Complaint to National Contact Point
for the OECD Guidelines
for Multinational Enterprises

Recipient

French / Korean / Norwegian NCP

Company concerned

Samsung Heavy Industries

+82 (31) 5171 7000
23, Pangyo-ro 227 bean-gil, Bundang-gu, Seongnam-si, Gyeonggi-do, 13486 Korea

Technip FMC

+33 (0) 1 47 78 24 00
75116 Paris, France (Operational headquarters)

Total

+33 (0) 1 47 44 45 46
Tour Coupole - 2 place Jean Millier 92078 Paris la Défense cedex, France

Total E&P Norge AS

+44 (0) 203 429 3950
Finnestadveien 44, 4029 Stavanger, Norway

Equinor

+47 51 99 00 00
Forusbeen 50, 4035 Stavanger, Norway

Complainant

The Samsung Heavy Industries Martin Linge Project Crane Accident Workers Support Team

The Korean Transnational Corporations Watch

[Contact Person]

Eunju Lee, Activist, MCGMAWHS, +82-10-3575-0489, mklabor@chol.com
Dong Hyun Kim, Attorney at Law, KTNC Watch, +82-2-364-1210, dhkim@hopeandlaw.org

Table of Contents

I. Status of the Stakeholders

1. Complainant

A. The Samsung Heavy Industries Martin Linge Project Crane Accident Workers Support Team

The Samsung Heavy Industries Martin Linge Project Crane Accident Workers Support Team (hereinafter referred to as the "Worker Support Team") is a coalition of Korean NGOs, for providing support to workers who suffer from either significant physical or mental damage at the hands of the accidents that occurred during the building of the Martin Linge oil platform at Samsung Heavy Industries. Members are as follows:

Masan Changwon Geoje Movement Association for Workers' Health and Safety (MCGMAWHS)

Korean Metal Workers` Union Legal Center

MINBYUN-Lawyers for a Democratic Society KYUNGNAM

B. The Korean Transnational Corporations Watch

The Korean Transnational Corporations Watch (hereinafter referred to as the KTNC Watch) is a coalition of Korean NGOs that advocate for human rights and the protection of the environment and local communities against corporate malfeasance. Members are as follows:

Advocates for Public Interest Law (APIL)

Corporation for All

Gong Gam Human Rights Law Foundation

Korean Confederation of Trade Unions (KCTU)

Korean Federation for Environmental Movement (KFEM)

Korean House for International Solidarity (KHIS)

Korean Lawyers for Public Interest and Human Rights (KLPH)

MINBYUN-Lawyers for a Democratic Society `s Labor Committee

2. Respondent

A. Respondent 1: Samsung Heavy Industries

The respondent Samsung Heavy Industries (hereinafter referred to as 'Respondent 1') was established in 1974 and conducts services in repair, remodeling, and sale of ships. PJJ's headquarters are located in South Korea and has an additional 12 oversea subsidiary branches in China, India, the United States, and Malaysia. Accordingly, Respondent 1 is required to comply with the OECD Guidelines for Multinational Enterprises.

The Martin Linge Platform was an offshore project produced as a piece of the overall Martin Linge Project. Respondent 1 is a stakeholder in the project who was directly involved with the construction of the platform. Specifically, the accident occurred at the Pier 7 of the Goeje Shipyard, one of the workplaces of Respondent 1 and the innermost platform of the Geoje Shipyard. The operation of Goliath cranes and alerting of any accidents related to these cranes were the responsibility of Respondent 1. There are exactly eleven Goliath cranes within Geoje Shipyard, all except for one are under the responsibility of Respondent 1.

B. Respondent 2: Technip

The respondent Technip (hereinafter referred to as 'Respondent 2') was established in 1958 and operates in areas of project management, engineering, and construction for energy-related projects. Respondent 2 is a multinational corporation based out of France with 48 separate subsidiary divisions in Australia, Brazil, China, Colombia, and France. Accordingly, Respondent 2 is required to comply with the OECD Guidelines for Multinational Enterprises.

Respondent 2 built the Martin Linge platform together with Respondent 1 and is the leader for the above consortium. In addition, it directly took part in engineering and procurement where Respondent 1 is not direclty in charge of , and is a stakeholder directly related to the construction of the platform.[1] [2]

C. Respondent 3: Total

[1] https://www.offshoreenergytoday.com/technip-samsung-to-supply-topsides-for-marting-linge-platform-norway/
[2] https://www.2b1stconsulting.com/total-awarded-main-packages-on-martin-linge-in-norway/

The respondent Total (hereinafter referred to as 'Respondent 3') was established in 1924 and engages predominantly in the oil and gas business. Respondent 3's headquarters are located in France and they have a total of 903 overseas subsidiary divisions in the United States, China, and the Netherlands. Respondent 3 is required to comply with the OECD Guidelines for Multinational Enterprises.

Respondent 3 is a stakeholder who is directly involved in the construction of the Martin Linge Platform and was the main operator of the project when the accident occurred.

D. Respondent 4: Equinor

Equinor ASA (formerly Statoil and StatoilHydro, hereinafter referred to as 'Respondent 4') is a Norwegian multinational energy company headquartered in Stavanger, Norway. It is a petroleum and wind energy company with operations in thirty-six countries. Thus, Respondent 4 is a multinational corporation and requires to comply with the OECD Guidelines for Multinational Enterprises.

Respondent 4 is a stakeholder of the Martin Linge Platform as a shareholder of the Martin Linge Project at the time of the accident as well as the current main operator of the project.

II. Overview of the Martin Linge Project Crane Accident

1. Overview of the Martin Linge Module

The Martin Linge Platform is a part of an offshore oil drilling plant located in the North Sea off the coast of Norway. The plant's facilities are accordingly fixated to the deep-sea floor for purposes of gas and crude oil extraction. The Martin Linge Platform is designed for crude oil extraction and Respondent 3 ordered its construction to Respondent 1 and Respondent 2. The total contract amount for the project amounts to 9.439 billion Korean Won (approximately 840 million USD) while the total weight of the platform according to initial orders for the project amount to around 19,520 tons. The original construction period of 38 months was extended to 52.5 months with a deadline for completion of June 13, 2017.

2. Shareholders of Martin Linge Project

The Martin Linge Project is a consortium of multinational corporations. Total Norge AS, a subsidiary of Respondent 3, Petoro, and Respondent 4 were members of the owner group at the time of ordering production of the module as well as at the time of the accident. Total Norge AS, the subsidiary of Respondent 3, was the company with the largest stake in the operation. After the accident, Total Norge AS sold all of its shares in the project to Respondent 4, who currently serves as the main operator of the project.[3]

[3] https://www.offshoreenergytoday.com/statoil-completes-1-45b-takeover-of-totals-martin-linge-garantiana-assets/

Shareholders at the time of the accident	Shareholders as of now
Statoil(Equinor)	Statoil(Equinor)
Total Norge AS	
Petoro	Petoro

3. Overview of the accident

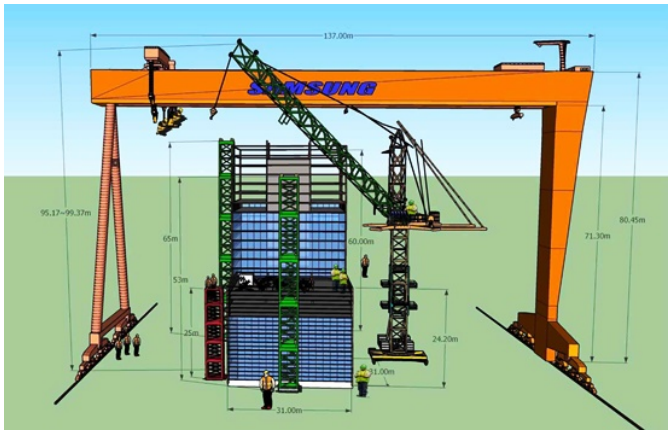
A. Details of Accident

Picture of the accident (Source: Korean Ministry of Employment Labor and Press Release)

On May 1, 2017 at around 14:50 pm at Pier 7 of the Geoje Shipyard, the site of the Martin Linge module project as well as the work area of Respondent 1, a Goliath crane (800 tons) moved from the south to the north in an attempt to transport elevators from one side of the module to the other. The tie bar of a jib crane (32 tons) hit the girder of the Goliath crane. The collision caused the wire rope of the jib crane to break and the wire rope as well as the main jib fell to the main deck below causing death and serious injuries to the workers positioned there. In particular, the wire rope and main jib fell in an area often frequented by workers as there were a number of portable restrooms and a smoking area there.

At the time of the accident, the goliath crane was moving along its rails from the south to the north carrying elevators installed on the east side of the module. At that time the jib crane was carrying the trash bin to the main deck of the Martin

Linge process module and untangling its lines. If the Goliath crane were to want to cross into the jib crane work area, the jib crane must lower its roughing jib. On the day of the accident, the Goliath crane travelled successfully across the jib crane working area a total of five times. During the sixth approach, the jib crane had failed to lower its roughing jib which in turn caused the roughing jib to collide with the Goliath crane.[4]



Goliath crane (from left to right) and jib crane (center) overlapping each other and interfering with each other (Source: Official Document of Korea Geoje Police)

Description of the Cranes

According to an official Notification issued by the Ministry of Employment and Labor in accordance with Article 34(1) of the Industrial Safety and Health Act of Korea on 'dangerous machines and apparatus safety certifications', crane is a machine or mechanical device intended to carry hung stuff up and down or left and right (horizontally or turning) by the power. The cranes that collided in this case are a Goliath crane and a jib crane.

The 'Goliath crane' is a large-scale crane used by the shipyard and is labeled as a 'gantry/portal bridge crane'. It is a crane with a girder supported by a leg installed upon the crane's runway. The Goliath crane can be classified accordingly as a 'gantry portal crane'.

The jib crane is also legally called a 'jib type crane' which distinguishes it from a regular tower crane which attaches its

[4] Overview of the accident was from Appendix 1. Shipbuilding Industry Disaster Survey Report

jibs horizontally. The crane is also called a 'roughing jib crane', which means that the jib is lifted by tilting it. The jib crane is smaller than the tower crane and is widely used in urban areas where the dangers of falling objects should be addressed and reduced accordingly.

B. Construction Decision for Jib-Goliath Crane Overlay and Related Procedures

As explained above, the direct cause of the accident was the crane collision. However, in order to determine the actual cause of the collision itself, it is necessary to examine the processes by which how such construction method was executed in the case at hand. A senior executive of Samsung Heavy Industries and relevant managers of affiliated companies made multiple statements to investigating agency that reflected this method of work is highly unusual and not a method that is commonly used in the field. Since this work method is so unusual and inherently risky, it is important to look at any changes that took place during the course of the project and how such a strategy was approved therein.

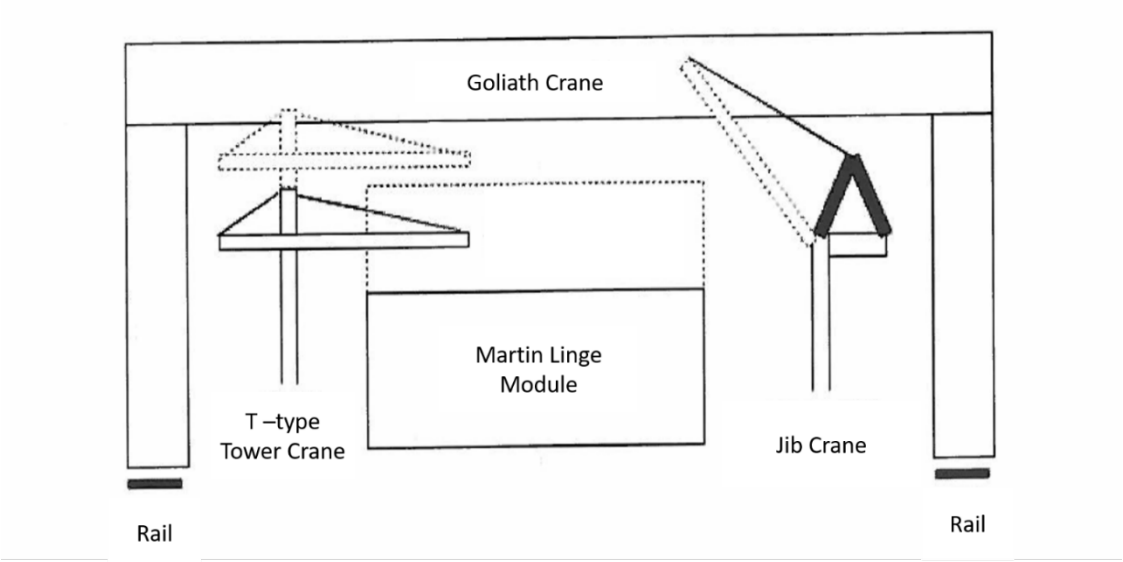
1) Changes in Design and Increase in Module Height

The original construction plan of of the Martin Linge module had the structure weighing 19,520 tons, yet at some point thereafter, the weight was revised to 23,330 tons which is increased by 20%.[5] Accordingly, it became necessary to change the construction method and modify the structural base of the whole module. In doing so, the height of the module was to be increased and the new designs meant that the module would increase in size by about 20%.

2) Change of Construction Method

Before the overlay method of the jib and Goliath cranes was implemented, which was the method adopted at the time of accident, a T-type tower crane and Goliath crane were used. However, if the height of a T-type tower crane were to be increased to accommodate for the new plans to raise the height of the module as well as the other design modifications, the issue of airspace interference between the T-type tower crane and the Goliath crane would occur.

[5] Appendix 2. Police statement on p.10



Comparison of Goliath T-type tower crane and a jib crane (Source: Appendix 2)

As shown in the image above, in order to work on the upper part of the module, the height of the T-type tower crane should be higher than the module itself but lower than the height of the lower-girder of the Goliath crane. However, in this case, it was impossible to use a T-type tower crane because of prospective interference with the Goliath crane. In order to solve this issue, the representatives of the project conducted 5-7 rounds of meetings and on their May 13, 2016, meeting ultimately decided to utilize a jib crane. On June 13, 2016, a jib crane was installed on at the Pier 7 workplace and operated until the accident occurred.

3) Dangerous and Unusual Work Methods

According to this work method, when the boom of the jib crane is lowered, it is safely lower than the lower girder of the Goliath crane. Yet, if the boom of the jib crane is raised, it sits higher than the lower girder of the Goliath crane. (See the above picture)

Yet, this method of work is highly unusual and dangerous. The height of the jib crane was 67.5 meters excluding the boom. Since the lower part of the Goliath crane sat at 71.3 meters high, this left only a free space of 3.8 meters high for the cranes to operate. Thus, it was only possible for the Goliath crane to pass through the jib crane area when the jib crane's boom was lower than 15 degrees. Accordingly, in order to allow the Goliath crane to pass back and forth, a very unconventional method of work was utilized that required alterations of standard work procedures as well as procedures surrounding the lowering of the jib crane and its boom.

Specifically, a senior executive from Samsung Heavy Industries has also been on record stating how unusual such a method

of work is in the field. In a police report, Chung Boo-Min, the second highest director, in charge of production at Samsung Heavy Industries Geoje Shipyard, mentioned specifically that "the Martin Linge Module has a height of six stories, which is much higher than ordinary modules (3 to 4 stories high). This is the first time I've seen anything of the sort" and that "Neither Daewoo Heavy Industries nor Hyundai Heavy Industries had produced a module of such height." Accordingly, it was impossible to proceed with the project using the conventional method of a T-type tower crane. (See Appendix 2 Police Statement).

In particular, the perception of the newly adopted work method as highly dangerous was widely known throughout all the relevant parties in the construction process including Respondent 1 and their subcontractors. According to statements made to police, Mr. Kim, a chief of shipbuilding workplace at the time of the accident, was also aware of the danger of overlapping cranes. In addition, the supervisors Mr, Lee and Mr. Ryu along with LINE Safety Manager Mr. Park were all aware of the dangers associated with the overlapping of a jib and Goliath crane. Furthermore, workers and supervisors of the Daeheung Corporation, a subcontractor of Respondent 1 who operated the jib crane, were also aware of the danger of the jib crane and Goliath crane colliding but stated that they would suffer disadvantages if they requested appropriate improvement measures to Respondent 1. Thus they were unable to raise this issue properly.[6]

4. Victims

The official statistics state that the accident killed a total of six workers and injured another 25. All of the workers who were killed or injured were employed by subcontractors contracted by Respondent 1.

First, the six deceased workers including Mr. Bok belonged to five separate companies, including Haedong Enterprises, of which were employed by Respondent 1 to conduct deck work for the offshore plant. Mr. Bok, Mr. Park, Mr. Go, and Mr. Park were all first-tier subcontracted laborers. Mr. Park was from Jinseong Industrial Company, a subcontractor of Respondent 1. Mr. Seo belonged to Gold Hynix, a second-tier subcontractor of Respondent1. (See Appendix 1 Shipbuilding Industry Disaster Survey Report).

All of the deceased workers were so called 'Mull-yang teams', a special form of Korean shipbuilding labor. The fact that all of the deceased workers were mull-yang team and not directly employed by Respondent 1 clearly shows the common practice of "risk-outsourcing" of industrial safety for Korean shipbuilding industry.[7]

---

[6] Appendix 2. Police statement on p.37.
[7] Refer to the following article for an introduction to the phenomenon of outsourcing risk
http://koreabizwire.com/outsourced-risk-80-of-shipyard-deaths-involve-subcontractors/123980

Description of the Mull-yang team

The Mull-yang team is a specific form of subcontracting that is derived from multi-layered subcontracting practice. These teams mainly are being used for short-term but heavy load jobs. In their contract, they are subcontracted, however, in actuality the implementation of such teams is illegal as the teams are being used as a form of dispatch service under the direct supervision of lead firms such as Respondent 1.

The Mull-yang team usually consist of about 10 team members, but in many cases team sizes can be up to 30-50 people. Since 2000, The Mull-yang teams started to be used on a mass scale in the shipbuilding industry, and the situation has worsened as the agencies, not the team leaders, recruited and sent workers to the teams.

Despite the fact that the problem of Mull-yang teams has been pointed out by the parliamentary inspection of the administration, these continue to operate within the Korean shipbuilding industry.[8] Contractually, contractors and shipbuilders are not responsible for any industrial accidents that involve supply teams. Also, shipbuilders still commonly utilize these illegal teams because many tasks can be assigned to these teams over the course of a short period of time.

Next, the official statistics reflect that 25 workers were injured in the accident. These workers were employed a total of eight companies including Haedong enterprises to work on the deck of the offshore plant. Most of the workers were employed by second-tier subcontractors.

Lastly, there are a number of workers who weren't physically injured but are still severely traumatized after the terrible scenes accident. On May 1, 2017 there were 1,623 workers who clocked in at Samsung Heavy Industries and at least 300 of these workers witnessed the accident. The workers witnessed some terrible and devastating images during the accident that has led to cases of insomnia and shock-related psychological anxiety. Yet despite this, only 11 of these workers have been approved for treatment and compensation by the government.

[8] http://www.usjournal.kr/news/articleView.html?idxno=71540

Stories of victims

1. The Story of Mr. K

K, who was working right under the block decks as a plumber at module P of the Martin Linge Project, was going up to the smoking room which was located on the deck at the time of the accident. There was awful loud sound and the boom fell off on the deck, which the workplace instantly turned into total chaos. K witnessed injured workers who were shedding blood. He phoned his elder brother, who was also working in the same shipyard. But the brother did not answer the phone.

"If I had found him a little earlier, my brother would have been able to live. I cried my eyes out and lost my mind for the rest of the day. My sister took me to the psychiatric hospital on May 8th. But even though I was in the hospital I had a really hard time. I left the hospital and went to my brother`s funeral without telling anybody because I wanted to see him."

Following the advice of his sister, K went to Geoje Health Center on May 24th where he received psychological counseling. The public health center informed him it was imperative that he receive further psychiatric treatment and advised him to consult with a health center in Seoul. On May 25th, K applied for industrial accident compensation to the Tongyeong branch of the Korea Workers` Compensation and Welfare Service but heard that it would be very difficult to have trauma recognized as an industrial accident and additionally that it might take some time to process the claim. K felt very frustrated that even though his condition greatly worsened, he felt that he still would not be able to have his trauma officially recognized as an injury or receive any assistance accordingly. On June 23rd K withdrew the documents he had submitted to the Service. K thought that perhaps his condition will just get better over time, yet he is wrecked with guilt from the prospect that if he forgot the accident, he would be doing a disservice to those who perished. This back and forth has been tortuous for K. Since K is unable to work, his life has become extremely difficult and the weight of his trouble is becoming heavier and heavier. As K had been working at shipyard, he was unable to find other types of work and as a result in the winter of 2018 was forced to go back to work at the Geoje Shipyard. Upon returning to the shipyard, the thoughts of the accident and surrounding trauma increased drastically. He was trapped by fears that the cranes above him would again collide and come tumbling down ultimately crushing him and his coworkers. K struggles to fall asleep at night alongside his coworkers, often finding himself sobbing under his breath in a corner of his living quarters.

2. The Story of Mr. J

On May 1, 2017, J was injured during the accident and was diagnosed with cervical sprains, multiple bruises, and right knee abrasions. On July 27, 2017, J applied for medical treatment to Korea Workers` Compensation and Welfare Service on October 22, 2018, the Industrial Accident Compensation Insurance Reconsideration Committee approved his claim for receiving medical care. J suffered greatly for a period of one year and six months to be approved but was however informed by the Korea Workers` Compensation and Welfare Service that his trauma from the accident could not be recognized.

It stated that it became difficult to decipher the actual presence of J's symptoms due to the lack of medical records during J's initial diagnosis and his psychological examination. He was notified that his clam for his current condition was rejected on the basis that treatment wasn't considered necessary.

Upon escaping the scene of the accident in 2017, J was diagnosed by the psychiatric department with 'acute situational stress reaction'. Even when trying not to think about the event, the scenes of falling wires and the images of other individuals were popping up all around him. These nightmares and other sleep problems have persisted, and J has been unable to cope with the stress.

At the time of his first visit to the hospital, the record indicated that J told doctors 'When I try to sleep at night, there is a terrible throbbing sensation of worms crawling in my arms and feet. In my dreams as well, I kept seeing a person bleeding continuously…and I would fall down from the second floor…and wake I would wake around 2 or 3 AM in the morning…I smoke cigarettes since I'm unable to fall back to sleep…though I usually lay down again, I'm unable to sleep comfortably. The accident comes up often in my mind. One time, somebody was riding a motorcycle and fell off which triggered my trauma of the accident.' As one can see from the above, the symptoms of J's stress were written in great detail in the record. J was diagnosed with acute stress disorder as well as insomnia and doctors stated that medicinal and further psychological treatment for J was necessary. Even though it is obvious to see how J could suffer from severe mental ailments in relation to the accident, it is hard to understand how others seem to still hold him to an objective standard and not take into account all that he has gone through. J wasn't treated for his industrial accidents and he is unable to pay for the high prices of the psychiatric treatment since he is unable to return to work at the shipyard.

3. The Story of Mr. A

On the day of the accident May 1, 2017, A, who was an electrician at the Martin Linge module, was accidentally struck on the deck by the falling crane while receiving work orders. A witnessed the death of co-workers who were buried under the broken pieces of the crane. A and these men had been colleagues working side by side for three years. After the accident, A suffered from the recurring images of going to rescue his colleague at the scene of the accident. After the accident, A's memory dropped drastically to the point he couldn't remember his own daughter's name and he began to seek treatment at the hospital. Doctors identified that A was suffering from post-traumatic stress disorder but also found that administering treatment for his case would be quite difficult. During his time at the hospital, A became even more stressed and eventually stopped treatment. Even now, A still suffers with back pain resulting from the accident. A still suffers from trauma but also is having difficulties in making since he can neither receive treatment nor get a job.

III. Violation of Guidelines

1. Respondent 1

According to the investigating agency, it was revealed that Respondent 1's change in the above-mentioned work method was not only unusual but also was ordered without a prior risk assessment. Firstly, Respondent 1 did not establish any sort of fundamental countermeasure to prevent such a crane collision from occurring despite the fact such incidents had occurred previously in the shipyard. Particularly, despite the fact that over the last ten years (2007 – March 2017) Respondent 1 had presided over seven similar crane collisions, there were no improvements made to Respondent 1's facilities or emergency alarm systems. Additionally, Respondent 1's internal standards state that if the cranes were likely to collide with each other that such risk could be avoided by checking accordingly in advance, but detailed procedures for how to accomplish such a task is lacking. In other words, if a new crane is to be built it should be designed so that the crane should collide with the crane that originally existed within the workplace. If overlap of the cranes' work areas is impossible to avoid, the following risks should be assessed, and the structure should be designed so as to avoid a crane collapse at all costs even in the case of a collision. General principles of risk assessment might have been created but yet were unfortunately not implemented. For example, on March 21, 2017, a countermeasure was established in response to the collision of a Goliath crane and a crawler crane at Pier 8 of the shipyard. Further, on November 3, 2016, another collision at Pier 7 occurred between a tower crane and elevator whereby

additional protective measures were established. It would seem that the risks of this accident were overlooked because previous in-house crane collision safety provisions only covered collisions that didn't lead to the collapse of a crane.

Secondly, the managers in charge of Respondent 1 neglected to properly supervise and direct their workers. The Goliath crane's manager was placed on the south side of tower crane 7-2 and the jib crane's manager was on the northwest side of tower crane 7-1. At the time the accident took place, The Goliath crane's had to work on assigning the next task. Concurrently, the jib crane's manager was in discussions with the tower crane driver as well as the head of Samsung Heavy Industries' mechanical support department to address a drum and sieve issue within tower crane 7-1.

Thirdly, the number of watchmen around the cranes. The Goliath crane watchman neglected his surveillance duties. The Goliath crane watchman, Mr. Jeong, informed the jib crane operator of the Goliath crane was moving but there was no watchman to confirm that the jib crane had lowered the main jib enough to prevent contact with the Goliath crane's main girder. At the time of the collision, only one of the six Goliath crane watchmen was located at a point within 400 meters of the accident site. Three of the watchmen were at the far eastern inner wall of the pier while two others were at the top of the elevator. Thus, they were not placed in the position to keep a watch on the collision. (See Appendix 1 Shipbuilding Industry Major Reinvestment Report)

With the lack of safety measures and the inappropriate assignment of work, supervision basically constitutes the violations of the Korean Occupational Safety and Health Act. Also, these violate the OECD Guidelines for Multinational Enterprises. If an existing and pre-approved work method is suddenly changed to an unusual and dangerous work method, it is imperative to establish appropriate safety measures such as risk assessments and to prepare safety regulations and procedures that reduce risk before adopting the new work method. In this regard, these practices constitute a violation of the general policies (II) A.10 and human rights articles (IV) 1 and 4 of the OECD Guidelines for Multinational Enterprises.

2. Respondent 2

Respondent 2, as the leader of the consortium that received the Martin Linge module jointly with Respondent 1, is formally responsible for the project.

Furthermore, Respondent 2 was involved directly in the construction process. As was referenced in the sections above, Respondent 2 was responsible for engineering and procurement for the project. It is common for a company like Respondent 2, the leader of the consortium that received the construction contract, to participate in the process of discussing and changing work methods as well as project design plans which result in the changes in the terms and conditions of the contract. In addition,

Respondent 2 having a field office at the Samsung Heavy Industries' shipyard and it is the common practice of the joint constructor of the to discuss the changes in the design with the main constructor.

Considering the above facts, Respondent 2 should have confirmed whether Respondent 1, which is in charge of the actual construction, had assessed the risk management and prepared the proper safety management during the changes of the module design. However, Respondent 2 did not check or take the proper measures though it was aware of the fact that Respondent 1 had not established the proper safety measures such as risk management or it was in the position to be aware of such an situation by its status and authority under the contract and in reality.

In other words, Respondent 2, as the leader of the project consortium that was the recipient of the construction contract and directly supervised the engineering procedures, should have acknowledged the safety management or measures such as prior risk management before the decision of the changes of work method to the overlay of the cranes, if Respondent 1 had not been established the proper measures, it should have advised or ordered to have it. However, Respondent 2 did not direct or suggest respondent 1 to establish such measures, even though the change of construction method was very unusual and dangerous.[9]

In this regard, Respondent 2, directly and indirectly, violated the OECD Guidelines for Multinational Enterprises (II) A.10, A.12, 13 and human rights policies (IV) 1 and 4.

3. Respondent 3

Firstly, Respondent 3 was the operating company of the Martin Linge Project at the time of the accident. Therefore, Respondent 3's violations relate to whether or not the company exerted due diligence throughout the course of the business relationship.

The OECD Guidelines for Multinational Enterprises stipulate that efforts should be made to prevent or mitigate any adverse impacts of business practices if they are directly related to the work at hand (II. A.11). The guidelines further state that the nature and extent of due diligence may differ depending on specific circumstances (II, A.10. Line 2). In this case, it is necessary to determine the level of authority and influence possessed by Respondent 3 related to the prevention of human rights violations during the course of its business conducted with Respondent 1 and Respondent 2.

First, as a general shipbuilding practice, ship buyers such as Repondent3 reside in the workplace of the main contractor and manages the progression of the project. Additionally, any changes in project design, net weight, or significant work methods

[9] Complainants sent the open letter to inquire the relevant facts to Respondent 2; however, Respondent 2 avoided providing the detailed answers to the questions and only asserting that they did not have responsibility on this matter.

are considered to be a change of the contractual terms require and it is common to see the ship buyers involved in the decision-making process for such changes. Finally, changes to significant work practices are subject to the approval of the buyer. In the process of the approval, buyers ask the contractors to submit the relevant safety measures (such as risk assessments) to the significant work practices. Therefore, Respondent 3 should have approved the change of construction method of overlay of cranes and should have also recognized that Samsung Heavy Industries' safety measures were insufficient and substandard.

Furthermore, Respondent 3 bears the burden of ensuring the safety of the workplace where the Martin Linge module was being built. [Petroleum Safety Authority Norway] (PSAN) is a Norwegian government agency that periodically inspects industrial safety at construction sites, such as plants ordered by the contractor, and requires the contractor to perform barrier management to the construction site.

In the case at hand, PSAN visited the worksite rom June 14-16, 2016 and published their findings in a report accordingly.[10] While there was no mention of the crane overlap in this report, the report did mention that "The activity specifically focused on how Total ensures that the contractor SHI / Technip taking into account the assumptions and recommendations of risk and hazard assessments and how barriers are role (strategy document) and performance requirements (performance standards) are implemented and verified in the installation and completion phase." In addition, according to another PSAN audit report, PSAN visited to the Geoje Shipyard to conduct field surveys and recommend improvements.

Collectively, this means that Respondent 3 must implement barrier management[11] for the construction of the Marin Linge module, which would then improve the safety of procedures conducted by Respondents 1 and 2.

Thus, when considering the common practices for shipbuilders and contractors in the general shipbuilding industry as well as the overseeing of barrier management, of which Respondent 3 is responsible for, it is necessary after work methods involving crane position changes are made to confirm whether safety regulations such as advance risk assessments have been prepared and executed. These are all matters of due diligence that during the course of the business relationship should have been followed up upon by Respondent 3, who had the status and authority to carry out such actions.

In this regard, Respondent 3 did not exert appropriate human rights due diligence. Thus, respondent 3 violated the OECD Guidelines for Multinational Enterprises (II) A.10, A.12, 13, Disclosure (III) 1. and human rights policies (IV) 1 and 4.

[10] http://www.ptil.no/supervision/audit-of-martin-linge-article12248-874.html
[11] Regarding barrier management, refer:
http://www.ptil.no/getfile.php/1319891/PDF/Barrierenotatet%202013%20engelsk%20april.pdf

4. Respondent 4

Respondent 4 is a shareholder at the time of accident at the Martin Linge Project and the operator currently. As it is explained above, the violation of the Guidelines by Respondent 4 depends on the exertion of the due diligence in the business relationship, especially whether Respondent 4 properly disclosed the information.

The OECD Guidelines for Multinational Enterprises stipulate that "Enterprises should ensure that timely and accurate information is disclosed on all material matters regarding their activities, structure, financial situation, performance, ownership and governance. This information should be disclosed for the enterprise as a whole, and, where appropriate, along business lines or geographic areas. Disclosure policies of enterprises should be tailored to the nature, size and location of the enterprise, with due regard taken of costs, business confidentiality and other competitive concerns."

Commentary for this chapter follows that the purpose of the OECD Guidelines to have the disclosure as an obligation is "to encourage improved understanding of the operations of multinational enterprises by shareholders and the financial community as well as other constituencies such as workers." Commentary also states that "to improve public understanding of enterprises and their interaction with society and the environment, enterprises should be transparent in their operations and responsive to the public's increasingly sophisticated demands for information."

Thus, the Guidelines require Respondent 4 to operate the company transparently by disclosing relevant information in order to improve the understanding of the operations of the company by workers; it must respond to the request to disclosure the information from the workers instead of disclosing information regarding operation of the company only to the shareholders.

Complainants expected Respondent 4 to fulfill the responsibility under the Guidelines as it is a Norwegian public entity with the great human rights standard. Thus, Complainants requested Respondent 4 to disclose the Accident Investigation Report regarding this event.[12] It is known that after the accident was occurred, Martin Linge Project independently made a report on the investigation report on the accident, and the Complainants considered the disclosure of this report is important to reveal the cause of the accident. Furthermore, Respondent 4 as the current operator, it is reasonable to assume that Respondent 4 had received all the relevant documents from the Respondent 3 when the operation right was transferred. However, Respondent 4 not only rejected to disclose the report but also denied any further conversation on the issue any more.[13]

Respondent 4's such attitude clearly constitutes the violation of the Guidelines. Though the information requested by the Complainants was necessary to reveal the truth of the accident as well as to provide the remedy to the victimized workers, Respondent 4 refused to disclose the information. The disclosure is not even excessive burden for the Respondent 4 for several

[12] Appendix 3. Open letter to Respondent 4
[13] Appendix 4. Reply from Respondent 4

reasons: since it is difficult to consider that the accident investigation report usually to contain the core trade secret of the company, the cost of the disclose of the report is not excessive, and the operation of the business would not be interfered as the construction of the module had been completed.

In this regard, Respondent 4 not only violated the disclosure chapter but also failed to exert the human rights due diligence. Thus, respondent 4 violated the OECD Guidelines for Multinational Enterprises (II) A.10, A.12, 13 and human rights policies (IV) 1 and 4.

IV. Conclusion

The business activities by the Respondents in this incident violate the OECD Guidelines for Multinational Enterprises, resulting in human rights violations and negative human rights impacts. Therefore, the Complainants who have been assisting the workers suffer from the accident and monitor the human rights violations by the multinational companies have come to file the complaint at hand.

The issue in this case is that the human rights violations and adverse human rights impacts occurred by the construction companies (shipbuilding companies) are against the OECD Guidelines for Multinational Enterprises. Also, whether Respondent 3, who was a buyer, and especially, was required to conduct barrier management by Norwegian industrial safety legislation, bears human rights due diligence according to the OECD guidelines.

We believe that the process by which the NCP provides a forum for discussion and debate between complainants and respondents so as to find solutions to these issues will ultimately serve as great contributions to the purpose and utility of the OECD Guidelines for Multinational Enterprises. We hope that this complaint will promote further recognition of human rights management in shipbuilding management for not just shipbuilding stakeholders but also the contractors and shipbuilders themselves in an attempt to prevent the re-occurrence of these tragic accidents in the shipbuilding business.

V. Request: Collaboration and Cooperation of NCPs

This case occurred in a workplace located in South Korea, but the relevant evidence and information, of which contain the root causes of the accident, were not only based here in Korea. For example, the Korean government's 2018 report on shipbuilding accidents is written only in Korean and is only available on the Korean government's homepage, making it difficult for other NCPs to access and understand. Similarly, barrier management and PSAN surveys are held by PSAN in Norway. The final pieces of information on what role Total Norge AS, a subsidiary of Respondent 3, played is presumed to exist in France within the headquarters of Respondent 2. In this regard, information and evidence relevant to this case are scattered throughout Korea, Norway, and France.

In addition, the information related to this complaint are only available to the respondents since they own all of the information and the materials related to this incident. Essentially, the information about the business operations is owned or held by each of the parties who are in charge of decision making and construction of the project. In order to verify all of this information, the complainants have sent a questionnaire to Respondent 4 and the other respondents. However, Respondent 1

has yet to reply and the rest Respondents refrained from giving any specific answers. [14]

Therefore, in light of these issues, the complainants request the NCPs actively collaborate and cooperate with each other in order to identify the remaining facts of the case and hand over the required evidence and information. Specifically, these requests for collaboration and cooperation entail sharing relevant data, translating data, sharing acquired information, and conducting field investigations to confirm the facts of the case. Collaboration and cooperation amongst these NCPs will also contribute to the effectiveness of the OECD Guidelines for Multinational Enterprises and the functionality of NCPs overall. In particular, as evidenced in the case involving a Korean NCP case, *Lok Shakti Abhiyan et. al vs. POSCO*, it should be noted that Korean NCPs have received criticism from domestic and foreign civil society because they did not accept requests from other NCPs in the past.

[14] open letters and replies from companies concerned are uploaded at http://www.mklabor.or.kr/v3/news/

Appendix

Appendix 1 Shipbuilding Industry Disaster Survey Report (Korean)

Appendix 2 Police Statement (Korean)

Appendix 3 Open letter to Respondent 4 (English)

Appendix 4 Reply from Respondent 4 (English)