m.v. "Petrolab"

Inquiry under Section 504
of the
Canada Shipping Act

Prepared for the Minister of Transport
by
Captain Robert Milne

September 23, 1999

MARINPRO

Table of Contents

Preface

This report summarises the findings of an inquiry into the conduct of Captain William O. Blagdon when acting as Master, and Mr. Brian Legge when acting as Chief Officer, of the m.v. "Petrolab", which was berthed at St. Barbe, Newfoundland, on July 19, 1997, and sustained extensive damage when an explosion and fire occurred.

The inquiry which was commissioned by the Honourable David M. Collenette, Minister of Transport pursuant to section 504 of the *Canada Shipping Act* was carried out by Captain Robert Chambers Milne, President, Marinpro Inc., Halifax, Nova Scotia.

Statement of Case

The m.v. "Petrolab" had returned to St Barbe, Newfoundland, in ballast after delivering a cargo of gasoline to St. Augustine, Quebec. The cargo to be loaded at St. Barbe was to be diesel oil, necessitating cleaning of the cargo tanks to avoid contamination of the diesel oil.

On July 19, 1997, at approximately 20:00 hrs. local time, an explosion and fire occurred resulting in extensive damage to the vessel, the death of the vessel's owner, Mr. William Normore and severe injuries to the vessel's Chief Engineer, Mr. David Blandin from which he later died.

It is alleged that Captain William O. Blagdon, the holder of Certificate of competency number 716881 as Master of Home Trade and Mr. Brian Legge, the holder of Certificate of competency number 82391 as Mate of Home Trade Steamship and Second Mate of a Foreign Going Steamship, on the m.v. "Petrolab" at the time bear responsibility for the explosion and fire which occurred, in that they failed:

1. to comply with the requirements of paragraph 33(1)(b) of the *Safe Working Practices Regulations* which states "In any working area where flammable gas, vapour or dust is present in the atmosphere, no person shall use....(b) any equipment or materials that are spark-producing";

2. to use the slop tank during the operation prior to the explosion so as to reduce the gaseous vapours in the 'tween deck area and through the ship. Use of the open cofferdam in place of the slop tank created a hazardous environment.

3. to carry out in a safe manner tank cleaning operations as follows:

   (a) tanks were not drained, gas freed and secured as each tank was completed;

   (b) gasoline/water residues were not pumped from the cargo tanks to the slop tank by the ship's piping system designed for this purpose;

   (c) the discharge line from the portable pump was rigged in such a way that there was a danger of a discharge of static electricity;

   (d) fumes from the open cofferdam were permitted to permeate other spaces on the ship, in particular the 'tween deck, through the grating at the top of the cofferdam, and to the main deck through the open hatch to the cofferdam, and to the machinery space through the hatch connecting the machinery space and the cofferdam.

4. to comply with the *Canada Labour Code* by failing to do the following:

(a) to use safety materials, equipment, devices and clothing as are prescribed for the employee's protection;

(b) to follow prescribed procedures with respect to the safety and health of employees;

(c) to take all reasonable and necessary precautions to ensure the safety and health of the employees and any person likely to be affected by the employee acts or omissions;

(d) to report to the employer any thing or circumstance in a work place that was likely to be hazardous to the safety or health of the employee, other employees or other persons granted access to the work place by the employer.

Conduct of the Inquiry

The inquiry was held over three days, on November 16, 1998 and on June 10 and June 11,1999 at the Delta Hotel in St. John's, Newfoundland.
Delays in convening the inquiry resulted from the personal family circumstances of one of the affected officers. As well, it became necessary to postpone the inquiry pending the conclusion of an RCMP investigation into the incident and an ongoing investigation by the Transportation Safety Board. These investigations were reported to have been completed prior to reconvening on June 10, 1999.

The following persons took part in the inquiry:

- Captain Robert C. Milne, Commissioner of Inquiry
- Elizabeth M. Heneghan, QC, legal assistant to the Commissioner
- Captain Wylie Stewart, presenter for the Department of Transport
- John Young, counsel for the Department of Transport
- Captain William O. Blagdon
- Corwin Mills, QC, counsel for Captain Blagdon
- Mr. Brian Legge
- Fred Constantine, counsel for Mr. Brian Legge.

Transcripts were prepared by Ms. Judy Lockyer, Discoveries Unlimited Inc.

Exhibits were entered into evidence. These are presently in the custody of Ms. Heneghan.

The inquiry was open to the public.

Although it is understood that some reports had been published in Newfoundland news media prior to the inquiry, it is important to note that the Commissioner did not see any of these articles. Thus only the evidence and testimony presented during the hearings was considered.

In addition, it should be noted that, in this present inquiry no witnesses were called other than the Master and the Mate. I have therefore given little weight to an affidavit of a previous master of the vessel, who was not available for cross-examination.

Thus, my findings are based primarily on the admissions and statements of Captain Blagdon and Mr. Legge as presented during the public hearings.

It should be noted that prior to reconvening the inquiry on June 10, 1999, Mr. Brian Legge had agreed to a statement of facts. That statement of facts was not considered in assessing the evidence and testimony relative to the case against Captain Blagdon.

Findings

Review of the evidence and testimony shows that the tragic incident on board the m.v."Petrolab" was an accident which was bound to happen sooner or later. While it is beyond the mandate of this inquiry to investigate the cause or causes of the accident and roles of individuals other than the Master and the Chief Officer, the evidence presented shows that a number of preconditions for disaster had been permitted to exist and develop over time. These include:

- ignorance of good tanker management practices;
- lack of technical knowledge on the part of the owners and crew;
- poor vessel maintenance;
- breakdown of the chain of command;
- flawed regulatory approval and inspection;
- fear of loss of employment;
- a lack of documented safety instructions

The above factors mitigate to some extent the conduct of the Master and the Mate of the m.v."Petrolab". However, if similar accidents are to be avoided in future it is incumbent on owners, regulatory authorities, masters and crews to reexamine their own practices and procedures and to determine if they are contributing to safe operating environments. The Transportation Safety Board inquiry into the cause of the explosion and fire has dealt to a large degree with the preconditions existing on the m.v."Petrolab". For that reason I have chosen not to comment particularly on the above factors.

Case against Brian Legge

Prior to resumption of the inquiry on June 10, 1999, Counsel for Mr. Legge and the Counsel for the Department had prepared a Joint Statement of Facts to which Mr. Legge agreed. This had the effect of reducing the allegations against Mr. Legge to No's. 1 and 3.(d).

First Allegation:
Failure to comply with the requirements of paragraph 33(1)(b) of the Safe Working Practices Regulations which prohibit the use of any equipment that is spark producing in a working area where gas is present in the atmosphere.

It was clearly established by photographic evidence and by Mr. Legge's testimony that a gasoline driven (i.e. spark producing) portable pump was being used on the deck of the m.v."Petrolab" at the time of the explosion. Although it has not been shown that this pump contributed to the explosion, the deck of the ship was entirely within the area which any prudent person, let alone the chief officer of the vessel, would normally assume to be hazardous. **I therefore consider the allegation to be proven.**

Third Allegation:
Failure to carry out in a safe manner tank cleaning operations as follows:

> (d) Fumes from the open cofferdam were permitted to permeate other spaces on the ship, in particular the 'tween deck, through the grating at the top of the cofferdam and to the main deck through the open hatch to the cofferdam and to the machinery space through the hatch connecting the machinery space to the cofferdam.

Use of the open cofferdam for the collection and retention of slops would have inevitably led to the production and collection fumes in the hazardous areas of the ship, including the machinery spaces and other areas open to the 'tween deck. Any knowledgeable ship's officer (tanker operator or not) would have been aware of the inherent dangers of the particular method of tank cleaning being used.

The evidence presented, pointed to Mr. Legge's ignorance of safe tanker operations. The fact that Mr. Legge had obtained all of his tanker experience on board the m.v."Petrolab" emphasises the dangers of a regulatory/ certification process which permitted officers to learn erroneous practices, on-the-job, from previous officers. Apparently none of the owners prior to Mr. Normore, nor Mr. Normore had seen fit to provide operational or safety manuals of instruction. Neither had any of these owners provided the opportunity for training key personnel. Mr. Legge for his own part, and by his own admission had done very little to learn proper safety procedures from textbooks. Nevertheless his tanker operator endorsement was legally obtained. One has to wonder how many other operator endorsements have been issued to officers who have had little but misguided on- the - job training!

I accept that **the allegation 3.(d) is true in substance**, and note that the Transport Canada presenter contended that responsibility may lie in greater part with other parties. I do not entirely share the latter contention. As one of only two officers (the other being the deceased Chief Engineer) having a tanker operator endorsement, and as the officer normally responsible for cargo operations, Mr. Legge had a responsibility to himself, his shipmates and the owner, to ensure safe operations. He was aware of the degree of reliance and trust placed in him by the vessel's owner. In my opinion, in accepting a position of responsibility and trust it was incumbent on Mr. Legge to improve his own knowledge of safe operations and to share that knowledge with the owner.

The Department of Transport withdrew all of the allegations for failure to comply with the Canada Labour Code.

Mr. Legge's Oil Tanker Endorsement was issued on the flawed assumption that his experience had provided him with the necessary knowledge to safely perform the duties of first mate on an oil tanker. The fatal explosion on m.v."Petrolab" occurred while unsafe methods were being used to clean the ship's cargo tanks. Mr Legge was the officer in charge of that operation. While it has not been possible to establish definitively the

point at which ignition occurred it is a fact that hydrocarbon gases in explosive mixture were released into the 'tween decks and pump room. There are strong indications that they might even have penetrated the engine room.

Mr. Legge has had no proper training in tanker operations, and although he obtained his endorsement through entirely legal means, he demonstrated a surprising degree of ignorance of basic principles in the safety aspects of these operations. Apart from some prior reading on tank cleaning procedures in crude oil tankers he had done nothing to learn about established methods for cleaning after gasoline and diesel oil cargoes.

Mr. Legge has recently been appointed chief officer aboard a passenger/truck/car ferry of some 7,400 tons. In such a key position, it is of fundamental importance to the safety of passengers and crew that he understands, respects and implements the relevant provisions of the Canada Labour Code. Mr. Legge has little or no knowledge of the requirements of the Code designed to provide a safe workplace.

In making the following recommendations, I have considered the degree of co-operation that Mr. Legge exhibited during the inquiry, as well as the trauma of his experience aboard the m.v."Petrolab". He has admitted that he has made mistakes and appears eager to learn from them. The recommendations are intended as corrective discipline to assist him meet his potential as a ship's senior officer. Mr.Legge has agreed that he is not competent to act as first mate of a tanker until he has received proper training.

Recommendation No. 1

It is recommended that the oil tanker endorsement to Brian Legge's Certificate of Competency as First Mate Home Trade/Second Mate Foreign-Going be withdrawn until he has successfully completed an Oil Tanker Safety Course, Level 2.

Recommendation No. 2

It is further recommended that Mr. Legge should be required to demonstrate to an Examiner of Masters and Mates that he understands the responsibilities of the employer and employees as defined by the Canada Labour Code, the Marine Occupational Safety and Health Regulations and the Safe Working Practices Regulations within nine months. Failure to do so should result in the suspension of his Certificate of Competency until such time as he does.

Case against William O. Blagdon

Prior to presenting the case against Captain Blagdon, Transport Canada withdrew some of the allegations.

The allegations which were allowed to stand are as follows:

That he failed:

1. to comply with the requirements of paragraph 33(1)(b) of the *Safe Working Practices Regulations* which states "In any working area where flammable gas, vapour or dust is present in the atmosphere, no person shall use....(b) any equipment or materials that are spark-producing";

3. to carry out in a safe manner tank cleaning operations as follows:

   (d) fumes from the open cofferdam were permitted to permeate other spaces on the ship, in particular the 'tween deck, through the grating at the top of the cofferdam, and to the main deck through the open hatch to the cofferdam, and to the machinery space through the hatch connecting the machinery space and the cofferdam.

4. to comply with the *Canada Labour Code* by failing to do the following:

   (b) to follow prescribed procedures with respect to the safety and health of employees;

   (c) to take all reasonable and necessary precautions to ensure the safety and health of the employees and any person likely to be affected by the employee acts or omissions;

   (d) to report to the employer any thing or circumstance in a work place that was likely to be hazardous to the safety or health of the employee, other employees or other persons granted access to the work place by the employer.

Captain Blagdon's Background.

William Oscar Blagdon was born in 1938, in English Harbour West, Newfoundland. His schooling took him up to Grade 8 in 1954, and thereafter he went to sea. His sea-going career started as a deckhand on fishing boats, and progressed in various capacities up to Master (Home Trade). His Certificates of Competency were obtained after successfully passing intermediate examinations for Master (350 tons), Mate Home Trade and ultimately, in 1978, Master Home Trade. Much of his studying for these examinations was self-directed and was carried out in spare time at sea. He was first appointed relief master (of a Fisheries Department vessel) in 1974 with a Department of

Transport exemption to the certification requirement.

His seagoing service has included a wide variety of experiences: on fishing vessels, fisheries protection vessel, hydrographic survey support ships, towing oil barges, small dry cargo vessels and coastal passenger ferries. However, he had not operated a tanker prior to being engaged as master of the m.v. "Petrolab" (once for a brief period of about two months in 1996, and again in 1997 immediately before the fatal incident).

Conditions on board.

Captain Blagdon testified that he was not happy with conditions aboard the m.v."Petrolab", including her state of repair and limitations on the level of authority he had been permitted to exercise during his first tour of duty aboard. He reported particularly that he was aware that the vessel's tank stripping system was inoperative and apparently had been that way for many years, and that fumes were present in the crew accommodation.

He also testified that the vessel's owner had informed him that the Mate, Brian Legge, was to be in charge of all cargo work. According to Captain Blagdon unsafe practices were continuously in use on board. These included chipping (de-scaling rust and paint) with spark producing tools, unorthodox use of the engine room escape hatch for routine exit to the deck, instances of overloading (sub-merging the vessel's loadline). His sailing orders would on occasion be received indirectly through crew members and even in one instance from the cook. The owner, Mr. William Normore, was frequently on board, sometimes sailing as a supernumerary. On these occasions Mr. Normore would take charge of all but the navigation of the ship. Complaints which Captain Blagdon made to the owner concerning unsafe working practices were apparently ignored. Likewise his concerns about circumvention of his authority as master were reported to be ignored. It is noted that no written evidence of these complaints was produced.

Captain Blagdon's testimony was largely substantiated by that of Mr. Brian Legge who, in addition, confirmed the absence on board of: safety procedures manuals, standing orders, written instructions from owners (past and present), and of master's written night orders.

The foregoing conditions existing on board were also confirmed in the Transportation Safety Board's report of the investigation into the cause of the incident.

Captain Blagdon further testified that following his first tour of duty on the m.v."Petrolab" he had no intention of returning to the vessel. He was apparently persuaded to rejoin in May 1997 when the owner promised to make the changes he had requested. In this regard it is unclear what specific changes Captain Blagdon had requested, other than repair of the stripping system and correction of problem of fumes in the accommodation. It is uncertain that Captain Blagdon confronted Mr. Normore at that time regarding his concerns about his level of authority. In any event, it appears that the only correction which had been made prior to his return to the m.v."Petrolab" on or about

May 25, 1997 was to eliminate the problem of fumes in the accommodation. Nothing was done to re-establish a proper chain of command on board. Again it is noted that Captain Blagdon did not put his complaints in writing. A prudent master would normally have recorded such serious concerns and would have obtained a written commitment from the owner prior to returning to the ship.

According to Captain Blagdon he was made to feel like an interloper on board. His authority was so undermined that following an incident in Fox Harbour on July 1st 1997, when Mr. Normore insisted on pumping out cargo during a fireworks display on the wharf, Captain Blagdon decided to resign. He set the date for August 8th, 1999.

Captain Blagdon's testimony was at times somewhat disjointed, lengthy and rambling. Nonetheless, what emerged was a picture of a knowledgeable and experienced master whose authority on the vessel was undermined by an untrained and uncertificated owner. The latter it would seem commanded the loyalty of the crew to the detriment of the authority of the most qualified professional seafarer on board the m.v. "Petrolab". Captain Blagdon had extensive technical knowledge which a prudent owner would have done well to exploit.

Captain Blagdon was obviously in a difficult situation. He had responsibility without authority. It would have taken a strong willed, decisive person to overcome that difficulty. If he complained too much he would be out of work. If he stayed aboard, he would undoubtedly become little more than what he regarded himself to be — the ship's navigator. As an outsider, he had no one with whom to discuss his untenable situation. He decided to quit — but not immediately.

Responsibility and Leadership

> *The captain of a merchant ship, qualified by the appropriate certificate of competency, is appointed by the shipowner. He has the responsibility to prosecute efficiently the voyage and has an overriding responsibility to ensure the safety of his passengers, crew, ship and cargo with the duty generally to save and preserve life at sea. In the event of his death or incapacity command descends to the second in command who is the senior deck officer and then through the other deck officers in order of rank.* (Shipmaster: as defined by the Nautical Institute).

It has long been the policy of the law to support the shipmaster in his task.
The merchant code of Pisa promulgated in 1160 A.D. affirmed the power of a *capitaneus marinarii* to make a general average sacrifice; while the title *majister sub deo* found in the contemporary English legal documents implied an absolute authority over ship and crew. Support from modern law takes a more paternal form, and the operation of a ship is closely regulated. Nevertheless the law is there to support the shipmaster.

Few people have to carry the burden of absolute responsibility for the safety of the ship and those on board, as society places on the shoulders of the ship master. It is therefore, distressing in the emotional sense of the word when the shipowner fails to support the

master in exercising authority. A master whose authority has been undermined can never be fully in command of his ship and, therefore can never be sure that orders given in time of emergency will be obeyed.

Leadership comes easily to some, whilst others have to learn the hard way. A master who fails to maintain standards, be they personal or professional, cannot expect others to maintain them.

In deciding to "bide his time" before leaving the ship and Mr. Normore's employ, Captain Blagdon did not recognise and fulfill his ultimate responsibility for the safety of his crew and his ship. In fact, it can be argued that his complacency contributed to the perpetuation and further deterioration of those sub- standard safety conditions over which he had expressed concern. Captain Blagdon, had he analysed his situation effectively, should have realised that he had options including reporting his concerns to a Transport Canada - Ships Safety Inspector or ultimately to walk off the ship, taking his Certificate of Competency with him, in which case the "Petrolab" would have been unable to sail.

Findings in the Case Against William Blagdon

The specific allegations related to the explosion and fire which took place on July 19, 1997 are addressed in this section.

First Allegation:
That he failed:

> to comply with the requirements of paragraph 33(1)(b) of the Safe Working Practices Regulations which states "In any working area where flammable gas, vapour or dust is present in the atmosphere, no person shall use....(b) any equipment or materials that are spark-producing";

Captain Blagdon's counsel argued that since the owner was on board and had taken charge of tank cleaning operations, the Master was not responsible for the methods used. I find that argument unconvincing. Captain Blagdon, (by his own admission), actually placed a rubber tire under the portable gasoline driven pump being used on the deck of the m.v."Petrolab" so that it would not move around. He made no attempt to stop the operation of the pump although he was well aware of its intrinsic spark producing nature. By so doing, he not only failed to comply with the requirements of paragraph 33(1)(b) of the *Safe Working Practices Regulations* , but actually contributed to the dangerous practice.

Additionally, the deck area of the m.v. "Petrolab" was entirely within the hazardous zone of the ship, and any prudent person would have realised it. However, Captain Blagdon was not just any person. He was master of the ship. Throughout his testimony he demonstrated considerable knowledge of tanker operations and was aware of the dangerous nature of tank cleaning operations.

As a consequence, I find the **allegation is proven**.

Third Allegation:
That he failed to carry out in a safe manner tank cleaning operations as follows:

> fumes from the open cofferdam were permitted to permeate other spaces on the ship, in particular the 'tween deck, through the grating at the top of the cofferdam, and to the main deck through the open hatch to the cofferdam, and to the machinery space through the hatch connecting the machinery space and the cofferdam.

Use of the open cofferdam for the collection and retention of slops would have inevitably led to the production and collection fumes in the hazardous areas of the ship, including the machinery spaces and other areas open to the 'tween deck. Any knowledgeable ship's officer (tanker operator or not) would have been aware of the inherent dangers of the particular method of tank cleaning being used. But Captain Blagdon was not just any knowledgeable officer. He was Master of the ship. He may not have been directly involved with the tank cleaning operation, but he did know it was being done.

Captain Blagdon had previously inspected the ship and knew that the open- top cofferdam was being used for collection of slops. He confirmed that he knew it was being used on July 19, 1997, because the Second Mate told him he had been inspecting the level in the tank when he got soaked with the discharge from the hose. Captain Blagdon complained to the owner about the danger of sending someone into the 'tween deck alone when the tank pumping was going on. At that time Captain Blagdon knew that there must have been fumes in the 'tween deck, since the Second Mate's wet clothing had "an awful odour of gas". Yet, he did nothing except to warn the owner not to send anyone into the 'tween deck.

I therefore find that the **allegation is true**.

Fourth Allegation:
That he failed to comply with the Canada Labour Code by failing to do the following:

> (b) to follow prescribed procedures with respect to the safety and health of employees;

No evidence was presented to support the existence of prescribed procedures, and furthermore, the vessel's owner was on board and directing the tank cleaning operation. Accordingly, this **allegation is not sustained**. However, as a Master with over 20 years experience Captain Blagdon should have been aware of the requirements of the Canada Labour Code.

> (c) to take all reasonable and necessary precaution to ensure the safety and health of the employees and any person likely to be affected by the employee acts or omissions;

This allegation is similar to that in (b). However although Captain Blagdon complained to the owner about certain unsafe practices, and in some situations did act to ensure the health of the employees, he did not take other more drastic measures to ensure the *safety and health* ---------*etc.* such as disabling the gasoline pump or of informing a Steamship Inspector or the RCMP. However, on the basis that on the fateful day, the owner was on board, technically the **allegation can not be sustained**.

> (d) to report to the employer any thing or circumstance in a work place that was likely to be hazardous to the safety or health of the employee, other employees or other persons granted access to the work place by the employer.

The evidence shows that Captain Blagdon was aware that the use of a gasoline driven pump that day was hazardous. In addition, he had placed a rubber tire under it to stop it vibrating over the deck. By so doing, it can be argued that he condoned the use of the pump. He did nothing to inform the owner (the employer) of his concerns.

As a consequence I must find that the **allegation is true.**

Summary of Findings in the Case Against William Blagdon

It has been established that Captain Blagdon failed to comply with 33(1)(b) of the Safe Working Practices Regulations by allowing the operation of a spark producing pump in the hazardous zone of the deck of the m.v."Petrolab" and consequently the first allegation of the Statement of Case is correct.

The allegation that he failed to carry out the tank cleaning operation in a safe manner by permitting gaseous fumes from the open cofferdam "to permeate other spaces on the ship, in particular the 'tween deck, through the grating at the top of the cofferdam and to the main deck through the open hatch to the cofferdam and to the machinery space through the hatch connecting the machinery space to the cofferdam", has also been sustained.

The allegations of failure to comply with the Canada Labour Code were not sustained except in the case of:

> d) failure to report to the employer anything or circumstance in a work place that was likely to be hazardous to the safety or health of the employee, other employees or other persons granted access to the work place by the employer.

which allegation I found to be true.

Captain Blagdon is a knowledgeable master who was caught up in the untenable situation of having his authority undermined by his employer. Undoubtedly, coming late in a long sea-going career, this incident will have had a traumatic effect on him. He believes that, in general, owners of small vessels routinely usurp masters' authority.

In testifying, Captain Blagdon exhibited the signs of stress one might expect in the situation. Also, I found some of his testimony rambling and conflicting.

He exhibited no signs of contrition nor acceptance of any part of the blame for the circumstances and conditions on the m.v. "Petrolab" which led to the tragic incident.

Throughout his two brief tours of duty on the ship, he did not succeed in taking command. He made no effort to establish written procedures for any of the vessel's operations, nor did he question the absence on board of instructions issued by the present or previous owners. He appeared to accept without question the Mate's superiority over him in matters of cargo operations.

He showed general knowledge of the principles of the relevant provisions of the Canada Labour Code, but ignorance of the detail.

His counsel contended that when the owner was on board Captain Blagdon could not be held responsible for any of the employer's obligations. While this may be technically correct, as previously mentioned there is long-standing precedent in support of a master's position as *majister sub deo* implying an absolute authority over ship and crew. Captain Blagdon showed no real willingness to accept his responsibilities despite his diminished authority.

In my opinion Captain Blagdon is presently unfit to be in command. I believe it will be necessary for him to convince an Examiner of Masters and Mates that he fully understands a master's responsibilities, and obligations to owner and crew.

Recommendation

It is recommended that Captain Blagdon's Certificate of Competency be suspended until he demonstrates to an Examiner of Masters and Mates that he understands the responsibilities of the employer and employees as defined by the Canada Labour Code, the Marine Occupational Safety and Health Regulations and the Safe Working Practices Regulations.