## Shipping's 'blame culture' is a barrier to preventing accidents and deaths

When accidents happen onboard ships it is almost always the seafarer who pays the price – firstly by suffering injury or death in the accident, and secondly by being blamed for the incident

I believe our great industry does itself, and those who work in it, a great disservice by pointing fingers in this simplistic way. I, and many others in the shipping industry, refer to this as a blame culture – and it has to stop!

It is no surprise that this blame culture has developed. Today's shipping industry is reliant on insurance provided by P and I Clubs. These not-for-profit mutual insurance associations provide cover for their shipowner and charterer members against third party liabilities arising out of the use and operation of ships. The system is geared towards attributing blame in that cover is only applicable if someone is found to be the 'guilty party' in explanation for the cause of the accident. Effectively they insure owners and charterers against crew negligence.

So, accidents happen because crew are negligent, ignorant, or lacking necessary skills? I argue this is not the case.

I believe the more pertinent questions to ask are:

- Who is responsible for the employment of these crew members?
- Who is responsible for the promotion of these crew?
- Who decides on the ship's crew component, quality and number?
- Who is responsible for the onboard rules and regulations, and for the ship's procedures?
- Who checks whether ships and their managers/owners/operators comply with industry regulations?
- Who is finally responsible for ensuring that those regulations are actually fit for purpose?

We know the answers to those questions. In the frame are the ship owners, the managers, the charterers, and shipping's international regulator, the International Maritime Organization. Yet the shipping industry does not routinely extend its accident investigation systems beyond the seafarer making a mistake. Crew pay the price and our great industry suffers reputational damage too.

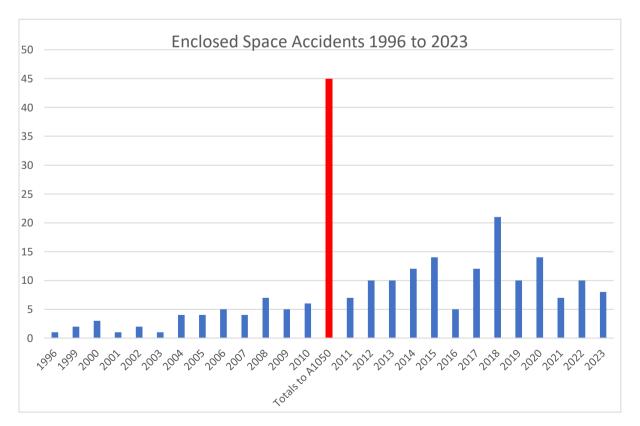
Let me explain in more detail what I mean by using the example of accidents (often deaths) in enclosed spaces. Onboard ships these dangerous spaces present a threat to life for those working in them due to a potential lack of oxygen or the presence of hazardous fumes, and are subject to strict procedures. Such spaces include: cargo spaces; double bottoms; fuel tanks; ballast tanks; cargo pump rooms; cargo compressor rooms; cofferdams; chain lockers; void spaces; duct keels; interbarrier spaces; boilers; engine crankcases; engine scavenge air receivers; the vessel's CO2 rooms; battery lockers; sewage tanks; and any adjacent connected spaces such as cargo space access ways or 'Australian' ladders.

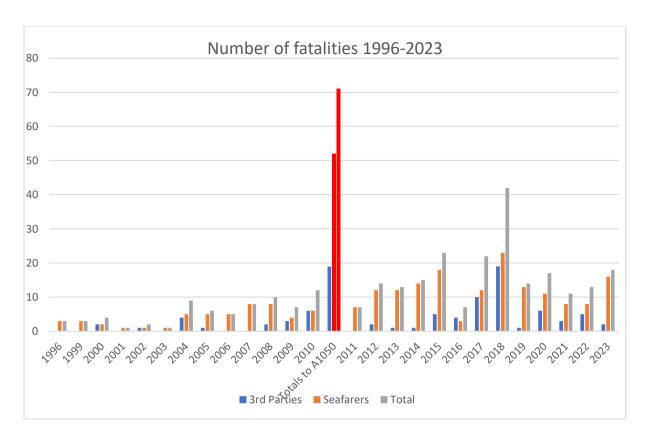
In 2018 InterManager conducted an industry-wide survey where we asked the primary stake holder – seafarers – one simple question: why do crew members die in enclosed spaces? More than 5000 seafarers responded and one key response stood out – almost a third of seafarers responded to say that conflicting procedures, rules and regulations were at fault.

As a result I dug deeper into what we, the shipping industry, know about enclosed space accidents. To my horror, I discovered that we knew very, very little indeed. In addition it seemed that P & I Clubs did not want to share their information. Out of 13 requests for cooperation only one provided some, limited, statistics.

As a result InterManager began to collate our own statistics. We found that the IMO's Global Integrated Shipping Information System (GISIS) was also grossly insufficient in its statistical recordings. We must remember that IMO is comprised of 178 nations – Flag States – as well as 81 Non Governmental Organisations. It is within our power to change things. However, it seems to me that the problem is that the industry doesn't recognise there is a problem.

Below chart demonstrates the issues clearly and also highlights that seafarers were correct. In 2011 the IMO introduced Resolution A1050 which aimed to reduce the number of accidents in enclosed spaces (*the red line*). In fact it seems to have had the opposite effect and more seafarers and stevedores now die in enclosed spaces than before A1050.

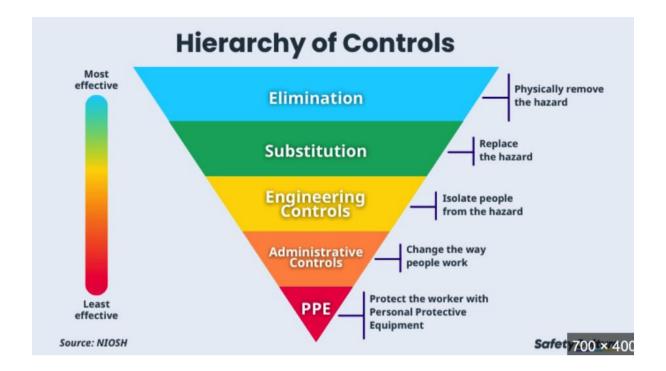




InterManager began collating its own statistics in 2018. That was a particularly bad year when more than 40 people lost their lives in enclosed spaces. The problem clearly persists and to date in 2023 we have already recorded 21 deaths.

So it is clear that the introduction of resolution A1050 IMO has not improved the situation. Nor have the many accident reports into these incidents identified a root cause? Nor have all the P&I clubs' videos, posters, circular letters made a difference to the statistics. In fact, following submissions from China with supporting papers from InterManager and other concerned bodies, the IMO has now agreed to revise its enclosed space recommendations.

Why has this problem escalated and we have reached this sorry state? In my opinion it is because we are barking up the wrong tree. Let me explain why I believe that.



As seafarers pointed out – they believe that administrative controls are the biggest issue with enclosed space working. We have conflicting procedures and regulations. Indeed, we even refer to the spaces themselves in different terms – sometimes enclosed spaces, sometimes dangerous spaces, sometimes confined spaces.

Conflicting procedures can confuse crew and lead to accidents. For example, in relation to one space the procedure may say "enter only if the atmosphere is safe" but only a few paragraphs later the same document may state that "if the atmosphere is not safe crew should use breathing apparatus" (BA). And then, in a further section of the same rules, crew may be reminded <u>in bold capitals</u> that BA SETS ARE ONLY TO BE USED ONLY IN AN EMERGENCY. So which instructions does the seafarer adhere to?

Seafarers can also receive very conflicting instructions, such as "all tanks to be ready by tomorrow morning" when the reality is that the procedures required mean that is insufficient time to complete the task correctly. How can this goal be compatible with reality if the tanker has only six deck crew and there are 18 tanks?

In the InterManager survey, time pressure was identified by seafarers as a leading cause of enclosed space risk.

Another problem is that captains and other senior officers can lack the authority to challenge such instructions, particular if they are employed in a 'hire and fire' situation. Who wants to hear or read "not for re-employment" at their end of the contract appraisal.

So the 'human element' has to solve this conundrum itself and I think the results shown in these two graphs speak for themselves in terms of how effective that situation has proved to be.

So coming back to blame culture, why am I concerned with how we investigate accidents today?

When we investigate an accident or a fatality we only do so up to the point when we find the 'guilty party'. Why? Because the majority of accident investigation courses are taught by police officers, because "this is the way we always have done". I don't believe an accident investigation is the same as a criminal inquiry. In addition P and I Clubs insure owners against crew negligence and therefore finding the "negligent party" suits P and I Club customers.

Unfortunately, by doing it this way we miss a golden opportunity to learn valuable lessons. We blame and therefore we inhibit knowledge transfer.

Ship management companies also miss the proverbial boat by not paying attention to the potential findings of internal audits and many, many other inspections. All these inspections concentrate on the 'human element' instead of supporting people who are usually screaming for help. These are the people at risk and they are usually very keen to indicate system shortcomings. They have already experienced the root causes of the issues and these root causes are being neglected, resulting in "safety drift".

The below picture illustrates safety drift:



We imagine, create, and describe the workplace as we wish it to be. Then time and financial pressures come into play and we start seeing work done under time and financial pressures. Those pressures cause our standards to buckle and drift. The situation is faced and confronted by our people, who try to resist this drift.

With deaths in enclosed spaces increasing, now is the time for action. In order to achieve the sought-after goal of zero deaths/accidents we absolutely must address all the issues I have outlined.

- 1. Regulations need to be amended to become clearer and more effective.
- 2. Pitfalls in procedures need to be removed.
- 3. Our regulatory and procedural frameworks must be rewritten to ensure they are consistent and easily understood throughout the international shipping industry.
- 4. We need to revise our approach to accident investigate to examine **why** an accident occurred and clearly identify **all** the contributing factors. Saying that John made a mistake and was injured/killed is not the end of the investigation. We need to look at why John did what he did and really dig deep into the factors involved the regulations and procedures which were or where not adhered to or properly understood, and why not.
- 5. Ship owners, operators, managers and charterers, and office staff, need to properly understand the impact of their requirements on crew activities. If you demand all 18 tanks cleaned overnight by six crew, you need to realise fully what you are asking those crew to do in this case cut corners and work at unrealistic speed.

We are all in this together and together we have a role to play in identifying and implementing the solutions. We all want an industry that is safe to work in and we all want to be proud of our industry's safety record.

I hope we can successfully achieve this goal together – lives depend on it!

Just imagine how much better Quality but also Health and Safety systems were geared up, tuned to pick up this drift ?!?! Our systems would help our people to stop the drift, to bring it back to the imagined, agreed, approved level!!

Also imagine accident investigators concentrated on the drift not on humans. Would we see same accidents happening again and again?

Captain Kuba Szymanski, FNI