THE MASTERS RESPONSIBILITY FOR SHORE WORKERS

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Increasingly in the shipping industry, as crews become smaller and ships become larger, the employment of shore labour at sea and in port is increasingly more common. In the oil and gas fields, on the FPSOs and installations, this type of employment of labour is quite normal. Strangely, responsibility for the safety of contractors or shore workers, whether the ship is at sea or in port or dry dock is a grey area in the marine industry.

Some time ago, the Mines Rescue Service, through their Marine Division, were called for advice on a case involving a shore contractor who was severely injured in an enclosed space on board a ship. During the course of the investigations it became clear that there was confusion as to responsibilities for shore workers in such a position.

This confusion was even more apparent when, in conversations with ship owners and dockyard managers, it was revealed that there was a practice in place of the yards giving a letter stating they assuming responsibility for the safety of workers on ships and installations, even though these were still under the command of Masters or the responsibility of the installation managers.

This assumption in many companies that contractors are responsible for the safety of their workers or that a port of dry dock can issue an indemnity stating they accept responsibility for safety of shore workers while on board the ship or installation is very unsafe, especially when considered internationally, as many countries are quite definite in their legal interpretation that, while the ship or installation is under management, in other words, not a ‘dead ship’, then the Captain or manager, of that ship or installation is responsible.

The appointed Safety Officer is also in a most difficult position if that transfer of responsibility is made by the Master or manager. It is questionable whether the Master can transfer the responsibility of the Safety Officer, especially if the Safety Officer’s authority devolves from the company rather than the Master. If it is from the company, then it would seem that a separate letter would be required from the company designated person clearly stating that the safety

officer is to hand over his responsibilities as well and is no longer responsible for the safety of shore personnel on board the ship or platform.

The HSE and MCA Memorandum of Understanding

The responsibility is even more problematic in countries like the UK, where shore workers are under the auspices of the Health and Safety Executive while the ship and crew are under the Maritime and Coastguard Agency. This leads to strange anomalies where a FPSO unit has two administrations working on board. The two authorities have a memorandum of understanding that is mainly directed at a recognised division of responsibilities, especially for investigation, however there are a number of implications from this memorandum that the industry should be aware of. These are;

HSE inspectors may;

Enter all work places including docks and offshore installations.

Investigate accidents to shore workers working in a port while loading and unloading a ship and similarly investigate accidents occurring to a ship's crew.

The HSE is primarily responsible for enforcing legislation covering the safety of shore based personnel and work equipment supplied by the shore even when working on a ship.

HSE is the lead authority for all dock operations whether or not crew are involved. HSE has enforcement responsibility for the provision and use of any work equipment supplied by the port irrespective of who is using it.

HSE is responsible for all shipbuilding or conversion work whether shore workers or ship's crew in any shipyard, harbour, Dry Dock or wet dock.

Where ships crews are carrying out voyage repairs under the Master's authority in harbour, responsibility is the MCA. All other ship repair activities in Dry Dock and major work not considered to be normal ship voyage repair activities are the responsibility of the HSE whether carried out by shore labour or crew.

For voyage repairs where ships crews and shore labour are working concurrently both MCA and HSE have equal responsibility. They must then agree a lead authority.

I suspect that many other countries will have a similar type of arrangement.

The factors to bear in mind regarding the memorandum of understanding between the HSE and the MCA is that ships rarely carry any information regarding HSE legislation and many may not have any knowledge of this document. If this is the case, most Masters are ignorant of any responsibilities they have to shore workers. Equally there is ignorance ashore, demonstrated by the fact that when some dry docks assume responsibility of all safety matters on the ship for their workers, quite often this is assumed to cover outside contractors employed by the dry dock for work on the ship.

The most important question is, does the HSE recognise this transfer of responsibility and exonerate the Master from any responsibility for any accident involving workers on the ship during that docking? All evidence points to the contrary and that the HSE would expect and hold the Master responsible for any breaches of HSE legislation.

Finally, according to the ISM-Code section 1.2.1 the objectives of the code are:

To ensure safety at sea, prevention of human injury or loss of life, and avoidance of damage to the environment, in particular, to the marine environment, and to property.

In section 1.2.2 the objectives are among others:

1 provide for safe practices in ship operation and safe working environment;

2 establish safeguards against all identified risks; and

3 continuously improve safety management skills of personnel ashore and aboard ships, including preparing for emergencies related both to safety and environmental protection.

This code does not say only at sea, nor does it say only the crew of a ship.

Section 5.2. states;

The Company should ensure that the SMS operating on board the ship contains a clear statement emphasizing the Master's authority. The Company should establish in the SMS that the master has the overriding authority and the responsibility to make decisions with respect to safety and pollution prevention and to request the Company's assistance as may be necessary.

This is of particular concern to the Master for it means that regardless of whatever the company says or any superintendent signs on behalf of the ship in a port or dockyard, it is the Master who has the complete authority over safety and of course will be ultimately held to account for any breach of safety regulations or casualties resulting from such a breach should it have occurred.

This is supported by common law which states that the Master is the '*supreme authority'* on his ship, even when the ship owner, charterer or employer is on board.

Legal Case Studies

A recent judgement in the High Court of the Hong Kong special administrative region was made concerning the death of a surveyor and an assisting crew member from oxygen depletion in an enclosed space on board a ship. The following is an extract;

'A harsher criterion was applied to the conduct of the Master who was found to be 50 per cent to blame. The court started from the premise that the Master is in overall charge of the vessel and responsible for the safety of all persons on board, including lawful visitors. The relevant safety codes provided for a planned entry into any enclosed space with a competent officer or other person appointed specifically for that operation. There was no such operation planned in this case. The fact that the Master had offered the services of the Chief Officer whose presence might have avoided the accident, and that the Surveyor rejected this offer, did not detract from the overriding responsibility of the Master.'

The most important finding of the court was on the question of whether the Master was entitled to assume that the Surveyor was qualified and competent to carry out the tasks expected of him and to follow safety procedures, in particular those relating to entry into enclosed spaces.

'The court held that the Master was not in possession of sufficient information to make a decision about the ability of the Surveyor to deal with any dangerous situation that might arise. The Master could make no assumptions in this respect.'

This makes very uncomfortable reading but certainly emphasises the case for the overall responsibility of the Master for all on board regardless of who they are, who they are working for or what work they are doing.

The next case deals with a contractor working on board a ship at sea when an accident occurred which highlighted the need for procedures to ensure the safe conduct of dive operations when the vessel's owner and operator were not the same as the diving contractors. The following is extracts from the MGN 424(M);

1.2. 'the responsibility for ensuring that appropriate shipboard control measures are taken rests with a vessel's crew.'

3.2. 'The Master has responsibility for all activities carried out on board their vessel'

From this it would seem that the MCA as well as the HSE consider that the Master is responsible not just for the shore workers themselves but for the way in which they work on board.

The final case involves a bulk carrier undergoing repairs to the stern seal in a European port.

'Subcontractors were contracted to build scaffolding around the stern and propeller blades in order to gain access to the stern tube seal.

At the same time, a second technician was contracted to carry out repairs and adjustments to the main engine controls in the engine room. To carry out this work, the technician required the turning gear to be rotated manually. As this was done, the propeller shaft turned, rotating the propellers, which knocked down the scaffolding. One of the contractors was killed by falling from the scaffolding.'

The master and chief engineer were accused of negligence and ordered to attend a criminal court. They were given a prison sentence, although this was overturned on appeal.

Here we have a situation where two separate contractors were working independently but unfortunately their safety arrangements were not co-ordinated. Even though the ships officers were not involved in the incident, again the Master is assumed to be responsible.

All of the above suggests that regardless of what any port or dockyard claim, whether at sea, alongside or in port waters, the responsibility of the ship or installation owners for safety for the shore workers cannot be abrogated to any

other authority while the owners managing representative, be it the Captain, Safety officer or manager, is on board.

Defining Responsibilities

Fifty years ago, Hopkins in 'Business and Law for the Shipmaster' wrote;

'Stevedores and other contractors who board a ship as invitees and persons who come on board as licensees for their own private purposes or as guests, are all entitled to adequate provision against pitfalls and traps. Apart from specific regulations, the Master has a common law duty to provide such protection.'

The now common practice of signing on shore workers for seagoing as 'passengers' instead of supernumeries further enhances the Masters responsibilities to them as, unless their contract includes a '*Himalaya*' clause, which protects the ships owners employees from legal action, the Master may be personally liable for any injuries they suffer.

This all leads to two separate responsibilities, that of the owner to protect the contractors or subcontractors from risks and dangers on the ship or the installation and that of the contractors to co-operate and follow the Masters and crews instructions to ensure their own safety and avoid putting others at risk.

However, should any accident ensure involving the shore labour, it would seem that the owners cannot avoid the consequences of any negligence resulting from the actions of those workers while on the ship or installation.

For this reason it is essential that the SMS code that is in place for the ship or installation has a clear and concise section outlining these responsibilities and the procedure in place for them to be implemented.

This is not as easy as it sounds. Consider the following;

Contractors arrive on board a general cargo ship for repairs in a ballast wing tank. They are operating under the legislation of the HSE. The ship is operating under the MCA which has no enclosed space legislation. The contractors have no knowledge of the MCA requirements and the ship does not know what is required under the HSE or even probably that they are also now temporarily under the HSE.

Hopefully the ship shows them the risk assessment for the space or the contractors ask for this. The contractors check that the space is gas free and safe

for entry. A work permit is issued by the ship and they enter. The ship does not require specific enclosed space entry equipment such as harnesses and EEBD's as they have no legislation requiring this. Nor does it check that those entering the space have enclosed space entry training as again, the MCA does not require this although the HSE does. *(Ref The Management of Health and Safety at Work Regulations 1999, regulation 7).*

While it can be expected that contractors will have their own enclosed space entry equipment, It is unlikely that they will bring a rescue team with equipment with them, especially if they are a small company. They are therefore relying on the ship to provide this.
While dealing with fire is urgent, there hopefully is time for the shore fire services to arrive to assist the ship. With enclosed spaces, the emergency response must be made within minutes therefore, even if in a dock or port, any available shore rescue team will not arrive in time. Clearly the ship's rescue team is the only response that can deal with an emergency.

An accident happens and a rescue team is required. The ships General Emergency Party arrive, which although trained for fire fighting has no enclosed space rescue training. They do drills every two months but without the training to base those drills on, that is not adequate. If the ship is under 1000 tons, then even drills are not required.

The HSE document, Safe Working in Enclosed Spaces states;

The Preparation of emergency arrangements
This will need to cover the necessary equipment, training and practice drills.
Provision of rescue harnesses
Lifelines attached to harnesses should run back to a point outside the confined Space
.
Yet the ship has no requirement to have harnesses or equipment or emergency training.

The rescue party then attempt to enter the space, but cannot get through because they are using fire equipment not designed for enclosed space entry and their BA sets are too large for the manhole. Again, there is no legislation on the design.

Confined Spaces Regulations 1997 Regulation 4 Work in confined spaces Regulation 11 of the Construction (Design and Management) Regulations 2007 places a duty on designers to ensure that any design includes adequate regard to the need to avoid foreseeable risks to the health and safety of any person on the structure at any time.

Eventually they manage to pull the casualty out using a length of rope as no tripod or winch arrangement is required.

Confined Spaces Regulations 1997 Regulations.
82 Rescue equipment will often include lifelines and lifting equipment (since even the strongest person is unlikely to be able to lift or handle an unconscious person on their own using only a rope),

The ship has no resuscitator to help revive him. Again, not required.

Confined Spaces Regulations 1997.
Regulation 5 Emergency arrangements
(b) They require, where the need for resuscitation of any person is a likely consequence of a relevant specified risk, the provision and maintenance of such equipment as is necessary to enable resuscitation procedures to be carried out.

Finally, it is worthwhile reading the HSE Enclosed space legislation on training;

Training

92 Those likely to be involved in any emergency rescue should be trained for that purpose. The training needs for each individual will vary according to their designated role. It is important that refresher training is organised and available on a regular basis, for example annually. Training should include the following, where appropriate:

(a) the likely causes of an emergency;

(b) use of rescue equipment, e.g., breathing apparatus, lifelines, and where necessary a knowledge of its construction and working;

(c) the check procedures to be followed when donning and using apparatus;

(d) checking of correct functioning and/or testing of emergency equipment (for immediate use and to enable specific periodic maintenance checks);

(e) identifying defects and dealing with malfunctions and failures of equipment during use;

(f) works, site or other local emergency procedures including the initiation of an emergency response;

(g) instruction on how to shut down relevant process plant as appropriate (this knowledge would be required by anyone likely to perform a rescue);

(h) resuscitation procedures and, where appropriate, the correct use of relevant ancillary equipment and any resuscitation equipment provided (if intended to be operated by those receiving emergency rescue training);

(i) emergency first aid and the use of the first aid equipment provided;

(j) use of fire-fighting equipment;

(k) liaison with local emergency services in the event of an incident, providing relevant information about conditions and risks, and providing appropriate space and facilities to enable the emergency services to carry out their tasks; and

(l) rescue techniques including regular and periodic rehearsals/exercises. This could include the use of a full-weight dummy. Training should be realistic and not just drill based, and should relate to practice and familiarity with equipment.

Conclusion

I accept it is easy to paint a scenario and develop it the way you wish to prove a case, but the base of what I have described above is constructed on an actual event.

When two authorities agree to a memorandum of understanding and a division of responsibilities with one of those authorities many years in legislative advance of the other, if there is no agreement on training and equipment as well as dissemination of that agreement and the implications it entails for those involved in it, confusion is bound to occur.

What is obvious is that owners must now seriously consider the inclusion in their SMS the requirement to take into account their responsibilities in ports and docks as well as to contractors at sea and the fact that it is the HSE legislation and investigation they must consider.

In a dry dock or repair yard, especially with the reduced crewing now on ships, the full responsibility for the control of safety on board of all the crew and workers could well be beyond the scope of the ship's crew and for this reason, the desire and common sense of both the ship and dry dock to transfer this responsibility can be understood, however this allocation should be formalised throughout the industry by clear legal safeguards for those on board the ship or platform. It also must be agreed to by the safety administration responsible for the safety of those in the dry dock. Such safety executive must make it clear that they;

1. Accept this transfer of responsibility and make legal provision for this.
2. Make it clear as to the workers covered by this, such as outside contractors employed by the dry dock.
3. Have provisions in place for the safety equipment that they require by their legislation that may not be on board the ship.
4. That the ship is provided with a statement of the Master's and Safety officer's responsibilities under this transfer.
5. Provide that safety executive's formal document for the transfer of responsibility.
6. Direct how the ship/installation risk assessment system is to be merged into the safety requirements of the Dock.
7. The responsible safety executive provide clear instructions as to the handing back of responsibility.

Finally it is essential that there is agreement in place between the dock and the ship as to the responsibilities for rescue, especially in enclosed spaces where minutes count. Unless the dock provides a permanent rescue team on standby on board the vessel during enclosed space work, it is highly unlikely that a rescue team on standby somewhere in the dockyard will be effective. On the other hand if the ship is responsible for this, they must have a trained and equipment rescue team on board, which presently is very unlikely.

In the various quotes from the HSE legislation for enclosed spaces, it is obvious that their requirements are far in advance of those required by the MCA.

In Australia, the marine industry now come under the Australian Occupational Health and Safety Inspectorate. Their enclosed space Legislation AS 2865-2009 covers all marine workers and states that those working within confined spaces must be trained and assessed as competent to perform those activities. Furthermore, training must be carried out by an approved training provider.

It covers design of spaces and most important for rescue, it requires that enclosed space equipment such as breathing apparatus, resuscitation equipment and safety harnesses, as well as appropriately trained persons must be immediately available.

After the Piper Alpha disaster, the HSE was made responsible for the safety of all those on the offshore installations. As now the HSE is responsible in port for those on board the ships, it would seem sensible to follow the Australian example and bring all the marine industry under the HSE legislation for enclosed spaces.

In the end we have to ask, does such an agreement of understanding benefit those involved in accidents, or was the agreement made purely to deal with the division of the investigation responsibilities and paperwork between two government departments for the benefit of their efficiency? Without an agreement on a joint approach to training and equipment it is difficult to see how the practical implementation can be done.