarter situation warmed by VTS
SMILE	16/SEP/2009	PTP	Unsafe Condition	Anchor fouled a wasted anchor chain at PTP anchorage.
EAGLE	18/OCT/2009	LAX	Unsafe use of Equipment	Black smoke from auxiliary boiler ignition.
EAGLE	23/OCT/2009	LAX	Unsafe Condition	Water mist burst out from M/E cylinder cover while blowing engine.
EAGLE	07/NOV/2010	At sea	Unsafe Condition	Water leaked from M/E air cooler alarmed CFW Exp Tk low level.

C. Analysis the accident, incident category:

Category	FFO	Injury Illness	Engine failure	Stipulation violated	Crew discipline	Total
2009	3	3	0	0	0	6

Category	Operational human error	Machinery / equipment defect	External factors	total
2009	5	0	1	6

D. Analysis the near miss category:

category	Unsafe Act	Unsafe Condition	Unsafe Equipment	Unsafe use of Equipment	Total
2009	2	4	1	2	9

category	Operational human error	Machinery / equipment defect	External factors	Total
2009	2	5	2	9

E. Conclusion:

Two fatal accidents related to shipboard operation in 2009 were the most significant cases ever which have involved MAIB investigation and MCA additional audit to review our safety management system. By the time of this meeting, MAIB's final investigation report has not been published yet. And as the result of MCA audit carried on 20/Jan/2010, we are advised to take the measures to reinforce on safety issues onboard, such as purchase of inflatable lifejacket to replace working vest, safety harness instead of safety belt, revising safe working procedures, etc.

One of root causes of these accidents is lack of personal safety awareness which was frequently ignored by shipboard personnel even they have received the training since join the ship. These cases showed that the effectiveness of training is poor. Safety culture must be developed among the crew by upgrading PPE to be more convenient for user, improving safe working procedures, auditing and reviewing crew's performance to gain safety awareness of shipboard personnel.

The second category of accidents in last year is "Touch-Bottom". One of two cases at Colombo was resulted from inaccurate chart information, by which the depth of entrance was not properly surveyed and updated by port authority. And another one was caused by unqualified pilot and poor BRM. Fortunately, by appropriate handling, both accidents had just only slight scratches and did not raise further hull or structural damage.

Regarding the near miss cases, increased slightly than 2008. Company has issued a Marine Circular to encouraged Masters to report all near miss cases with no-blame policy. Most of near miss cases were related to equipment defect causing unsafe condition. The shipboard computerized maintenance plan will be reviewed for those defects have been found.

In overall review of above analysis result, we learnt that the major causes of most accidents were related to inadequate shipboard training and maintenance. Company will target training and maintenance issues and intensify inspection on board against accident recurrence.

F. **Actions to be taken:**

1. Establish the comprehensive risk assessment data base for shipboard reference.
2. Develop safe working procedure of risky tasks.
3. Continually promote safety awareness for ship crew and Ship Safety Officer through the MAR-MAT and EMU-TWN auditors when carrying out routine onboard inspection or SQE internal audit.
4. Enhance the function of Shipboard Safety Meeting by Company reviewing shipboard Safety Meeting Minutes and other relevant documents (risk assessment, special

operation checklist etc.) to trace all concerned safety measure in every chance of inspector onboard both at THP or KSG.

5. Keep studying cases of "Near-Miss" or "Accident Report" and conclude the root cause and counter measures to produce feedback to fleet for preventing recurrence of similar case.

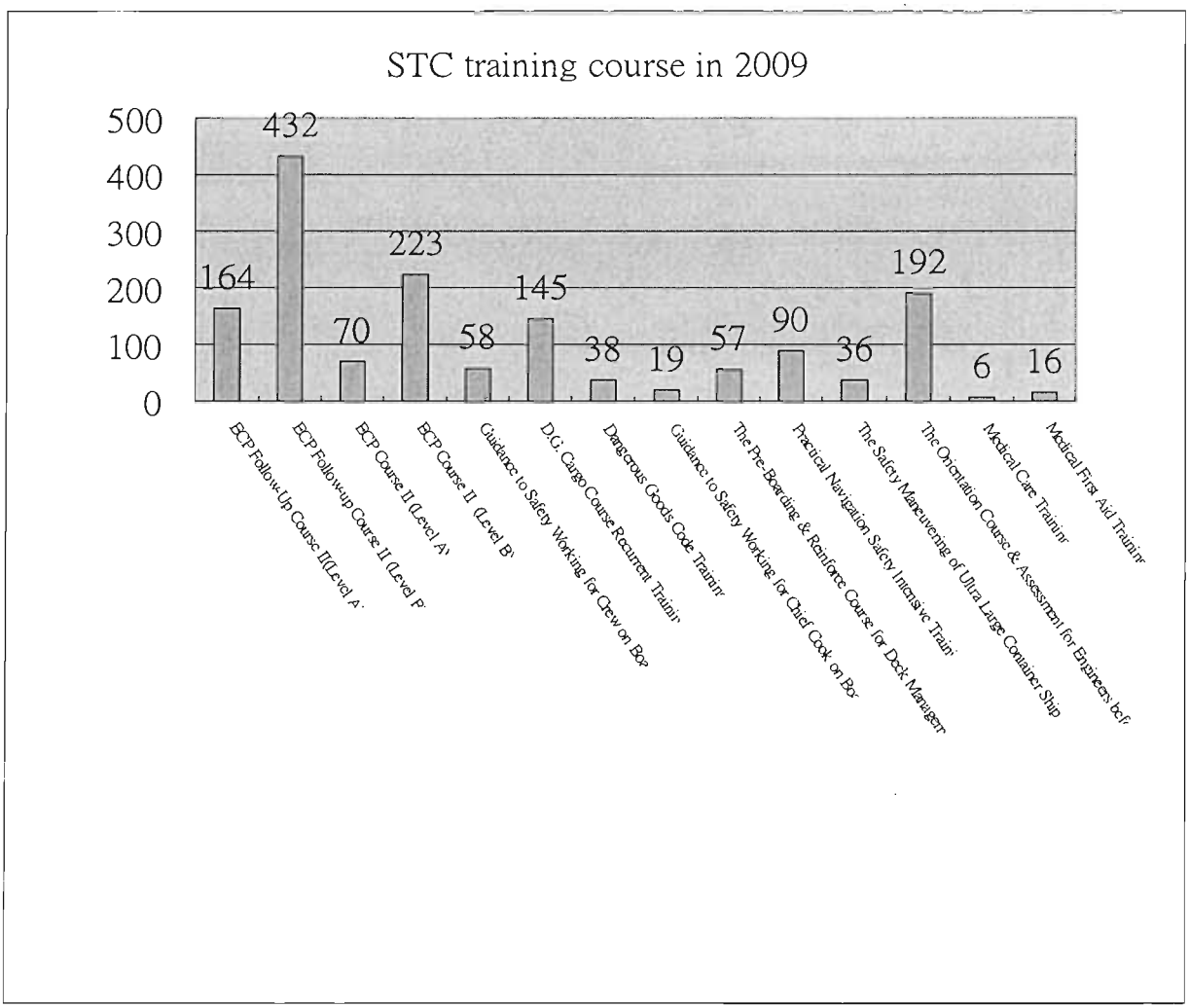
Topic_6 Overview and analysis of seafarer onshore training

The training courses arranged for Taiwanese and Filipino seafarers at Evergreen Seafarer Training Center (STC) and Evergreen Training Centre Manila (ETCM) are listed out and analysis as below respectively. All seafarers are shared in whole Evergreen group fleets, include EMC, EMS, EMU and ITS.

6.1 Total 1,546 seafarer trainees attend the training courses in Evergreen Seafarer Training Center (STC), with the result of all trainees passed the assessment, no one needs to be re-trained .

Data collected from Evergreen Seafarer Training Center for **01/JAN/2009~31/DEC/2009**.

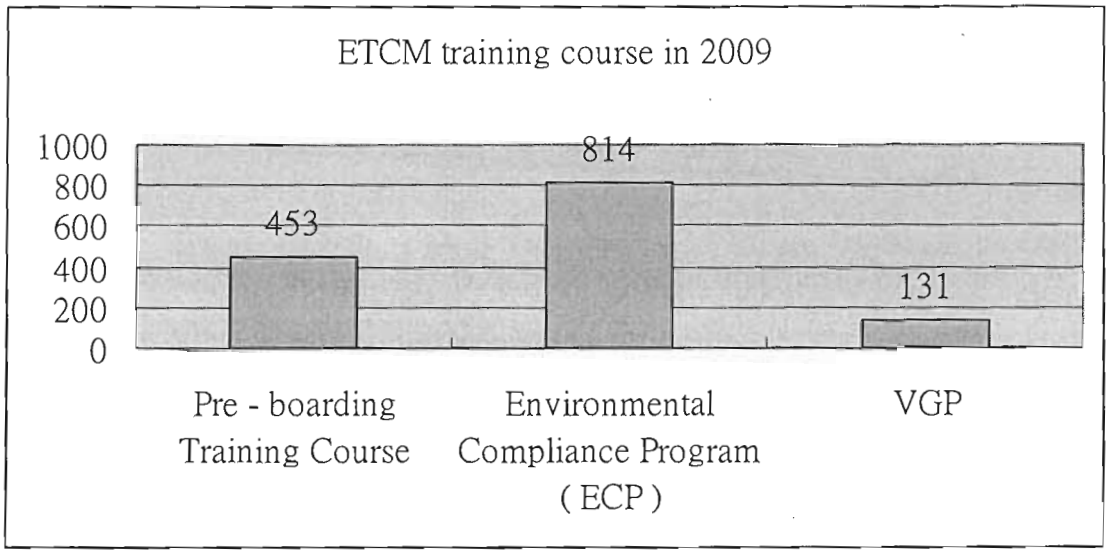
No.	COURSE	CATEGORY	TRAINEE
1	Environmental Compliance Program Follow-Up Course II(Level A)	Environment	164
2	Environmental Compliance Program Follow-up Course II (Level B)	Environment	432
3	Environmental Compliance Program Course II (Level A)	Environment	70
4	Environmental Compliance Program Course II (Level B)	Environment	223
5	Guidance to Safety Working for Crew on Board	Safety & Navigation	58
6	D.G. Cargo Course Recurrent Training	Cargo	145
7	Dangerous Goods Code Training	Cargo	38
8	Guidance to Safety Working for Chief Cook on Board	Health	19
9	The Pre-Boarding & Reinforce Course for Deck Management Level	Safety & Navigation	57
10	Practical Navigation Safety Intensive Training	Safety & Navigation	90
11	The Safety Maneuvering of Ultra Large Container Ship (ULCS) in Shallow Water	Safety & Navigation	36
12	The Orientation Course & Assessment for Engineers before Joining on Board	Safety & Navigation	192
13	Medical Care Training	Health	6
14	Medical First Aid Training	Health	16
TOTAL			**1,546**



6.2 Total 1398 Filipino seafarer trainees attended the training courses in ETCM (Evergreen Training Center Manila) from **01/Jan/2009 to 31/Dec/2009.** All people attended the training courses were passed without any failed.

Data collected from Cargo Safeway Inc. for **01/JAN/2009~31/DEC/2009**.

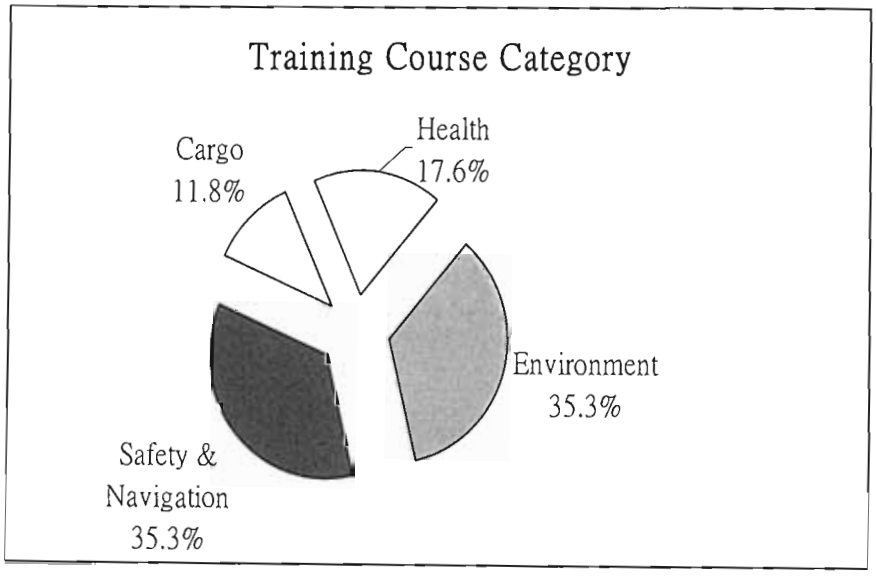
No.	COURSE IN THE PHILIPPINES	CATEGORY	TRAINEE
1	Pre - boarding Training course	Safety & Navigation	453
2	Environmental Compliance Program (ECP)	Environment	814
3	VGP	Environment	131
TOTAL			**1398**

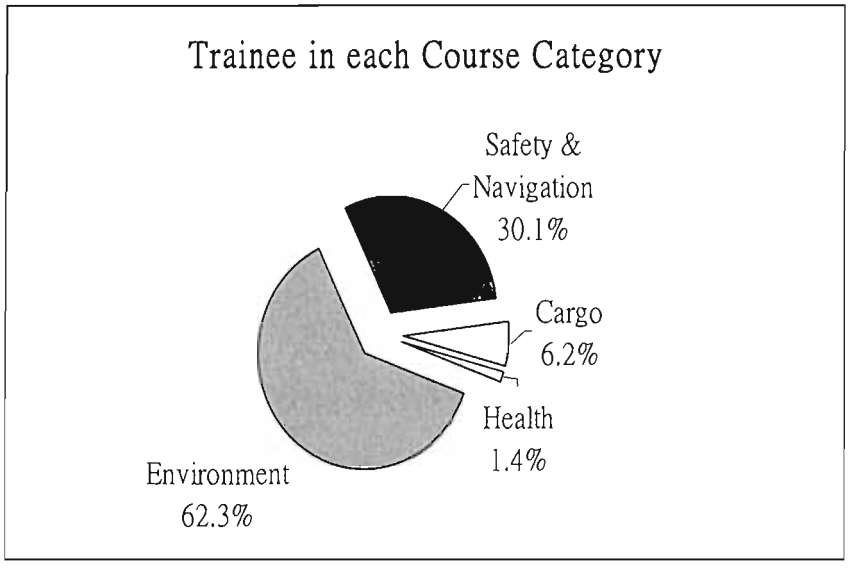


6.3 Overall, in year 2009, our seafarers received varies training courses before join ships and also get re-fresh courses after a long term service on board. In the below table and chart, says that our training courses are focus on the Environment and Safety & Navigation parts.

Analysis the type of training courses provided in STC and ETCM in year 2009.

Training course			Trainee	
Category	**Number**	**Percentage**	**Number**	**Percentage**
Environment	6	35.3%	1834	62.3%
Safety & Navigation	6	35.3%	886	30.1%
Cargo	2	11.8%	183	6.2%
Health	3	17.6%	41	1.4%
Total	**17**	**100%**	**2944**	**100%**





Topic_7 Overview and Analysis of Master review

According to HSQE Manual WK-FLT-0302, The Master shall periodically review all aspects including the standards of OHSAS, ISM code, ISO 9001 and ISO 14001 in order to evaluate the HSQE management system's effectiveness and make proposals for improvements by using the form "Master's Review" (FM-FLT-0302-1). The Master's Review shall be done at least once a year, but in cases where the Master's working contract is less than a year, the Master shall at lease review the shipboard management once prior to disembark that particular vessel.

During the period from January to December 2009, the Marine Section has totally received 11 reports of Master's Review. All the issues have been closed up or are being followed up accordingly by in charge Sections.

The summary of Master's opinions as following:

Ever Elite: 01/Mar/2009

Routine review only, no other issue raised by Master.

Company's Comments:

Thanks for his review and hope to see his valuable opinion in next review.

Ever Eagle: 10/Mar/2009

On Jan.30 evening when approaching to MYPTP pilot station and sailed from MYPTP next afternoon, found many vessels anchored very close to pilot station than before. As known, such anchored vessels including some long term lay-off vessels. Consequently, it is very difficult to find a clear route and/or main channel no matter for inbound to or outbound from the PTP pilot station. We suggest Company could send an official letter

to PTP port control authority to help and improve such confused and dangerous condition for navigation safety.

Company's Comments:

Company will look into this situation and response to concerned parties accordingly; in the meantime Master shall exercise extreme caution for navigation safety until the congestion becomes loosen.

The said situation had been improved and replied by ship Master after we sent a complaint letter to port authority.

Hatsu Excel: 12/Mar/2009

When in damage control/prevention of flooding drill, Crew prepared for emergency tools of flooding prevention, emergency tool water plug that the sizes 850, 200, 125, 65, 50, and 40 mm does exist o/b. For crew efficiently dispose to plug and cut off the various holes of hull plating and pipe. May I suggest adding to supply 750, 650, 550, 450, 350, and 250mm for contingent use.

Company's Comments:

EMU LDN/MAR-ENG: It would be appreciated if ship side could locate the suggested plugs, then we could make assessment of the necessity of these plugs to be supplied.

Since ship's hands did not inform the location of the said plugs needed, we would suggest the ship's hands to create a scenario for flooding drill to see if ship's hands can cope with the situation.

Ever Ethic: 27/Mar/2009

Routine review only, no other issue raised by Master.

Company's Comments:

Many thanks for received this review and as you know the "Master Review" is one of the key element designed to help ship's Master communicate with company (DP), we do hope to see your valuable opinion in your next review.

Ever Shine: 14/May/2009

Recently, ship's navigational equipment had many troubles, due to parts working hour limit overdue and caused failure, some parts must changed regularly, but we have no record about that. For example, Radar's magnetrons, working hour overdue will caused poor performance and finally malfunction. Some internal ventilation fan of equipments are also had limited working time, such as VDR, RADAR, INMARSAT, COMPUTERS 24hrs running instruments. Every equipments part have limit working hour but we do not have record of it completely. Ship's cornputers are very important equipment, need expert to inspection and maintenance periodically, for avoid failure, some problems are out of crew's ability.

Company's Comments:

EMU LDN/MAR-ENG: Grateful to Master's opinion and the response from Engineering Section as follows. Primarily, all navigation and communication equipments onboard the ship should be inspected and credited by Class surveyor annually on Safety Radio Survey to assure the said equipments can be further use safely, but still, if there is any equipment malfunction found in between the survey, ship hands are requested to make the repair application in time. As to the parts working hour limitation that Master mentioned, we would appreciate to the ship hands for creating such parts working hour record and remind the in change person of the Company to carry out the necessary maintenance according to the instruction book accompanied the equipment.

Ever Smile: 20/Jul/2009

VDR(Voyage Data Recorder) installed on ship , only one pc card (2GB) working inside to record important data for 13.5hrs use, after that new message will overwrite the previous one. it means that we also just can get partly record for reference when the event period over 13.5hrs, that incompletely data would not be enough for case study. For ship's safety and owner's interest sake, the integral record of any event is obviously very important. Therefore in case of company could supply another one pc card and one card reader to ship, any occurrence of accident from its beginning to an end, ship hands are able to use the two pc cards in turn and copy the pc card data into hard disc of computer by card reader to keep complete record for company studying and judgment.

VDR MODEL: JCY-1700, pc card model: 7HRJDD0001

Company's Comments:

With regard to the issue, Company will purchase spare memory card and card reader for fleet.

Company had supplied the spare memory card to whole fleet by the end of 2009.

Ever Sigma: 21/Sep/2009

Marine Circular MAR-2009-017 Accommodation ladder operation procedure, all preparation works are limited at alleyway only until completely berthed, which conflict with OCD-OPD operation prospect, please lower gangway with safety net within 30 minutes after your vessel made fast, the preparation work is difficult to fulfill OCD-OPD requirement.

Company's Comments:

With regard to accommodation ladder operation procedure, MAR is negotiating with concerned parties to amend the wording to waive the 30 minutes time limit. Please note that Company's Policy is always "Safety First", and there is no room to compromise. All crew should learn the lesson from the tragic fatal accident, and follow the accommodation ladder procedure as mentioned in Marine Circular MAR-2009-017 strictly to prevent reoccurrence.

Company has negotiated with EOC and observed that crew could prepare accommodation ladder within 30 minutes usually. It should be ample to finish. However, for the safety, Masters were advised that never press the crew on rush rigging, standard procedure must be followed up even can not complete within 30 minutes.

Ever Elite: 18/Oct/2009

Routine review only, no other issue raised by Master.

Company's Comments:

Regarding the fatal accident is still under investigation. Master is encouraged to express your opinions in all aspects of safety management system for Company continual improvement.

Ever Pride: 05/Nov/2007

In CK-FLT-0704-1 Cargo operation record item No.2 instructions for loading Danger or Reefer cargoes from WM-FLT-0704 should be instead of HSE PR-07-03.

Company's Comments:

Company will revise CK-FLT-0704-1 Cargo operation record as the mistake.

The said checklist had been revised and issue to fleet on 07/Jan/2010.

Hatsu Envoy: 09/Nov/2009

Routine review only, no other issue raised by Master.

Company's Comments:

Kindly bear in mind and provide your valuable opinions on your next review.

Ever Shine: 27/Nov/2009

According to suggestion of Marine Circular MAR-2009-028, Strengthen announce to all crew must been strictly followed this instruction. Beside, refer to COSWP charter 25 annex 25.1, drawing the snap-back zone for the fore' & aft deck to remind the potential risk of personnel while in the mooring operation. This subject is to be listed in shipboard familiarization training material. It was proposed addition deck department rating quota, e.g. AB or OS, It is in order to replace the experience insufficient engine crew (motorman). Meantime, let deck department have enough manpower to carry out the deck maintenance work or navigational bridge watch simultaneously. Also reinforce the education, requirement of safe working and safe work places on board the ship with monitoring strictly.

Company's Comments:

Company will evaluate the present manning level of deck hands onboard. Before manning level changed, please make sure that there is always sufficient manpower to

carry out shipboard activities safely especially for those hazards involved operations e.g. mooring, tug's line operation.

Company's evaluation shows that present manning level onboard is above the requirement of Safe Manning Certificate. But only the qualified personnel which have received proper training could carry out the task.

Ever Prima: 09/Dec/2009

1. In WM-FLT-0709 I found in the references paragraphs there are something inconsistent. It's better to revise on the next revision.

2. No monitor cameras onboard, if possible to install one set, it would be better to ship's safety and security.

Company's Comments:

1. Company is editing our new HSQE manual at the moment, the said inconsistency will be revised as well.

2. This security issue should be mentioned in ISPS review instead of ISM part. By the way, the installations of additional monitor cameras involve in some hardware modifications, before any change, please enhance manual monitoring by ship's hands.

Reviewing the report of Master's review, we are satisfying the result of shipboard management.

Overview the fleet Masters' review ports, we categorize the opinions as below:

Environmental aspect	: Nil
Onboard training	: Nil
Communication	: Nil
Maintenance plan	: 1
Safety equipment	: 1
Manual correction	: 2
Health aspect	: Nil
Emergency preparedness	: 1
Legislation	: Nil
Shipboard operation	: 3
No comment	: 3

The statistic above shows the most portions "Shipboard operation" and "No comment" are the top two over half of all reviews. From the increasing reviews of Shipboard Operation, it shows that safety awareness is promoting among our fleet. On other hand, for those reviews without suggestion, we encouraged our Masters by mentioning in Company's comment to feedback their opinions on any aspects of HSQE system.

Some reviews involved external parties were properly resolved by endeavour of the office. For instance, the case PTP overcrowded anchorage situation potentially endangers safety of navigation, so the D.P. had written a letter of complaint to Port Authority and relevant parties. Now the situation is better and that was improved and witnessed.

"Manual correction" once was the highest issue in the last three years, but it was reduced dramatically in 2009. Since the present edition of HSQE was launched from May/2007, many typo mistakes in the Manual had been found and revised accordingly during shipboard implementing process. In near future, a consolidated manual which synchronizes other ISM system manuals of group sister companies is ongoing for diminishing crew's confusion from transferring among different group companies.

Although few Master reported without comment, generally in conclusion, both Masters' review and performance for shipboard management during the last year are satisfied. All suggestions, opinions had been gave appropriate answer by relevant Sections, any follow-up actions were also closed out by the in charge Sections. Company shall keep open-minded to all masters of our fleet for continuous improving.

Topic_8 Legislation Review

1. New MSC Resolutions:

MSC.239(83)	Adoption of amendments to the international convention for the Safety of Life at Sea, 1974, as amended	
MSC.240(83)	Adoption of amendments to the protocol of 1988 relating to the international convention for the Safety of Life at Sea, 1974, as amended	
MSC.241(83)	Adoption of amendments to the international code for the Safe Carriage of Packaged Irradiated Nuclear Fuel, Plutonium and high-level Radioactive Wastes on Board Ships (INF Code)	Amends MSC.88(71)
MSC.242(83)	Use of the long-range identification and tracking information for maritime safety and marine environment protection purposes	
MSC.243(83)	Establishment of international LRIT data exchange on an interim basis	Revoked by MSC.264(84),
MSC.244(83)	Adoption of performance standard for protective coatings for void spaces on bulk carriers and oil tankers	
MSC.245(83)	Recommendation on a standard method for evaluating cross-flooding arrangements	
MSC.246(83)	Adoption of performance standards for survival craft AIS search and rescue transmitters (AIS-SART) for use in search and rescue operations	
MSC.247(83)	Adoption of amendments to performance standards for survival craft radar transponders for use in search and rescue operations (Resolution A.802(19))	Amends A.802(19)
MSC.248(83)	Adoption of a new ship reporting system "The Papah?naumoku?kea Marine National Monument" particularly sensitive sea area (PSSA)	
MSC.249(83)	Adoption of a new mandatory ship reporting system "on the approaches to the Polish ports in the gulf of Gdansk"	
MSC.250(83)	Adoption of a new mandatory ship reporting system "off the South and Southwest coast of Iceland (TRANSREP)"	
MSC.251(83)	Adoption of amendments to the existing mandatory ship reporting systems "Off Ushant", "off les Casquets" and "Dover Strait/Pas de Calais"	
MSC.252(83)	Adoption of the revised performance standards for integrated navigation systems (INS)	
MSC.253(83)	Adoption of the performance standards for navigation lights, navigation light controllers and associated equipment	
MSC.254(83)	Adoption of amendments to the performance standards and functional requirements for the long range identification and tracking of ships	Revoked by MSC.263(84),
MSC.255(84)	Adoption of the Code of the International Standards and Recommended Practices for a	

Annex M

EMU's Chairman's letter to MCA dated 3 June 2010

EVERGREEN MARINE (UK) LTD.

160 EUSTON ROAD,
LONDON NW1 2DX.
TEL: 020 7559 8112
FAX: 020 7559 8111
WEB: www.evergreen-marine.co.uk

VAT Registration No. 245743452

03 June 2010

Dear [redacted]

We acknowledge receipt of your letter dated 04 May 2010 regarding the position of MCA following the three fatal accidents occurred to personnel working for Evergreen in recent months.

We deeply regret the death of these crewmembers. The accidents have been considered with extreme seriousness by all our personnel at Evergreen Marine UK Limited.

For your reference, and in order to enhance our Safety Culture, additional precautions and actions have been taken:

- Detailed review of risk assessment before 01 July 2010;
- Further development and review of safe working procedures according to risk assessment;
- Marine Circulars of increasing safety awareness have been sent to all the fleet;
- Inspection/visiting (superintendant) to our ships will be increased by 50%;
- Safety target 2010-2011 with ***zero tolerance policy*** related to death has been set;
- Additional study of other international regulations for our reference;
- Close partnership with our Training Centre in Taiwan to develop courses related to safety with the aim to improve awareness of safe working activities onboard.

Please note that we will be dealing with any infringement severely, under the ***zero tolerance policy,*** we will penalize the person (s) who breaches the rules. The punishment includes dismissal and a record of demerit.

We expect our commitment to enhance additional measures and actions in the safety system will drive the company's fleet back to the Safety route which has always been asked for.

Best regards,

[redacted]

Chairman

Annex N

EMU Marine Circular 3 June 2010 - Letter to masters, officers and crew of all EMU vessels

MARINE CIRCULAR

EVERGREEN MARINE (UK) LIMITED

TO: **Master, C/E & all crews**

各輪船長、輪機長及全體船員

FM: EMU-LDN

Capt. Clement Yan

DATE: 03 / JUN / 2010

REF. NO.: MAR-2010-013

SUBJECT: Letter to Masters, Officers and Crew of all EMU vessels
致EMU船隊的信。

MESSAGE:

Regretfully, as all of you already know, Evergreen Marine UK Limited has been severely affected in the last few months due to the death of three crew members in fatal incidents.
在此我很遺憾的告知各位，或許你們早已經知道本公司(EMU)近幾個月來受到先前三件人員意外傷亡事件極大的沖擊。

These fatal incidents have called the attention of the British Maritime Authorities, and the company has been also forced to enhance safety awareness against any wrong and careless operations onboard from now on.
由於這些人員意外傷亡事件引起英國海事當局(MCA+MAIB)的高度注意，使得公司必須加強船員的安全認知以避免爾後再有因為錯誤操作或人為疏忽而導致傷亡的再度發生。

In order to improve a “Safety Culture”, precautions need to be taken to prevent personal injury or deaths. Furthermore, a risk assessment should be made to identify the hazards prior to work and to take suitable measures.
為了增進及落實”安全文化”，公司將採取各種安全措施以避免人員受傷甚至死亡；更進一步來說，船上人員在進行工作前須先作風險評估以確認潛在危險並採取適當之保護措施以移除或降低危險至可接受程度才能進行工作。

We would like to remind Safety Officers、Masters、C/E that is your responsibility to ensure crewmembers follow safety regulations. We will not tolerate any other breach of safety on board the ships nor any excuses for the failure to comply with established procedures.
在此，我必須要提醒各位船長/輪機長及船上安全官注意，你們的職責就是要確保所有船員皆遵循各項安全規範，爾後公司將(經由內稽、訪船、或船上報告得知)對船上不遵照及違反既有安全規範之人員予以嚴懲。

Please note that we will be dealing with any infringement severely applied to **the person (s)** who breached the safety rules and the **Safety Officer**. The punishment includes **a record of demerit and/or dismissal from the ship**.
請特別注意，公司將懲處違反安全規範之**個人**；且**船上安全官**亦將遭受連帶處分，處分包括：**記過或調下船**。

Every safety procedure, regulation, check list, drill, exercise etc have been developed with the purpose of protecting the safety and life of crewmembers onboard and the ship itself.
所有的安全步驟、規定、檢查表、操練、演習等等，皆是為了保護船員生命及船舶本身安全而制定的。

“Safety” is the fore front of every member of Evergreen Marine UK and that must be applied at all times.

每一位EMU員工必須將“安全”二字擺在第一位且無論何時皆須遵循之。

Please don’t hesitate to let us know any problem you face to fully implement protective safety actions.
如果你在實行上述之安全規範時遭遇任何窒礙困難或問題請立即告知公司以尋求幫助。

Your attention and good cooperation would be highly appreciated and anticipated.
感謝您對上述要求的理解與合作，謝謝！

Bon Voyage.
順頌　航安！

IMO MSC-MEPC.7/Circ.7 Guidance on near-miss reporting

INTERNATIONAL MARITIME ORGANIZATION
4 ALBERT EMBANKMENT
LONDON SE1 7SR

Telephone: 020 7735 7611
Fax: 020 7587 3210

IMO

E

Ref: T2-HES/4.2
T5-MEPC/1.01

MSC-MEPC.7/Circ.7
10 October 2008

GUIDANCE ON NEAR-MISS REPORTING

1 The Maritime Safety Committee, at its eighty-fourth session (7 to 16 May 2008), and the Marine Environment Protection Committee, at its fifty-eighth session (6 to 10 October 2008), noted that the Maritime Safety Committee, at its seventy-fourth session (30 May to 8 June 2001), considered the issue of reporting near-misses and how to promote a no-blame culture and issued MSC/Circ.1015 to encourage reporting of near-misses.

2 The Committees further noted that guidance was required:

.1 to encourage reporting of near-misses so that remedial measures can be taken to avoid recurrences; and

.2 on the implementation of near-miss reporting in accordance with the requirements of section 9 of the ISM Code with respect to reporting of hazardous situations.

3 Accordingly, in order to encourage the reporting of near-miss occurrences and promote a safety culture, the Committees approved the guidance as set out in the annex.

4 Member Governments and international organizations concerned are recommended to bring this circular to the attention of all parties concerned.

***

ANNEX

GUIDANCE ON NEAR-MISS REPORTING

1 Introduction

1.1 Companies should investigate near-misses as a regulatory requirement under the "Hazardous Occurrences" part of the ISM Code. Aside from the fact that near-miss reporting is a requirement, it also makes good business and economic sense because it can improve vessel and crew performance and, in many cases, reduce costs. Investigating near-misses is an integral component of continuous improvement in safety management systems. This benefit can only be achieved when seafarers are assured that such reporting will not result in punitive measures. Learning the lessons from near-misses should help to improve safety performance since near-misses can share the same underlying causes as losses.

1.2 For a company to realize the fullest potential benefits of near-miss reporting, seafarers and onshore employees need to understand the definition of a near-miss to ensure that all near-misses are reported. The company also needs to be clear about how the person who reports the near-miss and those persons involved will be treated. The guidance that follows suggests that the company should encourage near-miss reporting and investigation by adopting a "just culture" approach.

1.3 A "just culture" features an atmosphere of responsible behaviour and trust whereby people are encouraged to provide essential safety-related information without fear of retribution. However, a distinction is drawn between acceptable and unacceptable behaviour. Unacceptable behaviour will not necessarily receive a guarantee that a person will not face consequences.

1.4 It is a crucial requirement that the company clearly defines the circumstances in which it will guarantee a non-punitive outcome and confidentiality. The company should provide training and information about its approach to "just culture" near-miss reporting and investigation for all persons involved.

2 Defining near-miss

2.1 Near-miss: A sequence of events and/or conditions that could have resulted in loss. This loss was prevented only by a fortuitous break in the chain of events and/or conditions. The potential loss could be human injury, environmental damage, or negative business impact (e.g., repair or replacement costs, scheduling delays, contract violations, loss of reputation).

2.2 Some general examples of a near-miss help to illustrate this definition:

.1 Any event that leads to the implementation of an emergency procedure, plan or response and thus prevents a loss. For example, a collision is narrowly avoided; or a crew member double checks a valve and discovers a wrong pressure reading on the supply side.

.2 Any event where an unexpected condition could lead to an adverse consequence, but which does not occur. For example, a person moves from a location immediately before a crane unexpectedly drops a load of cargo there; or a ship finds itself off-course in normally shallow waters but does not ground because of an unusual high-spring tide.

.3 Any dangerous or hazardous situation or condition that is not discovered until after the danger has passed. For example, a vessel safely departs a port of call and discovers several hours into the voyage that the ship's radio was not tuned to the Harbour Master's radio frequency; or it is discovered that ECDIS display's scale does not match the scale, projection, or orientation of the chart and radar images.

3 Overcoming barriers to reporting near-misses

3.1 There are many barriers related to the reporting of near-misses. In many cases, near-misses are only known by the individual(s) involved who chose to report or not report the incident. Some of the main barriers to the reporting of near-misses include the fear of being blamed, disciplined, embarrassed, or found legally liable. These are more prevalent in an organization that has a blame-oriented culture. Amongst other barriers are unsupportive company management attitudes such as complacency about known deficiencies; insincerity about addressing safety issues and discouragement of the reporting of near-misses by demanding that seafarers conduct investigations in their own time.

3.2 These barriers can be overcome by management initiatives such as:

.1 Encouraging a "just-culture" in the company which covers near-miss reporting.

.2 Assuring confidentiality for reporting near-misses, both through company policy and by "sanitizing" analyses and reports so that personal information (information identifying an individual) of persons associated with a near-miss is removed and remain confidential. Personal information should not be retained once the investigation and reporting processes are complete.

.3 Ensuring that investigations are adequately resourced.

.4 Following through on the near-miss report suggestions and recommendations. Once a decision has been made to implement, or not implement, the report's recommendations should be disseminated widely.

4 The near-miss investigation process

4.1 As a minimum, the following information should be gathered about any near-miss:

.1 Who and what was involved?

.2 What happened, where, when, and in what sequence?

.3 What were the potential losses and their potential severity?

.4 What was the likelihood of a loss being realized?

.5 What is the likelihood of a recurrence of the chain of events and/or conditions that led to the near-miss?

4.2 The answer to these questions will determine if an in-depth investigation is needed, or if a cursory report will suffice. An in-depth investigation is required of those near-misses which are likely to recur and/or which could have had severe consequences.

4.3 Once a decision has been taken to proceed with a full investigation, further decisions are taken about levels of staffing required, who should be responsible, and what resources are required for the investigation to be completed successfully. The main steps in the investigation are:

Gathering near-miss information

4.4 Regardless of the nature of the near-miss, the basic categories of data that should be gathered include: people, paper documents, electronic data, physical, and position/location. These data are vital for ensuring that an understanding can be reached about what, how, who, and eventually why the near-miss occurred. Data gathering is done by interviews of key personnel and the collection of physical, position and location data, using such things as photographs, VDR recordings, charts, logs, or any damaged components. Furthermore, information should be gathered regarding safeguards in place to protect the persons on board and the public, and the operational systems impacting the near-miss event.

Analysing information

4.5 Applying data analysis techniques helps to identify information that still needs to be collected to resolve open questions about the near-miss and its causes. This can make the collection of additional data more efficient. The end goal of this activity is to identify all causal factors.

Identifying causal factors

4.6 At this point the who, what, where, why, and when of the near-miss is understood, and the human errors, structural/machinery/equipment/outfitting problems, and external factors that led to the near-miss, have been identified. The next step is to better understand the causal factors that contributed to the near-miss. There are a variety of identification methods for this purpose, including taxonomies of causes. These can be used for deep probing past the most evident causes.

Developing and implementing recommendations

4.7 Any recommendations made need to address all of the identified causal factors to improve organizational and shipboard policies, practices and procedures. Implementing appropriate recommendations is the key to eliminating or reducing the potential for the reoccurrence of similar near-misses or more serious losses.

5 Completing the investigation

5.1 Completion of the investigation process requires the generation of a report (either brief or extensive, depending on the depth of analysis performed and the extent of risk), and collating and storing the information in a way that supports subsequent (long term) trend analysis.

5.2 The ultimate objective of near-miss reporting and investigating is to identify areas of concern and implement appropriate corrective actions to avoid future losses. To do so requires that reports are to be generated, shared, read, and acted upon. Companies are encouraged to consider whether their report should be disseminated to a wider audience.

5.3 It may take years for safety trends to be discerned, and so reporting must be archived and revisited on a timely basis. Near-miss reports should be considered along with actual casualty or incident reports to determine trends. There should be consistency in the identification and nomenclature of causal factors across near-miss and casualty/incident reports.

_____

Annex P

EMU Marine Circular 2 October 2009 - Working Safety

MARINE CIRCULAR

EVERGREEN MARINE (UK) LIMITED

TO: Master, C/E and all Crew

FM: EMU-LDN
MAR-ENG

DATE: 02 / OCT / 2009

REF. NO.: MAR-2009-024

SUBJECT: **Working Safety**

工作安全

MESSAGE:

In order to achieve a safe and smooth equipment handling/operation and maintenance, you are kindly requested to follow up the listed hereunder

為了能安全及平順地實施船舶裝備的操作和保養, 煩請遵行下列要求

1. Familiar with the equipment you work on.

   Through Maker's instruction book of the equipment, you can get a lot of information about the equipment, such as equipment specification, equipment handling/operation procedure, maintenance procedure, cautions…etc. To read the instruction book attentively and with it will help you to understand the equipment in details and to avoid unnecessary redundant process or miss out the point.

   熟悉您所需操作和保養的裝備.

   從製造商提供的操作說明書中您可以得到許多該項裝備的相關資訊, 例如 規格尺寸, 操作使用程序,保養程序, 注意事項...等. 仔細閱讀說明書並依照它的要求, 能協助您瞭解裝備整個的狀況,避免做無謂的白工或漏失重點.

2. Well perusal of MCA COSWP (Code of Safe Working Practice for Merchant Seamen) and Company HSQE policy then follow suit.

   Always bear in mind that **safety first is the priority** of Company policy, meantime, the safety is the corner stone of personal health and families wealth as well.

   詳讀英國海事巡防局(MCA)發行的商船船員工作安全法規及公司 HSQE 政策並遵行之

   永遠銘記在心**安全第一**是公司的首要政策,同時要知道安全也是個人健康及家庭財富的基石.

3. Well study of Marine Circular

   The context of Marine Circular mostly indicated the point that neglected in the recently incident happened on the ship of the Group or the point we need to emphasize/focus on. Through study Marine Circular will help to avoid the similar incident recurrence.

   詳細研究公司所發的海事通告

   海事通告通常指出了集團近期事故船隻疏忽之處或者需要加強重視的地方, 藉由研讀海事通告有助於避免類似事故再發生.

謝謝各位的配合。
Your kind attention and cooperation to the above will be highly appreciated.

Bon Voyage