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**Dr Phil's Diagnosis...** Welcome to issue 2 of ReportISM, the quarterly newsletter from **ConsultISM**, the experts in the ISM Code and safety management.

Our first issue generated a lot of comment and interest, and as a result we are pleased to welcome all our new readers and clients.

Inside we will be tackling the issues of people and safety, lessons from the "Bow Mariner" tragedy, the Master and hours of rest and also looking at ways of bringing your SMS in line with the requirements of the International Ship and Port Facility (ISPS) Code .

We hope you find this issue interesting and useful. If you would like to discuss how ConsultISM can help you and your organisation. please contact us, or visit our website **[www.consultism.co.uk](http://www.consultism.co.uk)**

## When will we ever learn ?

It was with great sadness that we read the recently released United States Coastguard's (USCG) report following their investigation into the tragic loss of the tanker "Bow Mariner".

Sadness at the loss of life of 21 seamen and their ship. Sadness that the incident could almost certainly have been prevented. Sadness that the safety management system which should have protected the seafarers – was not being implemented. Sadness that highly respected names in the shipping industry were involved in the operation of this ship and its SMS, Sadness that no-one seems to have picked up that things were going seriously wrong on board "Bow Mariner" before the bubble finally burst.

The "Bow Mariner" was lost off the Atlantic coast of the USA, on the 28<sup>th</sup> February 2004, after a huge explosion tore through the vessel. The explosions caused catastrophic structural damage and led to immediate flooding of nearly the entire cargo area.

The ship sank after an hour and half, spilling ethyl alcohol, and a mixture of fuel oils and slops into the U.S.

Exclusive Economic Zone (EEZ).

So what caused such a disaster? According to the findings of the USCG, the explosion was caused by the venting of cargo onto the deck, an incredible error that led to the fumes igniting and causing a tragic explosion.

It would appear that the problems went deeper than that – there were mistakes throughout the entire operation and these have been highlighted within the report. The USCG found a litany of mistakes, of mismanagement, even of bullying and serious irregularities with paperwork, and of a shipboard team rent asunder by cultural differences and divides. A cocktail for disaster.

The mistakes and malpractice were confounded, it seems, when the Master and Senior Officers left the vessel, knowing that a number of crew were still alive, and that they needed assistance and guidance.

The USCG has not held back in its criticism of the ship operators and the senior officers on board. This is a highly emotive incident and report, and some of the findings will make all who read the report shake their heads

in disbelief. However, we would suggest that the situation which existed on board "Bow Mariner" was not unique. It is genuinely feared that there are other vessels and other companies – many highly respected – who are operating in similar conditions.

Sometimes it requires someone from 'outside' of the system to properly look with a totally objective eye and see where weaknesses might be creeping in, where bad practices might be developing and where hazards are no longer under control. The time to make that sort of interrogation is not through a formal investigation by a Flag State or Coastal State Administration, or in a Court Room following a major casualty. The time to act is now – please contact **ConsultISM** to see how we can help.

Let's make sure that we all learn from these mistakes, and that no more lives are lost through such elementary mistakes, nor through such a fundamentally flawed working environment.

The full text of the USCG report can be downloaded as a .pdf document at: **<http://www.uscg.mil>**

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## Safety – Giving Staff a clear role

Ironically, it had been our intention in this issue of ReportISM to focus on the importance of giving staff a clear role within any safety culture – the report of the “Bow Mariner” vindicates our belief in the importance of this proposal.

There are very important lessons to be learnt from the loss of the “Bow Mariner” ; upmost is the fact that it is primarily people that make ships safe, and not the systems they work within. Effective and proper safety management systems are vital, but if they are ignored then accidents are inevitable. It is therefore imperative that all shipboard personnel clearly understand their own safety role and the contribution they can make.

It has often been stressed that the first people to realise that something is going wrong with the safety regime are those that work within it, yet often they do not voice their concerns, or they voice them in the wrong way. It seems that on the “Bow Mariner” the bullying and abuse of junior officers and crew made it impossible for them to speak out about any safety failings for fear of losing their job.

The report stated that the senior officers were abusive to the junior officers and crew. Apparently there was a lack of cohesion between the three senior Greek officers and the Filipino crew. The Filipino officers did not eat their meals in the officer's mess, and were given only menial tasks. The survivors reportedly feared the Greek officers, and each stated that they would obey any order from them, even if they knew the order to be unsafe. One AB stated that orders from the Greeks were like “words from God.”

This atmosphere of fear and distrust was obviously not conducive to a positive working environment. A good safety culture is one where the mental attitude of both workers and management is such that when a safety risk is perceived it will be reported promptly, allowing thorough investigation and action taken to reduce the risk.



A shipping company can have wonderful systems in place, but if the people on board do not apply them, and if the people ashore do not manage them, then all will be for naught.

In the “Bow Mariner” case it becomes apparent that the system failed, there were operational errors, and also individual errors. There were errors of judgement and of management – there is also the question of how such a divisive onboard management structure could exist in a supposedly compliant ISM system?

On paper the “Bow Mariner” was fully ISM compliant with the SMC having been issued on 25-Feb-2002 by the American Bureau of Shipping (ABS). Compliance does not begin and end with pieces of paper, it is the philosophy onboard, the beliefs and values of the people and the bringing alive of the SMS that counts.

The USCG stated that one of the major contributing factors to this casualty was the failure of the operator, and the senior officers to properly implement the company and vessel Safety, Quality, Environmental Management System (SQEMS).

This failure of implementation was patently demonstrated by the fact that the cargo tanks were not inerted

during the discharge in New York, as required by the SQEMS. The Second Engineer also stated that he was specifically prohibited from performing many of the duties listed for his position by the Chief Engineer.

Then there was the fateful decision to open the cargo tanks, which was “a stunningly significant breach of normal safe practices” and which according to the USCG defies explanation or excuse.

If the tanks had remained closed, the explosion would not have occurred. Opening the tanks, had numerous dreadful consequences, this act

- Exposed the crew to toxic fumes,
- Permitted flammable vapors to accumulate on deck, and
- Brought the cargo tanks into the flammable range.
- Led to the explosion

Once the explosion had occurred it seems that the safety failings that had led to the accident were evidenced again as the failure to properly respond to the emergency contributed to the high loss of life. The ship was abandoned without sending a distress signal, without attempting to contact a nearby ship, without conducting a proper muster or search for injured crewmen, and without attempting to launch primary lifesaving appliances.

## Giving staff a clear role continued...

The failure to conduct regular and effective fire and boat drills contributed to the high loss of life. It is widely accepted that people react in emergencies precisely as they have trained – practice makes perfect...and permanent.

In this casualty, the Officer-On-Watch (OOV) failed to sound the general alarm, failed to make an announcement and failed to send a distress signal. Several crewmen panicked and no one reported to their muster stations with the equipment they were assigned to bring. Those who gathered were utterly disorganised, bewildered and in desperate need of leadership. It is obvious that their role in the safety of the vessel was not defined, and as a result they were left helpless in the face of a devastating series of events.

It is vital to fully appreciate the failings of a system and to work towards a solution, it is better to accept the truth



Bow Mariner Source: [www.burgoynes.com](http://www.burgoynes.com)

and work with it, rather than to live in the false hope and confidence generated by a flawed Safety Management System. In this case and, we fear, on board other vessels, many seafarers onboard do not fully understand or appreciate their safety roles and the protection afforded when all are looking at safety and reporting hazards and near misses.

Undoubtedly, had all staff been given

a clear safety role then many of the tragic mistakes that were made could have been avoided, and the response to the emergency may have saved lives instead of taking them.

If you would like to discuss how we at **ConsultISM** can help you generate clearer safety roles for your staff please contact us: see back page for details, or [www.consultism.co.uk](http://www.consultism.co.uk)

## Harmonising ISM and ISPS systems



As many companies have now successfully negotiated the hurdle of becoming ISPS compliant, **ConsultISM** are espousing the common sense approach of having an integrated safety and security management system within a Company and onboard ship.

This sounds like a sensible and practical approach but there is a need for caution, especially as the components pertaining to both ISM and ISPS compliance need to be clearly identifiable and traceable, so as to be able to demonstrate

observance with each distinct Code.

Also, ISM audits are not to duplicate or replace other surveys or verifications so ISM and ISPS verification audits also need to be distinct. That is, an ISM audit cannot replace an ISPS audit. However ISPS verification audits can be done during the same ship visit by suitably qualified auditors, but each survey or audit is to be done sequentially.

What we have seen, on far too many occasions, when reviewing Company Safety Management Systems are residual references to out-of-date, and sometimes contradictory guidance and advice on security issues that are now contained in their Security Manuals.

Whereas the advice regarding stowaways, piracy patrols, searching and security responses may have been correct pre-ISPS, they may now be actively in opposition to the new provisions laid down within the

vessel's Ship Security Plan (SSP).

It is vital therefore that a proper, up-to-date SMS makes the correct references to the vessel's security regime – while obviously not openly promulgated classified, or restricted information.

This all has serious implications for the security provisions within the SMS, and unless these are amended or removed the vessel is likely to find itself non-conforming and subject to potential control measures, in the event of an audit, whether it be for ISM or ISPS.

It is crucial that the SMS is kept up to date – not only to have credibility but, much more importantly, to work to the benefit of all involved.

If you need any further guidance on the harmonisation of ISM and ISPS within your SMS please contact us: see back page for details, or visit [www.consultism.co.uk](http://www.consultism.co.uk)

# Master's Hours of Rest

Issue 1 of ReportISM carried an article '*Flogged logs cost dear*' – which addressed a problem which seems to exist in some quarters, of adjusting seafarers hour of work / hours of rest records to ensure, apparent, compliance with Section A-VIII/1 of the STCW Code stipulations.

Another, extremely worrying and dangerous perception – or misconception has come to light in the meantime, which we believe needs addressing – in case it may be a widely held view.

The point was first raised within the context of STCW when it was suggested to us that Section A-VIII/1 of the STCW Code did not apply to the Master of a ship and, consequently, the Masters hours of work / rest were not restricted. Further, it was argued, there was no requirement to maintain any records of the Masters hours of work / rest.

We would suggest that such a view is erroneous, dangerous and is likely to land the individual Master and the Company in very deep water indeed. However, having researched the point we can understand how such conclusions could perhaps have been reached and, consequently, believe that the wording of certain Conventions and other Regulations may be in need of amending to remove any ambiguity.

By way of Authority and support for his argument, the individual who had raised the point was relying upon a literal reading of Section A-VIII/1 – Paragraph 1 – which says:

*'All persons who are assigned duty as officer in charge of a watch or a rating forming part of a watch shall be provided a minimum of 10 hours of rest in any 24 hour period... etc.'*

Regulation 1/1 of Chapter I of the STCW Convention provides the following definitions:

- **Master** means the person having command of a ship;
- **Officer** means a member of the



crew, other than the master, designated as such by national law or regulation etc...

- **Rating** means a member of the ship's crew other than the master or an officer.

The argument ran along the lines that Section A-VIII/1 applies to Officers and Ratings and does not include the Master.

The main 'international' authority to which reference could be made for clarification and guidance would be the International Labour Organisation (ILO) Convention C180 'Seafarers' Hours of Work and the Manning of Ship Convention, 1996'.

The relevant regulations regarding hours of work and hours of rest are set out in Article 5 – these differ slightly from STCW, but that is not the issue here. Those regulations are not restricted to watchkeeping or watchkeepers but apply generally to 'seafarers'. Unfortunately the definition of a seafarer, within Article 2 of the Convention, is not particularly helpful:

*'...the term **seafarer** means any person defined as such by national laws or regulations or collective agreements who is employed or engaged in any capacity on board a seagoing ship to which this Convention applies...'*

Certainly it does not 'exclude' the Master – but may be ambiguous as to whether the Master is included in the term *seafarer*. Consider the wording of Article 8:

*'1. The Member shall require that records of seafarers' daily hours*

*of work or of their daily hours of rest be maintained to allow monitoring of compliance with the provisions set out in Article 5. The seafarer shall receive a copy of the records pertaining to him or her which shall be endorsed by the master ... and by the seafarer.'*

An interpretation of this could well be that a distinction is being drawn between the master and the seafarer. This same possible ambiguity appears to have been carried over by the EU when it acceded to ILO C180 with Council Directive 1999/63/EC of 21 June 1999 dealing with the working hours of seafarers on board ships of EU Member states and Council Directive 1999/95/EC of 13 December 1999 which deals with seafarers' hours of work on board ships calling at Community ports.

As far as the UK is concerned, as an example of how one flag State Administration, has implemented the ILO Convention, we refer to 'Statutory Instrument 2002 No. 2125 – The Merchant Shipping (Hours of Work) Regulations 2002. In Section 2 – 'Interpretation' – it unambiguously includes the master within the general definition of 'seafarer':-

*'... "**seafarer**" means any person, including a master, who is employed or engaged in any capacity on board a ship... etc.'*

Here there is no doubt that the Master is subject to exactly the same minimum hours of rest regulations as any other seafarer and must also maintain records of those periods of rest (or hours of work). This is reiterated and reinforced in the UK MSN 1767 (M) 'Hours of Work, Safe Manning and Watchkeeping Revised Provisions from 7 September 2002.

## Masters Hours of Rest continued...

Interestingly, UK legislation actually spells out very clearly the provisions relating to the hours of work of a master of a domestic passenger ship in the Merchant Shipping (Local Passenger Vessels) (Master's Licences and Hours, Manning and Training) Regulations (SI 1993/1213).

The regulations apply only to the master of the ship. Masters must ensure that they are properly rested before beginning work (regulation 12). It is an offence for the master to go on duty when not properly rested.

Specific requirements are that:

- The working day of the master must not exceed 16 hours
- The master must not on a vessel for periods amounting in total to more than 10 hours
- After 6 hours work the master must have a break of at least 30 minutes

Clearly common sense must prevail

and it must be recognised that one of the main reasons why legislation was introduced to regulate and enforce minimum hours of rest / maximum hours of work was safety and specifically to reduce the risk of fatigue setting in and affecting an individual's decision making ability.

Whilst a great deal is expected of a ship master they are still, at the end of the day, mere mortals and do not possess superhuman powers which allow them to overcome the effects of fatigue. Unfortunately, anecdotal stories relayed to us would indicate that some ship operators, and some masters, may be of a different view.

In the event of a serious incident, it is quite likely that the hours of work / hours of rest of the master will be interrogated very closely. Appropriate and meticulous records will be expected. Those records are also likely to be subjected to cross verification by an expert to check their accuracy – and it would be a mistake

to believe that the wool could be pulled over the eyes of the investigator. If records prove to be inaccurate then this could have devastating effects for both the master personally and the ship operator as the responsible Company – particularly if there is a suggestion that fatigue may have been causative of the incident.

If masters are not currently monitoring and recording their hours of rest / work then they are strongly recommended to start doing so without delay. Clearly, with this goes the requirement to ensure that they remain within the legal limits. If they cannot undertake all that is required of them within the legal limits then that problem should be flashed up as a hazardous occurrence and dealt with immediately.

You are urged to read: **UK MGN 211 (M) – Fatigue: Duties of Owners and Operators under Merchant Shipping Legislation** – available at [www.mcga.gov.uk](http://www.mcga.gov.uk)

## Meet the team...Steven Jones

One of the aims of ReportISM is to allow our present and future clients to get to know **ConsultISM** better and also the individuals within the company.

In this first "Meet the team" article we introduce **Steven Jones**, a marine safety management consultant who has been with **ConsultISM** since the company was launched over a year ago.

Steven served as a Deck Officer for 10 years on a variety of ships, but predominantly with Cable and Wireless (Marine), before moving ashore and gaining a BSc (Hons) in Maritime Studies.

He then moved to work within Lloyd's Marine Intelligence Unit (LMIU) as a Marine Investigator and Maritime Security Consultant. It was through this position that Steven participated at the IMO and within the industry during the development and implementation of the International Ship and Port Facility (ISPS) Code.

A former member of the North of England P&I Association's Risk Management team and more recently engaged as Marine Safety Manager with a major international RO-PAX operator.

Steven has been involved in many ISM related audits, both within companies and also as a third party. In addition to this he has produced many ISPS assessments and plans, all to the satisfaction of clients and flag States.

He is a qualified marine surveyor, and is an active member of the Nautical Institute and of the Institute of Chartered Shipbrokers.

### ***What led you to work within the safety management industry?***

I was fortunate to work for a very good shipping company, Cable & Wireless (Marine), and as a result managing safety was simply second nature. I then branched out into other areas of the industry, but it is the lessons that I



learnt as a cadet and junior officer that have stayed with me, and given me an insight into how safety can work, how people can gain job satisfaction and yet be protected from accidents.

This initial education, and the experience gained in loss prevention for a leading P&I Club have been the mainstay of my safety management consultancy skills – though one never stops learning, as everyday brings a new challenge.

## Meet the team continued...

### ***What have been the most frustrating management elements you have witnessed?***

The lack of either "carrot or stick"...we see many officers and crew working under complex employment arrangements.

They lack any real link to the shipowner or to the SMS, and so they can't be induced to make the safety provisions work, as no-one can guarantee them work, promotion and conversely even the threat of losing their jobs isn't real – as the companies offer no loyalty to them in the first place. A far from ideal basis on which to work.

### ***What of the future, how will maritime safety evolve?***

Laws do not make people good! So the future will see a slowing up in the amount of legislation thrown at vessels and shipping companies, but a switch in emphasis to ensure that they do all necessary and possible to make the existing rules work.

The Tanker Management Self-Assessment (TMSA) scheme is a view of the future. Compliance is not going to be enough; the future will call for excellence.

### ***What advice would you give to a DPA today?***

Protect yourself..."an ounce of prevention is worth a tonne of cure", as Henry de Bracton once said. Don't find out the weaknesses of your sys-

tems in a courtroom – sort it out now!

The line between success and failure is very thin, so you must do all you can to not only comply, but you must do everything possible to excel.

Don't over complicate, and don't covet other company's systems. Look at your own and make a SMS that honestly and properly reflects what your company and vessels do.

### ***What makes a safe ship?***

Put very simplistically it is the people that make a safe ship. Good people, well trained, motivated, fully resourced and supported, all pulling together in a system that they believe in and understand. That's what makes a safe ship.

## ConsultISM – Out and About

### **Oil Spills and the ISM Code**

ExCeL, in London, will host the largest and most prestigious oil spill related event of 2006 from 21 – 23 March: The 'Spill06 International Exhibition' and the 'Interspill London 2006 Conference'

**ConsultISM's**, Dr. Phil Anderson has been invited to address the opening session on the important, but often misunderstood, impact of the ISM Code on prosecutions following shipboard pollution incidents. We reproduce below the Abstract of Dr. Anderson's paper which may spark sufficient interest for you to pop along to hear and debate his suggestions.

*If a pollution incident occurs then the legal responsibility will be dealt on the basis of 'strict liability' – in other words the polluter pays.*

*The calculation of actual costs, expenses and damages suffered should not be too difficult. However, the level of the punitive fine which may be imposed would be a more subjective matter.*

*Pollution incidents tend to be emotive affairs with pressure on those responsible for administering justice to severely punish the offenders. On some occasions a harsh punishment may be fully justifiable but on other occasions such level of punishment would be totally inappropriate. Unfortunately human beings can, on occasions, make mistakes.*

*It will then fall upon the Magistrate or Judge to decide upon the level of fine most appropriate. They will have some discretion as to the level of fine to impose and, in some jurisdictions, the length of prison sentence! Those imposing the punishment will need to consider not only the facts, but also the background to the incident.*

*In this paper it will be argued that the evidence to be considered will exist within the Safety Management System (SMS) of the ISM Code – this will be the benchmark. If the SMS has been implemented properly then the fine should be at the lower end of the scale; if only lip service has been paid to the ISM requirements then the ship operator, and Master, should expect to face the consequences!*

Full details of the event, including registration, can be found online at [www.spill06.com](http://www.spill06.com)

### **"ISM on Trial" hits the road!**

Following the two very successful ISM mock trials hosted in London during 2005, and organised by the London Shipping Law Centre, the 'Court' is going out on the road.

In conjunction with BIMCO, the LSLC will be hosting an inaugural 'annual' conference at the Excelsior Hotel on Syngrou Avenue in Athens on Friday 5<sup>th</sup> May 2006.

Again Dr. Phil Anderson will appear as the ISM Expert Witness to advise the Court. He will join a panel of most distinguished judges, lawyers and ISM experts.

Previous events were totally sold out and it is anticipated that the event in Athens will be even more popular. So reserve your places early.

Full details can be found at: [www.london-shipping-law.com](http://www.london-shipping-law.com)

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