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COMMISSION OF ENQUIRY

APPOINTED TO ENQUIRE INTO THE TRAGIC

INCIDENTS WHICH OCCURED ON THE 25th FEBRUARY 2022 AT

FACILITIES OWNED BY PARIA FUEL TRADING CO.LTD

LOCATED AT NO.36 SEALINE RISER ON BERTH NO.6,

POINT-A-PIERRE

LMCS CLOSING SUBMISSIONS

One must take care not to cause injury to others, but there is no general duty to act for the benefit of others. The rule is that I must not harm my neighbour (misfeasance), not that I am required to save him (nonfeasance). "*The very parable of the good Samaritan…which was invoked by Lord Atkin in* ***Donoghue v Stevenson****…illustrates, in the conduct of the priest and the Levite who passed by on the other side, an omission which was likely to*

have as its reasonable and probable consequence damage to the health of the victim of the thieves, but for which the priest and the Levite would have incurred no civil liability in English Law." Page 92 Winfield and Jolowitcz on Tort 13th edition taken from **Home Office v Dorset Yacht Co. Ltd** [1970] A.C. 1004 at 1060 per Lord Diplock. It seems that this legal position is the guiding light which pervades Paria's stance taken from the onset of their position on the Scope of Works to the decision not to permit a viable rescue of the men within the 30 inch pipelines at S.L.36.

SCOPE OF WORKS

Contrary to reasonable commercial considerations, industry standard and specifically stated conditions as expressed in the scope of work, **Paria Fuel Trading Company Limited** seems to be saying to this Commission that the contract between itself and LMCS was on a "Turn Key" contract basis.

I have extrapolated from various sources that the very basic features of a turn key contract vests (1) design (2) source of materials (3) control or substantial control of site and (4) completion time ENTIRELY TO THE CONTRACTOR. Turn key concept of contract envisions that the

CONTRACTOR takes CHARGE of the project. It is not subjected to a system requiring approvals and permits and vesting in the asset owner a STOP policy.

None of these key concepts were in LMCS control. In fact, in Paria's investigation report, they themselves were not convinced that this contract was a turn key contract. Page 1200 of the Core Bundle at clause 1.9 where it is stated that "Paria contracted LMCS Ltd to execute a TURN KEY TYPE CONTRACT entitled miscellaneous repairs and refurbishment works at No. 5 and 6 Berths." This report was subsequent to the incident, just to be clear.

This scope of work was, according to Paria's code system, assigned under code 8107 for Installation and Maintenance work which is a category designated as HIGH RISK WORKS. (Page 7701 of Bundle of Submissions). This particular code is instrumental in deciphering, one would expect, the contract and commercial considerations for the job to be tendered. The inherent high risk component of the contracted works therefore placed its execution to be subjected to a "Permit to Work/ Standard Work Instructions/Safety Rules" requirement. This is specifically codified in the

Scope of Works at paragraph 8.0. There is no inference of the fact of this condition. It is expressly stated. It follows in the context of industry standards. Paria did not attempt at this initial stage of its contract to extricate itself from this duty and standards contained in their PERMIT TO WORK/STANDARD WORK INSTRUCTION AND SAFETY RULES.

Paria's position advanced after the 25th February, 2022 is however different. I have, read and flipped and perused the Scope of Works from which Paria's conditions of the work were expressed and am still to find one clause which expresses that any of the contractor bidding for this scope of works was to provide expertise that is to say ADVICE on the job. We can accept that the contract is for a specialist services and equipment. But this is very different from being a specialist contractor hired for its expertise within the meaning of ADVICE.

At the very introduction at 1.0 of the SOW Paria page 560 of CB, being the author of this document, states "Paria Fuel Trading Company Limited (Paria) is seeking to engage the services of an experienced and qualified Construction and Fabrication Contractors for the execution of

miscellaneous works detailed below". This Scope of Works is the basis of what Paria required. It is a document being communicated to a number of contractors that are registered under service code 8107 which according to Paria's Rajendra Mahase has some 259 recommended applicants. I invited you Mr. Chairman and Mr. Commissioner to look at this Scope of Works and to come to the very quick conclusion that Paria is by peddling a narrative of "turn key" and "special contractor" and "expert" is attempting to do nothing more than to shift the duty of care to ensure a safe system of work from itself to be squarely on LMCS Limited. [Paria has a clear appreciation of the difference between the SERVICE contract and ADVICE contract.]

Kenson's denial of certain duties, I believe, has shattered protection on privilege in respect of the contract existing between itself and Paria. I invite this Commission to consider Kenson's contractual obligations as Kenson was not treated as a separate entity from Paria (bound by agency).

The confirmation that LMCS understood it was a job for provisions of services and equipment are contained in:

1. LMCS proposal contained at CB – PAGE 654 where LMCS confirms that "the work entails the provision of labour, equipment, material as specified, and supervision for the Civil Works required…"
2. CB 658- the work plan would be carried out as follows:
    - LMCS Limited will work with Paria Fuel Trading Company Limited to confirm all engineering requirements (including quality control/assurance activities) for the contract prior to placement of the purchase orders for equipment and materials.
    - Paria Fuel Trading Company Limited and LMCS Limited will conduct Job Hazard Analysis (JHA's) and Risk Assessments as required for all activities associated with the Project.
3. CB 656 Project Control- Progress measurement and reporting frequency/formats will be determined by the LMCS Ltd and Paria Fuel Trading Company Limited Project Teams. Paria's reliance on LMCS "expert advice" in whichever incarnation of the term is plainly put unsupported and ought to be rejected as a matter of fact.

EXPERT

The value of having an EXPERT contractually called "project consultant" or "project engineer", I submit, is the fundamental basis upon which the delta p event leading to the death of the 4 LMCS workers rests for several reasons. In the first place, the development of the scope of works lacked crucial information on the layout of S.L. 36. A schematic was presented. There may be no fault on the face of the drawing, but it was clearly misleading. To date we still don't know the bottom profile of SL 36. This system it seems from the evidence is of some vintage. The contract carried out by LMCS I am sure will not be the last of contracts to be performed on this system. Paria had a duty to LMCS and any other contractor providing services on its system to have a comprehensive inspection report. This seems to be common sense.

The second aspect of the scope of work deficiency is the lack of this expertise to evaluate intricacies which the job required. Paria's tender note at page 928 of the CB reads "LMCS has demonstrated in their prior performance that they have the required **management and resource competencies** to satisfy the contract requirements" and at page 931 under

the rubric "Technical Evaluation" the notes states "A technical evaluation of the five bids submitted was conducted by Technical and Maintenance Department and only one bid submission was found to be technically compliant with the requirements in the scope of works." What qualification and experience was brought to this evaluation process is? From the evidence, Paria is suggesting that LMCS possessed the expertise. Essentially hiring itself. Doing this clearly placed LMCS and its employees at an even higher level of risk in the performance of their work, as is evidence by the tragic incident. Clearly Paria lacked the expertise at the outset of the formulation of the scope and then evaluation.

Paria has admitted to knowing of its option of hiring a project engineer/consultant who would have had the requisite expertise to advise in the execution of this contract, but it chose not to. Mr. Terrence Rampersingh in his evidence relates that this was the MO of 2020 contract similar to this one. Saving the dollar for the cost of lives. That is what this decision comes down to.

EXECUTION OF WORKS

The works were executed, presumably, under a Safe System of Work policy which is the Paria's Permit to Work System/ Work Instruction/Safety System.

1. On the instructions issued by Paria for line clearing, I will submit that this is not a mere internal document. It was incorporated as an obligation in the Scope of Works at paragraph 8.0. However, the monitoring of this process for line content removal rest squarely with Paria (both in respect of measurements and systemic control). It is Kazim Ali's evidence that the measurement of line content received was "negligible" and LMCS aim was to ensure an ullage (See page 36-37 of the Transcripts of Day 4). What is clear is that between the contractor and Paria there seem to be a variance on the amount line content to be removed. A clear indication that a single appointed project manager/engineer from Paria would have eliminated misunderstandings. If LMCS knew the amount of content being removed, then it will have been clear that there wasn't a solid leg of liquid under the plug, on which its methodology was

premised. [In the investigation of the movement of barge issue with Dexter Guerra, there is a statement to Mr. Archbold about LMCS being concerned of the pollution **[see 2922 of Supplemental Witness Statement bundle]**. Certainly, if LMCS knew it removed all or most of the line content this will never have been a concern- POINT TO GENUINE BELIEF OF LINE CONTENT- STATEMENT BEFORE INCIDENT]

2. The PTW system incorporates 3 categories of approved documents (which it incorporates and should be taken together as a whole)- Method Statements, JHA's and Certificates. LMCS produced Method Statements and Job Hazards Analysis to Paria for review and approval. These were provided by way of emails. The purpose being to execute the works safely. This review and approval process must be predicated on Paria's competence and expertise to effectively evaluate and scrutinize the contractor's proposed work method. This is a burden that Paria carries. Save for one clarification about the plugs, all was accepted and approved. That specific clarification FROM PARIA dealt the plugs, where Paria was informed that the methodology to be

employed will be to removed them manually and to reinstalled at the top of the riser. IT CLARIFIES THE METHODOLOGY LMCS is to employ. The PTW **does not** specify methodology of the work to be accomplished. There is no more clarity to this.

This brings me to issue of the PTW 9320 which stated "barriers to be use". Barriers to be used cannot and should not be equated to barrier to remain or barrier not to be removed. This is a convenient argument mounted by Paria, as the removal of the barrier was the delta p event.

In this safe work system however, there are checks and balances in place. Therein lies the importance of Tool Box meeting. What we have on this issue is Christopher Boodram's evidence that the removal of the plugs was discussed [See: pages 6 and 7 of Day 2 Transcripts]. This is corroborated by the action of the workers in the chamber. Missing, as a check and balance, was Mr. Majardsingh from the toolbox meeting, who as the Applicant for the works that day and who would have been in the position to make an objection

RIGHT THERE AND THEN. Claiming that monitoring of LMCS or any other contractor performing high risk work periodically around 4 times per day is wholly unacceptable in the scheme of safe system of work. This is a system failure.

Communication within the chamber while the men worked. This was established with both camera and radio- a simple request to adjust the view could be made. It seems ludicrous that Paria can have paid personnel on site who was actually monitoring the works in chamber out of curiosity but couldn't do so a matter of duty. This is a systemic failure of Paria. KENSON/PARIA CONTRACT.

DELTA P EVENT

Operating in an environment of consistent systemic failure allowed for the delta p event to take place.

LMCS in proceeding with the methodology to establish an ullage, from which LMCS assumed there was a solid leg of liquid/fluid. However, Mr. Ziad Khan opined that in addition to the excessive line content removal that the pressure at #5 was locked in until 25th February, and **only**

released when the riser was opened to conduct the Carber Test. I will invite the Commission to consider that this opinion is not based on the facts. Paria's daily report sheets **(Page 7288, Line 1)** shows that the line content removal was completed on Feb. 5th 2022.

Mr. Ali stated that the pressure was released (bleed out) from both ends of the pipe via the risers prior to ullage measurements pages 53 to 61 of transcript for Day 4.

Additionally, the daily report sheet **(Page 7291 & 7292 of the Bundle of Submissions)** for 10th and 11th February shows that the piping at the top of the riser was removed at #5 and line plugs were installed and a new flange welded on the riser Berth 5. The line plugs were then removed and a blind flange placed on the newly installed flange. Paria's reports show that the line plugs were then installed on February 13th Berth No. 6.

RESCUE

It is accepted that attempting to remove the inflatable plug created the delta p event causing the men, tools and BREATHING AIR to be sucked into the pipeline.

Once the disturbed waters around the chamber settled and the chamber returned to normal function mode, Andrew Farah in two separate incursions determined:

(i) The men were no longer in the chamber nor were the tools, bolts and **diving gear**

(ii) The riser was full of water

(iii) There was no sign of the contents of the chamber in the immediate vicinity of the riser, on the seabed, or floating on the surface surrounding the berth

this led to the conclusion that the men were in the pipe.

After discussion with site personnel Kazim Ali, Andrew Farrah and Dexter Guerra decided that they had, at the least, the minimum resources to do an incursion into the pipe. In addition to this on site plan, Farah called out Conrad and Conan Beddoe for additional divers and equipment. Sometime within this time-frame Kazim Ali spoke with Collin Piper and was told of this deduction.

There was no indication of an ICT being activated. In fact, up until these hearings LMCS never understood that Paria had activated the standardised ICT. They seem to be functioning for various places. This only highlights further a systemic failure of Paria.

The evidence elicited has shown that:

1. Paria prevented LMCS Ltd. from executing rescue plans that were continuously modified as more resources and information came to hand. The first denial to mount rescue attempts came around 3:30 PM when the PTW was pulled with the countervailing instruction to cease all diving. (Closed out work permit)
2. Paria made the rescuers believe that TTCG will be conducting a rescue when in fact there was no such determination until around 9PM.
3. Paria had no plans or attempt at any rescue over 25th, 26th, 27th February 2022.
4. Paria was informed of proof of life within the pipeline by the fact of Christopher Boodram's survival and distress signalling continued up to and beyond 2:30AM Saturday 26th, 2022. Boodram's

emergence from the pipeline UNAIDED was indicative of the conditions for a rescue being probably. Instead of acting on proof of life, Paria chose to discredit:

(i) The knocking heard emanating from the pipe at #5, saying it was noise from the equipment running at #6 Berth, a distance of a quarter mile away.

(ii) After Christopher's life saving heroics, Paria also chose to create denial of the existence of air pockets, saying they were not seen on camara footage, even though Christopher Boodram and 4 men survived for three hours with five tanks (which would have only given them one hour to live if they each used a tank).

5. Mr. Piper claimed that he wanted more information from camara footage before considering any dive rescue, but his repeated requests up to 9.00 p.m. on Friday, to the Coast Guard, to do a dive does not support this claim. (**Page 3011 Paragraph 10)**. From the statement of Mr. Seales **(Page 3135 paragraph 23)**, it can be seen that the TTCG were requested to consider 12.15 a.m. on 26 February.

6. After the footage was received at midnight Mr. Piper again asked the Coast Guard to dive and remove obstacles in the line, even though they had already told him that they were not trained for that and commercial divers would be more suitable.
7. Mr. Piper knew that LMCS had experienced commercial divers, onsite, some related and some not related, who were prepared to dive, yet they were not asked.

MISINFORMATION

8. Colin Piper, Mushtaq Mohammed, Michal Wei and Randy Archbald all say that they got expert advice that they should not allow diving into the pipe. The experts listed were OSHA, TTCG, OTSL, HULL, HHSL, EERS, Eastern Diving Services, Mitchell Professional Diving Services (MPDSL). From this list, the evidence shows that TTCG, EERS, and MPDSL were only asked if they would conduct a rescue. They said they, themselves, would not perform a rescue but never advised Paria that a rescue should not be performed. Mr. Seales denied any involvement as an ICT member or advisor to Paria.

9. Mr. Piper advised all, that Christopher Boodram said: "The men did not make it".
10. Then the other misinformation given was that there were dive bottles lodged in the line, the distance of that blockage location kept increasing in what seems to be an attempt to solicit a particular advice from the "experts" or to deter a rescue plan being executed or to justify not taking any action. Consideration of Mr. Piper's evidence that the spooling of the ROV tether, the length of the tether from the top of the riser and the slack of the tether MUST BE considered in respect of ACTUAL distance. There may have been an error of some 300% which only suited to DETER rescue efforts.

FURTHER MISINFORMATION- DELIBERATELY TO PROPAGATE AN UNTRUTHFUL PERCEPTION IN PUBLIC

There is a difference, it must be appreciated between I'm not prepared to go or send my men down the pipeline as it is too dangerous for them, and it is too risky to send divers into the pipe to rescue the men. The willingness of competent divers trained to undertake these risks with

equipment and support for the execution of the plan was all that was needed.

The first position seems to sit with ALL of the "EXPERTS" Paria placed reliance, while the latter seems to be the POSITION taken by Paria. It is of note that there is no evidence of "experts" being asked to show experience or a CV of any sort prior to Paria engaging them. In fact, it seems from the evidence that the experts weren't experts at all. In fact, diving into pipeline "is not a thing", yet there is evidence of Andrew Farrah, Kazim Ali, Christopher Boodram and Micheal Kurban diving into a pipeline.

One point of agreement from Mr. Donawa, Mr. Seales and Mr. Fuentes seems to be the best way to advise on a rescue plan was to undertake a site visit or soliciting information from on site personnel.

In his witness statement Mr. Piper made no mention of his fears of confined space rescuers dying whilst attempting to rescue people. Paria has its own Confined Space Rescue Protocol that could easily have been employed to formulate a rescue plan for the men in the pipe.

Mr. Piper's reference, spoke mainly of would-be rescuers rushing in to remove a victim without preparation: breathing air, communication and light. The incident happening at Berth #6 under water would negate any possibility of any rescuer impulsively rushing in, without his own breathing air, Scuba or surface supply.

LMCS PLANS

All plans considered by LMCS involved divers with air supply, and underwater light and initially rope for tethering and signalling and later umbilical in addition to rope that included camera lights and voice communication. This issue could have been easily dispelled with a hands-on approach with the divers on site or at the very least through Catherine Balkissoon.

Feet First / Head First?

LMCS always considered a feet first entry for rescue, this was what was discussed with Paria site personnel on Friday 25th and was the method of diving executed by Michael Kurban. If Paria had any degree of interest in a rescue then, the task of de-risking this methodology laid out by LMCS

could have been explored with all on site via Catherine through simply conferencing with the ICT from on site with LMCS personnel.

NOT SERIOUS ABOUT SAVING LIVES- Time was passing along while workers were reported hearing knocking noise. This was determined by varying knocking intensity and frequency. This was first heard by LMCS people at around 6.15 by Beverly **(Page 465 Paragraph 36).**

PARIA, FROM THEIR EVIDENCE, DID NOT SHARE THIS VIEW. Their evidence is that they verified no knocking noises. From the autopsy report we know that there was life within this pipeline at the time the knocking noises were being heard. Paria continued to prevent a rescue diving plan from Berth 6, LMCS's main goal on saving these men turned to the entry point at Berth 5 where the knocking noises were being heard. On being informed of the knocking and confirming as coming from the pipe (ICT records knocking sounds heard at **1959 HRS**, **Page 1573.**

LMCS requested of Paria (i) Install riser extension at #6, removal of Blind Flange from top of Riser at Berth #5 and to remove chamber from over riser at # 6 Berth. This would have allowed at the very least an

investigation of system and at best allow easier access into the riser for rescue purpose. Statements of Kazim Ali at (**Page 2867 & 2872 Paragraph 98)-23.01.10- Supplemental witness bundle.** ICT logs **(Page 1573)** Statement of Randolph Archbald (**Page 1323-Paragraph 58),** Mushtaq Mohammed **(Page 1453 Paragraph 59)**, Catherine Balkissoon **(Page 1332-Paragraph 24)** and Colin Piper **(Page 1361,1362-Paragraph 81,84)**

Compressor failure was not reason for the request of riser installation. Mr. Piper himself confirmed that LMCS possessed a back-up compressor. The compressor in operations was functioning. LMCS on information being presented in real time, revisited rescue from an alternate point of entry. In this regard, LMCS suggestion for the blank to be removed from Berth 5 to hopefully save the men's lives from that end. However, to do so the belief was that the riser being extended to atmospheric height will not interfere with construct within the pipe thereby allowing the blank to be removed from Berth No. 5 to conduct at the very least investigation from No. 5 riser to mount a rescue or at best to actually rescue the men from this end.

Eventually Paria authorized the addition of the riser extension and the removal of the blank. However, the permission to remove the blank was withdrawn and not authorize until 5.00 am on the 26th February. Therefore, from 10PM on Friday to 5:00 am on Saturday there was no point of entry into SL 36. This secured only one thing- prevention of any diver having access into the pipeline. Removal of chamber came until 9.00 pm on the 26th February and eventually removed from over riser top. Of course, installation of the riser only meant completion of the sub-sea works at riser 6.

The need for "policing" on site to control LMCS workers is a diversion of efforts on all fronts. It takes away Paria from attending to…whatever they were attending to and ONLY creation of distrust. Had Catherine Balkissoon genuinely felt threatened by the LMCS workers' behaviour, would she have continued to be in their presence on their barge?

Mr. Ali's meetings to plead for rescue on Saturday was not treated with any seriousness or thought. Then the meetings on 27th February, 2022 were clearly only for the benefit of indulging LMCS, as a decision to move

to recovery was already made since Saturday night between Mr. Piper and Mr. Mohammed. In common parlance "a pappy show".

LMCS participation in this enquiry has been channelled to ensure that it delivers all that it has and all that it knows. However, despite the best efforts, it would not be surprising that the ever-evolving strategies engaged by Paria will warrant further information. LMCS itself possessed no strategy of conjuring or redesigning what has passed. However, what has become clear from the live evidence elicited is that there are three distinct categories of information- WHAT WAS, WHAT COULD HAVE BEEN AND WHAT SHOULD HAVE BEEN. These are not proceedings confined to pleadings and as this Commission will retire to deliberate on the evidence from the various documents, statements and viva voce evidence, I wish to volunteer to the Commission that should there be a need to seek any clarification on any aspect for which LMCS may assist, we stand ready.

Systematic failure of Paria in all stages:

1. From the design of the scope of works, commercial considerations outweighing safety considerations, improper evaluation process, lack of coherence between departments and with contractor, inefficiency and ineptitude in emergency response or refusal to respond, lack of consideration for the families.
2. Need for INTERNAL AUDIT OF THIS SYSTEM as a requirement of operations and it should be continuous.
3. Establishment of standards for school and diving- recognition and elimination of the hazards is fundamental.

THANKS

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