

Regs4ships

Port Marine Safety Code Audit

River Hamble Harbour Authority October 2014

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1 Executive Summary

The River Hamble Harbour Authority remains compliant with the Port Marine Safety Code, subject to the findings of this report.

The one outstanding non-conformity (1/13) regarding access to the fishermen's jetty has been closed out as an access ramp and the gate has been fitted.

The outstanding observation (1/13) regarding a multi-agency drill has been actioned as a major emergency drill, involving the emergency planning team from Hampshire County Council and other agencies, and is planned for 03/12/14.

Since our last audit the Courts have reiterated the importance of compliance with the PMSC. In 2007 the tug "Flying Phantom" girted and capsized with the loss of 3 of the 4 crew. The tug operators did not have a sufficiently robust Safety Management System and were fined £1.7M. The Harbour Authority, among other things, failed to:

"make a suitable and sufficient assessment of the risks to the health and safety of persons not in your employment but who may be affected by the conduct of your undertaking"

and

"provide a Safety Management System to reduce to a level as low as reasonably practicable the risks associated with marine operations in the Clyde Harbour Area, in terms of the Port Marine Safety Code, and failed to appoint a suitable individual or individuals to share the function of 'Designated Person' to provide you as the duty holder with independent assurance that your Safety Management System was working effectively and to audit your compliance with the Port Marine Safety Code"

The Harbour Authority was fined £650,000.

Whilst RHHA strives to meet or exceed the requirements of the PMSC, this case highlighted the need to ensure that compliance is robust and that the Designated Person remains effective. It also highlighted the need to consider the risks to all persons, not only those employed by the Harbour Authority.

As a consequence of this case, the senior staff at RHHA reviewed all the risks assessments and made amendments to some of the standard operating procedures. They developed a comprehensive "mind map" that identified all risks to everybody that might be affected, having identified all the activities both on the river and on its curtilages. The identified risks were cross referenced with the existing risk assessments. This useful and well executed exercise generated 18 new risk assessments and prompted amendments to others.

This demonstrates that there is always room for improvement and that a Safety Management System should never be a moribund collection of documents.

We have made 2 recommendations:-

1.1 Recommendation 5/14

A clause is added to the general LNtRU 1 “General Instructions and Advice” (which is re-issued annually) to remind all contractors that they have a legal obligation to provide safe systems of work and that they should be skilled and/or qualified and hold appropriate insurance. The advice should also remind all those that engage contractors to ensure the contractor has produced risk assessments and method statements wherever appropriate.

1.2 Recommendation 6/14

Records are kept of:

- Kill cord operation checks.
- Inspections of patrol boat PPE.
- Chainsaw maintenance and safety checks.

2 Background

The Port Marine Safety Code requires that the Designated Person audits the Harbour Authority’s compliance with the Code and provides independent assurance to the duty holder. The main responsibility of the DP is to determine, through assessment and audit, the effectiveness of the marine SMS in ensuring compliance with the Code.

We report accordingly and ask that this report be presented to the Board at the next Board meeting.

We enclose a Certificate of Compliance confirming compliance with the Code subject to the contents of this report. This should be filed in the appropriate section of the SMS.

3 Close out of non-conformity and observations from previous audit

3.1 Non-conformity Fishermen’s jetty 1/13

In the light of the recent risk assessment that found that the access to the jetty needed improvement and that the risks associated with its use was not ALARP, and coupled with the observations made in this report, the use and access to the Fishermen’s Jetty needs review. Close out required within 6 months.

This non-conformity is closed out.

An access ramp and gate has been fitted.

3.2 Observation 1/13

Whilst multi agency drills for major accident drills are extremely difficult to organise we urge that consideration be given to exercise a major accident such as this, even if it is an internal desk top drill involving all of the Harbour Staff.

This Observation is closed out.

A multi-agency drill is planned for 03/12/14.

3.3 Recommendation 1/14

The report of the Oil Spill Exercise should be filed with the Oil Spill Response Plan.

This recommendation is closed out.

3.4 Recommendation 2/14

When a drill is held a formal record should be generated including “lessons learned”.

This recommendation is closed out pending the record and “lessons learned” generated after the next drill.

3.5 Recommendation 3/14

The Oil Spill Contingency Plan contains a safe refuelling procedure and this should be incorporated into a SOP within the SMS.

This recommendation is closed out.

3.6 Recommendation 4/14

The management of dry side risks and the involvement of the Health and Safety experts at HCC should be revisited and reviewed especially the risks associated with the workshop, chainsaw and grinding etc.

Ongoing.

4 “Flying Phantom”:- Lessons learned.

Nearly 7 years ago, the “Flying Phantom” was bow tug to the large bulk carrier “Red Jasmine” on passage up the Clyde. In thick fog the tug girted and tragically 3 of the 4 crew were killed.

Last year the tug owners were fined £1.7M for failing to assess risks and provide a safe system of work. Yesterday, the harbour authority was fined £650,000 for failing to assess risks and provide a safe system of work. Reliance on the skill, training and experience of professionals involved in marine operations is not sufficient. There must be a formal system which must be kept up to date, generate records and be audited.

For a Harbour Authority, this formal system is wrapped up in compliance with the Port Marine Safety Code (PMSC). The PMSC does not have the force of law but this case has demonstrated that does not dilute its importance.

Lord Turnbull in his sentencing statement of HMA v Svitzer Marine said:-

“...the company had still failed to make a suitable risk assessment of the risks to the safety of its employees so as to ensure, so far as reasonably practicable, the safety of its employees arising out of the risks of grounding, girting and collision while engaged in acts of towage in darkness and in conditions of restricted visibility due to fog.”

“Separately, the company had failed to provide a system of work that was, so far as reasonably practicable, safe for its employees serving as crew engaged in acts of towage in darkness and in conditions of restricted visibility due to fog.”

Lord Kinclaven in his sentencing statement of HMA v Clydeport Operations Limited said:-

“The charge before the Court relates to failures on the part of Clydeport to adequately assess risks and provide a safe system of work.”

“It was Clydeport’s duty under the Health and Safety at Work etc. Act 1974 to conduct their undertaking in such a way as to ensure, so far as was reasonably practicable, that persons not in their employment (my emphasis) who may be affected by the conduct of Clydeport’s undertaking were not exposed thereby to risks to their health or safety – including persons serving as crew of tugs.”

(Clydeport) ... “did fail to provide a safe system of work in that:-

(it) did fail to have in place an adequate contingency plan if conditions of restricted visibility due to fog were encountered during an act of towage of a vessel .

(it) did fail to provide a Safety Management System to reduce to a level as low as reasonably practicable the risks associated with marine operations in the Clyde Harbour Area, in terms of the Port Marine Safety Code, and fail to appoint a suitable individual or individuals to share the function of 'Designated Person' to provide (Clydeport) as the duty holder with independent assurance that (the) Safety Management System was working effectively and to audit compliance with the Port Marine Safety Code”.

The lessons to be learned are:

1. Comply with the Port Marine Safety Code.
2. Manage risks associated with marine operations by way of a risk-based Safety Management System.
3. Appoint a Designated Person to provide the duty holder with independent assurance that the Safety Management System is working effectively and to audit compliance with the Port Marine Safety Code.
4. Keep records.

Whilst RHHA strive to meet or exceed the requirements of the PMSC this case highlighted the need to ensure that compliance is a continual process and that the Designated Person remains effective. It also highlighted the need to consider the risks to all persons, not only those employed by the harbour authority.

As a consequence of this case the senior staff at RHHA reviewed all the risks assessments and made amendments to some of the standard operating procedures. They developed a comprehensive “mind map” that identified all risks that may impact anybody on or near the river having identified

all the activities both on the river and on its curtilages. The identified risks were cross referenced with the existing risk assessments. This useful and well executed exercise generated 18 new risk assessments and prompted amendments to others. Examples include:

- Operating chainsaw.
- Use of GRP (hand lay-up).
- Dealing with fires on vessels.
- High speed operations in emergencies.
- Operations in fog (fog and dense fog defined).

There are now 56 activity based risk assessments, all of which have had considerable thought and input by the professionals involved. RHHA uses a simple manual approach to risk assessments and my experience at other harbour authorities indicates that this method remains sound as I have found that software generated risk assessments may not be fully understood.

This demonstrates that there is always room for improvement and that a Safety Management System should never be a moribund collection of documents.

5 Incident Records

These continue to be well compiled and analysed. There is nothing recorded of note or that causes concern.

6 Contractors working within the jurisdiction

Contractors (including riggers and engineers) that are not engaged by RHHA, work within the jurisdiction. Where there is not a contractual relationship between RHHA and the contractor it is difficult, if not impossible, to monitor the contractor's ability to safely carry out the work and to check their Safety Management System.

6.1 Recommendation 5/14

A clause is added to the general LNtRU 1 "General Instructions and Advice" (which is re-issued annually) to remind all contractors that they have a legal obligation to provide safe systems of work and that they should be skilled and/or qualified and hold appropriate insurance. The advice should also remind all those that engage contractors to ensure the contractor has produced risk assessments and method statements wherever appropriate.

7 Dry side risks

HCC are in the process of improving the management of dry side risks. The senior risk advisor is due to finalise the risk assessments. In the meantime the existing risk register has been updated.

In June 2014 "Manual Handling" was updated specific to the tasks undertaken by the RHHA including recovering a "man overboard".

8 Towage Authorisation

For tows over 22m, RHHA now requires prior notice by way of a completed towage authorisation form. This form is related to the towing risk assessment and requires a risk assessment and a method statement from the tug operators and confirmation of insurance.

9 Crabbing

Crabbing is now a popular activity which has been embraced by RHHA. Precautions to manage the risks have been incorporated into the fishing risk assessment.

10 Lone working afloat

“Auto tethers” are being introduced to both patrol boats. These will remotely operate the kill cords when the wearer of the device falls overboard.

11 Changing navigation lights on piles

To ensure that no personnel are tempted to work from the roof of the patrol boat the Risk Assessment has been amended. **Working from the roof of a work boat is prohibited.**

12 Records

The records generated by the SMS are vital; not only for audit purposes to demonstrate that RHHA have done what they said they would do as reflected in the Safety Management System but also during scrutiny after an accident.

As part of this audit a random sample of records was examined. Those in red indicate improvement is required.

1. Last patrol to upper reaches of River. 6/10/14.
2. Last MOB recovery. 3/6/14.
3. Last electrical check on HM jetty. June 2010.
4. **Last time kill cords operated. No records.**
5. Last service on “Crowns” engines – kept by Honda dealer.
6. Last service on HM lifejacket. 11/2/14.
7. Last check on nav lights 6/10/14 (last by Trinity House 9/9/14 (some piles gone pink).
8. Last hydrographic survey of entrance channel 4/11/13 (part) and 11/12.
9. **PPE Patrol Boats – no formal inspection although its use is covered in the SOP.**
10. **Last inspection records for chainsaw. No records.**
11. Fire drill in HM office. Completed annually records stored in store room.
12. Last staff appraisals. Encompassed in “Individual Performance Planning”.
13. RA swimmer hit by ferry. Last up dated 10/14.

12.1 Recommendation 6/14

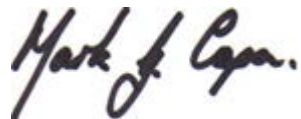
Records are kept of

- Kill cord operation checks.
- Inspections of patrol boat PPE.
- Chainsaw maintenance and safety checks.

13 Conclusion

This audit confirms compliance with the Port Marine Safety Code. Compliance is audited independently and assured to the Duty Holder by an independent Designated Person.

Respectfully submitted



Mark G Capon
Designated Person under the Port Marine Safety Code
For and on behalf of Regs4ships Ltd

The following forms part of this report:

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