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COMMISSION OF ENQUIRY

INTO

ALL OF THE CIRCUMSTANCES WHICH LED TO THE TRAGIC INCIDENTS WHICH OCCURRED ON FRIDAY FEBRUARY 25, 2022, AT FACILITIES OWNED BY PARIA FUEL TRADING COMPANY LIMITED, LOCATED AT NO. 36 SEALINE RISER ON BERTH NO. 6, POINTE-A-PIERRE, WHICH LED TO THE DEATHS OF FOUR (4) EMPLOYEES OF LMCS LIMITED

SUBMISSIONS OF LMCS LIMITED ON LEGAL PROPOSITION RELATING TO NEGLIGENCE AND/OR CRIMINAL LIABILITY OF PARIA FUEL TRADING COMPANY LIMITED

BRIEF OVERVIEW

The Commission of Enquiry was appointed by the President of the Republic of Trinidad and Tobago.

The Commission is in charge of its own procedure and by Rules issued on 13th July, 2022 under **section 9 of the Commissions of Enquiry Act Chapter 19:01**, it published those rules. The Evidential hearings were concluded on the 13th January, 2023, which is specific to the Commission's Terms of Reference at (1) (i-xii) concerned mainly with the

inquisition into facts. However, arising from these Term of Reference at (2), is the Commission's mandate:

To make such findings, observations and recommendations arising out of its deliberations, as may be deemed appropriate, in relation to:

1. whether there has been any breach of duty by any persons or entities;
2. whether there are any grounds for any criminal proceedings to be initiated against any persons or entities;
3. whether criminal proceedings should be recommended to the Director of Public Prosecutions for his consideration;
4. the appropriate and best practices and/or policies and/or procedures to be utilised by companies such as Paria and LMCS for the conduct of these types of maintenance exercises and in response to these types of incidents;
5. the policies, measures, mechanisms and systems that should be implemented to prevent the recurrence of the tragic incidents which occurred on Friday February 25, 2022 and continuing up to the recovery of the bodies of the four (4) LMCS' divers; and
6. making any other recommendations that may be deemed necessary in the circumstances.

INVITATION FOR LEGAL SUBMISSIONS

On the final day of Live Evidential Hearing on 13th January, 2023, the Hon. Chairman to the Commission invited the parties, apart from the Legal Team to the Enquiry, to proffer their respective legal submission on the narrow issue of THE DUTY TO RESCUE the LMCS Limited (hereinafter "LMCS") workers trapped within the S.L. 36 between Berth

No. 5 and Berth No.6. With permission obtained from the Commission's Secretariat, these are the submissions on behalf of LMCS Limited.

UNCONTROVERTED EVIDENCE

It is uncontroverted evidence is that Paria prevented and/or directed and/or withdrew permission to LMCS Limited (whether by its own personnel or its volunteer divers on their behalf) to mount a rescue of the 4 men- Fyzul Kurban, Kazim Ali Jr, Rishi Nagassar and Yussuf Henry.

MULTIPLE CAUSES OF ACTION IN NEGLIGENCE

It may well be undisputed that the law is settled in respect of the proposition that Paria Fuel Trading Company Limited (hereinafter "Paria") has a non-delegable duty of care owed to the workers of LMCS Ltd at SL 36, Berth No. 6 on the 25th February, 2022. This proposition is supported on both a factual and legal front- classification of the works as "high risks", extrapolation from the evidence of the fact of the job being inherently dangerous and subject to the PTW system. See: the development of the principles that the employer's duty are threefold- "competent staff, adequate material and a proper system and effective supervision" **Wilsons and Clyde Coal co. v English** [1938] A.C. 57 to the local case of CV 2015-03381 **Ray Cheddie and Anor v National Infrastructure Development Company Limited** (already referenced by Counsel to the Commission in his submissions made on 13th January, 2023).

This particular non-delegable duty of care to which Paria is saddled is however separate and apart from the duty under consideration. That is to say, **the duty of Paria Fuel Trading Company Limited to ensure that LMCS Ltd workers trapped in SL 36 were rescued or, alternatively stated, that Paria had a duty to allow rescue attempts of the 4**

workers trapped in S.L. 36. Consequently, there are multiple breaches of duty arising from the incident of 25th February, 2022 leading to the death of the 4 LMCS employees.

THE DUTY OF CARE IN NEGLIGENCE

The general concept of duty of care is best explained in the treatise **Charlesworth & Percy on Negligence 12th Ed at paragraph 2.2** as follows:

"The word "duty" connotes a relationship by which an **obligation is imposed** upon one person for the benefit of another to take reasonable care in all the circumstances. Whether or not a duty of care exists on given facts is a **question of law**. Unless the existence of such a duty can be established, an action in negligence must fail. As Lord Wright put it in *Grant v Australian Knitting Mills Ltd*:

> "All that is necessary as a step to establish the tort of actionable negligence is to define the precise relationship from which the duty to take care is deduced. It is, however, essential in English law that the duty should be established: **the mere fact that a man is injured by another's act gives in itself no cause of action**: **if the act is deliberate, the party injured will have no claim in law even though the injury is intentional, so long as the other party is merely exercising a legal right:** if the act involves lack of due care, again no case of actionable negligence will arise unless the duty to be careful exists." (emphasis mine).

This is the justified veil behind which Paria, seems to be carefully shielding behind in its IMT's indecision to mount a rescue for the 4 LMCS workers and/or allow LMCS rescue divers to mount its rescue plans. This is so since on the face of the law, there seems to be no legal obligation which imposes a duty to rescue.

DUTY TO RESCUE AT COMMON LAW

There is no general duty to rescue a person in peril. In **Hargrave v Goldman** (1963) 110 CLR 40 at page 66 per Windeyer J it was stated that the law "casts no duty upon a man to go to aid of another who is in peril or distress, **not caused by him**". As such, it is fortunate that for every rule there must be exceptions. Lord Nicholls of the House of Lords in the case of **Stovin v Wise** [1996] 3 ALL ER 801 at page 807 states:

> "…the **bystander does not owe** the drowning child or the heedless pedestrian a duty to take steps to save him. **Something more is required** than being a bystander**. There must be some additional reason why it is fair and reasonable that one person should be regarded as his brother's keeper and have legal obligations in that regard**." (emphasis mine)

This proposition was the premise of the address by Chief Justice Terrence Higgins of the Supreme Court of the Australian Capital Territory titled "The Rescuer's Duty of Care". Chief Justice Higgins went on to state that there are 2 instances where **such a duty to rescue may arise**. The first being where the danger was created by the rescuers themselves: **Sutherland Shire Council v Heyman** (1985) 157 CLR 424 at pages 478-479. The second **circumstance arising from relationship between the endangered and the rescuer**: **Horsley v MacLaren** (1971) 22 DLR 3rd 545 (emphasis mine). At any rate, Chief Justice Higgins went on to state that common examples of such relationships include that of employers and employees.

In **Horsley v MacLaren**, *op cit* "M, an invited guest on a cabin cruiser, which was owned and was being operated by the respondent K, accidentally fell overboard. In the course of rescue operations, another invited guest, H, dived into the water to help him. The effort was without avail. The rescuer was pulled from the water by others on board, could not be resuscitated and was later pronounced dead. The body of the rescuee was never recovered. It was held per curiam **that there was a duty on the part of the respondent K in his capacity as a host and as the owner and operator of the cabin cruiser to do the**

best he could to effect the rescue of M." The majority of the Court decided that the rescue effort of the boat owner/operator, which was not done to recommended standard, was not a matter of negligence but a matter of error of judgment. There was dissent to this finding. There are two crucial elements of this case that are noteworthy. The first being that the obligation to rescue arose from the relationship between the owner/operator of the boat and invited guest. The second element being that the boat owner/operator did as a matter of fact employ a rescue manoeuvre.

It is uncontroverted that LMCS employees were present at Berth No. 6 at SL 36 for the sole purpose of executing works for Paria. There was an employer/contractor or employer/employee relationship in existence. It is fair and reasonable to accept that this relationship created the fertile ground for the duty to rescue to arise. Further, after Christopher Boodram's emergence followed by Michael Kurban's failed attempt to rescue the men (but his safe return from SL 36), Paria, as a matter of uncontroverted fact prevented any diving into SL 36, which sole purpose was for rescue. In other words, rescue was PREVENTED. Sometime between 6:30 PM and 7:00 PM on the said 25th February, 2022 LMCS Limited possessed the requisite man-power and equipment to proceed with rescue.

DECISION TO PREVENT LMCS DIVERS FROM RESCUE BY PARIA

Quite apart from the relationship of employer/contractor Paria is the owner/controller of the asset in question, i.e., SL 36. Paria has in its evidence disclosed that it could not allow rescue efforts as LMCS divers were "emotional" and considered instead the dangers to the rescuer. The facts below seem to have played little significance to Paria:

- That the divers were competent and possessed the requisite equipment. This should have been considered favourably by Paria, both at the material real time of the unfolding of the events on 25th February, 2022 and in hindsight.

- That the divers were suitably qualified and by the time of Christopher Boodram's unaided emergency from the pipeline, it was REASONABLE to assume that a strong, competent diver with all the necessary equipment would have been successful in mounting a rescue for the retrieval of the men or even introduction of breathable air to the men for their eventual rescue or at the very least allow for the development of an alternative rescue plan.

In **Tomlinson v. Congelton Borough Council** [2004] 1 AC 46, a matter concerning damage sustained by the Tomlinson while using a public lake, Lord Hoffman addresses "free will" as follows:

45. *I think it will be extremely rare for an occupier of land to be under a duty to prevent people from taking risks which are inherent in the activities they freely choose to undertake upon the land. If people want to climb mountains, go hang gliding or swim or dive in ponds or lakes, that is their affair. Of course the landowner may for his own reasons wish to prohibit such activities. He may be think that they are a danger or inconvenience to himself or others. Or he may take a paternalist view and prefer people not to undertake risky activities on his land. He is entitled to impose such conditions, as the Council did by prohibiting swimming.* ***But the law does not require him to do so***.

    At paragraph 46 he continues "*A duty to protect against obvious risks or self-inflicted harm exists only in cases in which there is no genuine and informed choice, or in the case of employees, or some lack of capacity, such as the inability of children to recognise danger (British Railways Board v Herrington [1972] AC 877) or the despair of prisoners which may lead them to inflict injury on themselves (Reeves v Commissioner of Police [2000] 1 AC 360).*

47. *It is of course understandable that organisations like the Royal Society for the Prevention of Accidents should favour policies which require people to be prevented from taking risks. Their function is to prevent accidents and that is one way of doing so. But they do not have*

to consider the cost, not only in money but also in deprivation of liberty, which such restrictions entail. The courts will naturally respect the technical expertise of such organisations in drawing attention to what can be done to prevent accidents. But the balance between risk on the one hand and individual autonomy on the other is not a matter of expert opinion. It is a judgment which the courts must make and which in England ***reflects the individualist values of the common law." (emphasis mine)***

While these views were expressed in the context of a person engaging in a risky recreational activity in a public space, it is instructive as to the choices taken by individuals, whether as recreation or to rescue. In various territories there have been legalisation which have been promulgated to address the issue of negligence of rescuers. This however does not arise in this case, as there was no rescue allowed.

As stated in the closing address of LMCS, Paria's modus operandi on the 25th February, 2022 up until 27th February, 2022 seemed to have been guided by the proposition of Law that: "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 however, that this was gross negligence on Paria's part.

CRIMINAL LIABILITY AT LAW ON GROSS NEGLIGENCE

In the case **of Inquest into the death of Ojo Moyo Oliver**, INQ 10 of 2008, Nalini Singh (sitting as Coroner) as she then was, aptly summarizes the law at page 12 as follows:

> *"It is stated in **Archbold 2008** at paragraph 19-110 that where an allegation of manslaughter is based on **AN OMISSION TO ACT** (not itself being unlawful), the issues to be left to the jury are whether a duty of care was owed to the deceased, whether there has been a breach of that duty; whether the breach caused death; and whether it should be characterised as gross negligence and, therefore a criminal act.*
>
> ***Charlesworth & Percy on Negligence** (London: Sweet and Maxwell, 2006) is also useful in this regard since it is stated at paragraph 1-16 under the rubric "Criminal Negligence" that "it must be proved, to the criminal standard, that the conduct of the accused was, in the first instance, such as to amount to **a breach of duty of care towards the victim**. The Crown must then show that the negligence in question **caused the victim's death** and should be characterized as gross negligence and therefore a crime. It is for the judge to direct the jury whether the facts are capable of giving rise to a duty of care and for the jury to decide, in light of the judge's directions, whether there was indeed such a duty on the particular facts. The jury must then consider whether, having regard to the risk of death, the accused conduct was so bad in all the circumstances as to amount to a criminal act or omission."*

The evidence already summarized is worth repeating as it shows that:

1. Paria prevented LMCS Ltd. from executing rescue plans that were continuously modified as more resources and information came to hand.

2. Paria closed out work permit soon after the incident in its first step at preventing LMCS from attempting a rescue, prior to Christopher Boodram's unaided emergency into the chamber.

3. Subsequent to Christopher Boodram's emergence, Michael Kurban attempted a rescue dive but the length of the breathing apparatus was not long enough to go far into the horizontal portion of SL 36.

4. Paria knew of Michael Kurban's safe emergence from the pipe in his attempted rescue, without oil on his person, but ignored the significance of same towards allowing rescue when additional competent, qualified divers and equipment came on site.

5. Paria did not attempt and rescue over 25th, 26th, 27th February 2022.

6. Paria was informed of proof of life within the pipeline; distress signalling continued up to and beyond 2:30AM Saturday 26th, 2022. 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) Paria also chose to deny 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 as all were alive.

7. Mr. Piper claimed that he wanted more information from camara footage before considering any dive rescue, but his repeated request up to 9.00 p.m. on Friday, to the Coast Guard, to do a dive does not support this claim.

8. 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.

9. 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.

10. 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.

11. Mr. Piper advised all, that Christopher Boodram said: "The men did not make it". The other misinformation given was that there were dive bottles lodged in the line, but, they kept increasing the distance of that blockage location in the line in their advice to "experts".

    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. It was obvious that none of the had experience diving in pipeline of any size, unlike LMCS's Andrew Farrah, Kazim Ali and Micheal Kurban which they wrongly claimed was "not a thing". They produced no evidence to show this.

12. 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. The study Mr. Piper referenced, 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 being under water would negate any possibility of any rescuer impulsively rushing in, without

his own breathing air, Scuba, or surface supply. 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. Had Mr. Piper relayed these fears in the numerous phone calls with LMCS they could have been easily allayed.

13. Paria and Mr. Piper treated LMCS as being "emotional" and disregarded the plans for rescue dive related on site to Catherine Balkissoon. There was no other willing "expert" other than LMCS and its volunteer divers, who was capable and willing to take the risk of rescue. Yet Paria, disregarded them and instead relegated the plans as being "mutterings".

14. Mr. Piper was quick to act on suggestion of installation of the riser at Berth #6 but did not accede to removal of blind flange at Berth #5 until 5AM on 26th February, 2022 thereby ensuring that no diver had access to SL 36 to attempt a rescue from around 10 PM on 25th February, 2022 to 5AM on 26th February, 2022 (all the while there being signalling being heard at Berth No.5.

CONCLUSION

From the legal authorities and facts as established before this Commission, it seems clear that Paria's decision to disallow rescue by LMCS divers (whether employed or volunteered) amounts to gross criminal negligence as:

1. Beyond a reasonable doubt, Paria owed a duty of care to the LMCS employees trapped within SL 36 from the relationship of employer/employee (contractor);

2. The fact that LMCS was an independent contract is immaterial to Paria's duty of care to provide a safe system of work (non-delegable) and a duty to rescue the entrapped workers.
3. Paria breached its duty of care to rescue by refusing rescue plans of LMCS;
4. The refusal to allow LMCS divers (whether employed or voluntary) to carry out rescue plans secured the death of 4 workers in the pipeline as no attempt was made by Paria to rescue them.

In these circumstances, it is submitted that there is sufficient evidence, beyond a reasonable doubt, to support:

1. A finding that there was a breach of duty by Paria to rescue the LMCS employees and in particular, Mr. Collin Piper;
2. There is sufficient evidence disclosed which supports a finding that there are grounds from criminal proceedings in manslaughter against Paria and in particular Mr. Collin Piper;
3. A recommendation for the DPP to consider the evidence can be made with a view of criminal charges being laid.

Unless further clarifications are required, these are the submissions of LMCS.

Dated this 3rd day of February, 2023.

KAMINI PERSAUD-MARAJ

To: Secretary of the Commission of Enquiry
Ms. Sarah Sinanan