

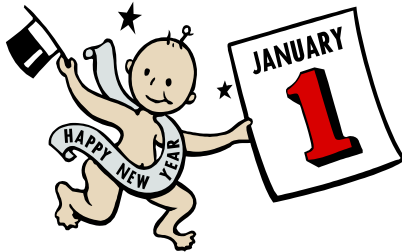
GCMAN NEWS

The Voice for Mariners



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THE "ARTCO SIX" Pilots Sue Towing Company On Oversized and Overloaded Tow Issue

The Dysart Law Firm⁽¹⁾ representing six experienced towing vessel Pilots filed a lawsuit in Federal District Court for the Southern District of Illinois on December 18, 2003 against the American River Transportation Company (ARTCO).

The suit alleges that the six plaintiffs, all with many years of pilothouse experience on large towboats, were coerced by their employer "to push bigger loads, or 'oversized' loads, for example, loads in excess of 35 barges..." against their better professional judgment. When the Pilots would not agree to handle a number of barges they judged was excessive and risky based upon their towboat's power, age, handling characteristics or mechanical condition, the suit alleges that ARTCO officials wrongfully terminated them from their jobs. ^[1]Christopher W. Dysart, Esq., Dysart Law Firm, 720 Olive Street, Suite 2250, St. Louis, MO, 63101. Tel # (314) 421-2273; Fax (314) 621-6060.]

The suit states that the mariners declined to agree to handle these extremely large tows in "...apprehension of serious injury was such that a reasonable person, under similar circumstances, would conclude that there is a real danger of an injury or serious impairment of health resulting from the performance of the duties required by (ARTCO)."

The Pilots faced a dilemma since they realize that they have not only an obligation to satisfy their employer but also walk a narrow line to protect their

licenses because, without a license, they not only cannot work for ARTCO but cannot work for any other employer. The exceptionally large size of the tows increases the risk of not successfully completing a trip without a reportable accident.

Equally important with a skilled work force advancing in age, the issues of health including the stress of handling exceptionally large tows in confined waters both by day and night looms large. Pushing acres of barges with limited horsepower in relation to the number of barges in the tow leads to constant and unrelieved anxiety and stress. The Pilot on duty carries this entire burden alone because only one officer is available for each 6-hour watch stood in rotation for up to 30 days at a time.

There is no relief for a Pilot whose illness does not require a replacement to be rushed to the boat because there are only two licensed officers on a towboat up to 200 feet in length. The Pilot stands watch alone for a total of 12 hours per day for his entire tour of duty. Standing watch involves long periods of sedentary operation with little exercise.

A greater understanding of the toll that stress takes and many examples of Pilots whose careers are cut short by heart conditions and diabetes played an increasing role in these mariners declining to take risks that could destroy their health and sideline them forever.

As they become older, increasingly tighter Coast Guard and industry health standards challenge their career longevity. It is not hard to understand why each of the six Pilots declined to push an oversized tow even if it meant he would receive a smaller paycheck.

This refusal did not satisfy their employer's wishes to move larger and

larger flotillas of barges with the same boats, some a quarter-century old, regardless of risk and regardless of complaints voiced by individual pilots. In addition, there were numerous complaints by other waterway users that ARTCO's huge tows were slow, cumbersome, took far too long to maneuver, hogged all the available space in the channel and clogged the waterways. GCMA received a steady stream of calls voicing these complaints from mariners for well over a year.

The wording of a Coast Guard regulation⁽¹⁾ familiar to many mariners whose career it has touched defines "negligence," one of the three major charges the Coast Guard can bring against any licensee, as "the commission of an act which a reasonable and prudent person of the same station, under the same circumstances, would not commit, or the failure to perform an act which a reasonable and prudent person of the same station, under the same circumstances, would not fail to perform." The six Pilots consider themselves to be "reasonable and prudent persons" that were no longer willing to risk their licenses, their career, and their livelihood taking chances on the outcome of pushing a flotilla of barges "6-long" by 7 or 8 barges wide (i.e., 1,400 feet long including the towboat by 280 feet wide) down the Lower Mississippi River south of Cairo, IL, to New Orleans and beyond. [⁽¹⁾Refer to 46 CFR 5.29.]

This lawsuit involves matters of principle and should be a matter of interest and concern for every one of the 30,000 mariners who work in the towing industry. If successful, it could serve as a "shot across the bow" for every company that takes unfair advantage of their employees by expecting them to take unacceptable risks that endanger the public, other mariners using the waterway, and the infrastructure of the waterway itself. The infrastructure includes locks, dams, bridges, docks and private and public facilities – all of which are at risk from oversized tows.

Of the danger to the infrastructure, the most direct hazard applies to bridges. A report by the Coast Guard and the American Waterways Operators in May 2003 cited "...2,692 bridge allision cases involving towing vessels and barges in U.S. waters for the years 1992-2001" with 90% related to human performance (78% to pilot error and 12% to other operational errors). Where the AWO report shows the horrendous number of bridge allisions, GCMA Report #R-293 describes many of the most outstanding bridge accidents in detail. These reports clearly establish that towing vessel Pilots face very real and very serious risks. In reality, the risk falls entirely upon any Pilot who is willing to accept the challenge. Considering the industry's unenviable safety record in the past few years, the "challenge" is no longer a "professional" or even a reasonable challenge. It has become a challenge to pique an individual pilot's ego or vanity.

The six Pilots in this case reached a point in their lives where no financial reward was equal to the risk from the challenge they faced. They, and many other mariners, are awakening to the fact that the only "winners" are corporate abusers, and only then if their voyages do not rack up greater monetary damages than profits. Everyone else

loses!

If successful, the lawsuit seeks "compensatory damages in reasonable amounts." To ensure that the company will not abuse other mariners in the same way in the future, the suit seeks ten million dollars in punitive damages for each plaintiff. Punitive damages are compensation in excess of actual damages. It provides a form of punishment to the wrongdoer and excess enhancement to the injured. However, actual damages must exist before punitive damages will be found. Punitive damages are awarded only in rare instances of malicious and willful misconduct – exactly the type of misconduct this lawsuit alleges. The suit alleges for each plaintiff:

- Wrongful discrimination in violation of 46 U.S. Code §2114, Protection of Seamen Against Discrimination. This statute was revised last year in part through ongoing efforts of GCMA.
- Wrongful termination under Federal Maritime Common Law.
- Wrongful termination under state law.
- Intentional infliction of emotional distress.
- Negligent infliction of emotional distress.

GCMA and other mariner groups followed the matter of oversized and overloaded tows for a number of years. On December 4, 2002 GCMA met with the former Eighth District Commander, RADM Roy Casto, to discuss the matter. We brought several of our most experienced river pilots with decades of experience to the meeting. As a direct result of the meeting, we prepared GCMA Report #R-340 that outlined 27 important problems in regard to oversized and overloaded tows.

During the past year, GCMA edited and revised Report #R-340 so that it describes the problems our licensed mariners face in greater detail. We continue to update it as mariners report new information and accidents to us.

Although it is well aware of the problem, the Coast Guard's Eighth District Marine Safety Division declined to look into the matter by simply ignoring the expertise our pilots presented in the meeting and report. Consequently, GCMA examined a number of accident reports involving oversized or overloaded tows and found the reports deficient in several areas. As we progressed, we began to receive an increasing number of calls about vessel accidents from mariners – accidents that companies apparently never reported to the Coast Guard as required by regulations. Added to this, a large number of personal injuries that GCMA Attorney Mark Ross found undocumented by accident reports required by Coast Guard regulations, makes it painfully clear that working mariners can expect very little protection from executive branch agencies like the Coast Guard or OSHA in their workplace. It is for this reason that GCMA routinely directs many of its appeals on behalf of working mariners directly to Congress.

River pilots must display considerable skill when piloting a towing vessel. The Coast Guard was slow to realize this until mariners spoke out at several public meetings leading up to the new licensing regulations that went into effect on May 21, 2001. Up to that time, a

“western rivers” towing vessel operator’s license was considered to be a “lesser included license”... less than inland, near coastal or oceans licenses. In 1996, the Coast Guard, for reasons of their own convenience, canceled the opportunity for hundreds of river pilots on the 6,000-mile western rivers system to voluntarily seek “first class pilotage” as a means of proving their professional status to potential employers as well as the Coast Guard. From that point, the situation has deteriorated so that these six dedicated mariners stood their ground to plead for greater safety and against coercion within the towing industry.

This lawsuit presents a rare opportunity for these six pilots to present evidence to a federal judge of coercion by their employer to perform the unsafe and risky activities that we outline in GCMA Report #R-340. It is clear to our Association that presenting this evidence to the Coast Guard again would be futile. The remedy that these mariners seek, if they are successful, will make an important statement about the actions of the petty tyrants in a large corporation that made life a living hell for them. It will send an important message to the entire industry that professional mariners are starting to assert their professional judgment without fear of losing their license or their livelihood. Until this happens, mariners will continue to have every type of indignity heaped on them not only by their employers but also by the Coast Guard as a regulatory agency.

For these mariners, the “carrot and stick” approach did not yield the results that management expected. The “carrot” reportedly was an extra \$50 per day to push an oversized or overloaded tow. These six mariners left the carrot untouched.

The old standby for refusing to take a tow is “if you won’t do it, we’ll get someone who will” served as the “stick.” This, according to the mariners involved, was pursued with a vengeance. Each pilot was replaced rather than submit even though most requested reassignment to smaller, more manageable tows, often with a smaller paycheck. The replacement for each Pilot in most cases was by an individual with less experience and a greater propensity for risk taking.

GCMA declined to name the six pilots for fear that they will be “blacklisted” by their former employer. This is a common means of drumming mariners out of the towing industry. Blacklisting made the towing industry a much less desirable place to work over the years.

Our Association asks any mariner with further information and examples of oversized and overloaded tows to contact us. However, if this information deals specifically with ARTCO, we ask you to contact the Dysart Law Firm in St. Louis directly.

THE REC RUNAROUND

[Continued from our last newsletter]

We devoted several pages in the December 2003 newsletter to the “**REC Runaround**” citing correspondence with REC Memphis.

Several days after publishing the newsletter, LCDR Jim Stewart, coordinator of all the Eighth District’s RECs, invited us to attend a meeting where the staff of the New Orleans Regional Exam Center encouraged concerned members of the public to form of a local committee of persons interested in licensing issues. We learned that this was an initiative of our new District Commander, RADM Robert Duncan. A similar group was formed about a year ago in the Midwest.

Initially, we were concerned that industry representatives dominated the Midwest group with participation by only a few carefully selected mariners and with only limited participation by training schools. However, after examining the minutes of their meetings, it became clear that their concerns and ours are parallel and that they took some necessary steps in the right direction. The current problems with the RECs affect our individual mariners as well as their employers.

The new “working group” (still to be named) is scheduled to meet again on Thursday January 22, 2004 at Delgado College. GCMA plans to attend and urges any of our mariners with licensing problems to call us for the specific time and place where the meeting will take place.

REC New Orleans provided us with three Coast Guard documents that we include and comment upon below:

USCG Document #1. Dec. 10, 2003. REC New Orleans.

There are five major steps in the merchant license and document issuance process: 1). User fee collection and initial review; 2). Evaluation; 3). Background check and medical waiver review; 4). Examination; 5). Issuance of credential.

Each application we receive goes through each of these five steps. Recent analysis of the process revealed that it takes, on average, 17 weeks for an application to be completely evaluated and a credential issued to a mariner.

For the month of October 2003 the following was the average time period for each type of credential: MMD - 15 weeks; STCW 95 - 20 weeks; License - 14 weeks. For the month of November 2003 the following was the average time period for each type of credential: MMD - 16 weeks; STCW 95 - 20 weeks; License - 15 weeks.

What you can do: One major delay in the process is due to submittal of incomplete applications, usually due to missing information associated with the background checks. One way you can help is to distribute the "Top Ten Reasons Why Coast Guard Applications Are Delayed" to the mariners you employ. Secondly, go a step further, and help your employees complete their application packages and ensure they have thoroughly answered each question.

USCG Document #2: Top Ten Reasons Why CG Licensing Applications Are Delayed.

1. Applications. If application is not completed, the application will be returned for correction. Three signatures are mandatory: Section III (Have you ever...? questions), Section V (consent of National Driver Registry check), and Section VI (application certification). Page two or three of the application are sometimes not sent in with the packet. Also when the "Applying for:" block is left blank or incomplete the REC is left to guess what you want.

[GCMA Comment: Many mariners are not familiar with the STCW or Towing license terminology that has changed since their last renewal. These questions could be resolved over the phone but only if our mariners can reach the REC by phone.]

2. Drug screen. A drug screen is often rejected because it does not contain the Medical Review Officer's (MRO) signature, is a photocopy, or a company compliance letter is over 60 days old or not written to meet the requirements of the Code of Federal Regulations, title 46 CFR 16.220.

[GCMA Comment: The license examiner should pick up the telephone and call the careless Medical Review Officer or Company Official to resolve any minor clerical problems on the spot as part of the application process you pay for.]

3. Photographs. Merchant Mariner Documents (MMD) and STCW certificates cannot be printed without a photograph. Two passport size photos are needed when applying for a STCW or MMD, with the additional requirement of a thumbprint for a MMD (camera setup sheet).

[GCMA Comment: Since mariners must now appear in person at the REC, the Coast Guard, like state drivers license officials, should take photographs that meet their specifications as part of the identification process.]

4. Physical Exam. If the Merchant Marine Personnel Physical Examination/Certification Report is not complete it will be returned for correction. Particular attention is paid to the "competent, not competent, and needs further review" boxes (just above the physician's address), which are frequently blank. Often the type of color vision exam given in section IV is not indicated, or mariners who wear glasses and/or contacts submit exams without their uncorrected vision listed in section III. The physician's and/or the mariner's certification signature is often omitted from the physical.

[GCMA Comment: The license examiner should pick up

the telephone and call the doctor to resolve any minor clerical problems on the spot as part of the application

process you pay for.]

5. Original Certificates. Photocopies of essential documents, even if notarized, are not accepted. Only original signatures, those signed by the issuing authority (such as course completion certificates) or official custodian (such as birth certificates), documents are acceptable. Original certificates will be returned when the evaluation is completed and the REC mails the newly issued credentials to the applicant.

[GCMA Comment: Mariners have legitimate concerns that documents mailed to the REC are lost, misplaced or misfiled. We believe this blanket statement of non-acceptable photocopies is unreasonable. There should be a reasonable distinction between essential and non-essential papers. Photocopies of non-essential papers should be accepted.]

6. User Fees. No or incorrect fees are included with the application. Licensing user fees changed as of October 4, 1999. Current fees are published in the most recent Code of Federal Regulations, title 46, part 10, section 109.

[GCMA Comment: The Coast Guard assumption that you have the latest CFR or that you understand how much money you must send could be in error? If in doubt, you must be able to reach the REC by phone to make an inquiry.]

7. Current or Past License, Document, and/or STCW. A mariner who is holding, or has held, a license, MMD, and/or STCW certificated who does not indicate it in the history, (section II), of the application or does not include a copy of their credentials (front and back) with the application package. This especially applies for renewals, and mariners with past transactions at other RECs.

8. Sea Service. Missing or conflicting information on the sea service letter such as: not including tonnage or horsepower, the position listed does not agree with other documents in the application package, or conflicting waters. Service should be documented with: discharges, letters from marine employers, or small boat sea service forms. If a small boat service form is used, it must be certified and signed by the owner, or proof of individual ownership is required.

[GCMA Comment: We pointed out that many USCG Marine Safety Offices do not keep Certificates of Discharge in stock.]

9. Written Statement. If an applicant marks "Yes" in any block of Section III, a statement is required. Note that all questions begin with "Have you ever..." **includes**

all past convictions, even ones that may have already been disclosed.⁽¹⁾ Simply stating "on file" will not suffice, statements should include the what, when, where, and penalties assessed for each incident and if it has already been disclosed to the REC and if there have been any new incidents since. Even if all the information is there, the statement must be signed and dated by the applicant. If the statement includes a NDR offense (DUI, etc.), proof that a state driver's license has been reinstated must be provided with the statement.

[GCMA Comment: What the REC may forget or chooses not to mention is that REC employees purged many files in the mid-1990s to save filing space and threw out some of your old files. We believe it is unfair that they now place the burden on you to furnish the information you previously provided and was accepted at the time.]

10. Medical Condition. Additional medical information is required whenever a medical condition is identified on the Merchant Marine Personnel Physical Examination Report and the proper information is not included on or with the physical exam report.

USCG Document #3: Dear Mariner/Marine Employer Letter by R.E. Wells, Assistant Chief, REC New Orleans dated August 29, 2003:

This is to advise you of recent changes to the **requirements to qualify for a Mate 500/1600 Gross Registered Ton (GRT) license**, and to advise of the option of receiving a Mate, Offshore Supply Vessel (OSV) license.

[GCMA Comment: The Mate (OSV) license is a "trade restricted" license that restricts your service to "offshore supply vessels."]

On February 1, 2002 the International Convention on Standards of Training, Certification, and Watchkeeping for Seafarers (STCW for short) came fully into effect. This international treaty obligated the United States to change many requirements for receiving a USCG credential for offshore mariners. The STCW does not apply to mariners or vessels working inside the boundary line.

[GCMA Comment: STCW along with unfathomable bureaucracy and inflated costs was crammed down our mariners' throats by the Coast Guard.]

To implement these changes the National Maritime Center (NMC) published NMC Policy Letter 01-02 on 8 Jan 2002 listing the new STCW requirements for all Mate licenses over 200 GRT. It is a long document available in 4 parts at:

- <http://www.uscg.mil/hq/q-m/marpers/pag/1-02.pdf>
- <http://www.uscg.mil/hq/g-m/marpers/pag/1-02-enclosure1.pdf>
- <http://www.uscg.mil/hq/g-m/marpers/pag/1-02-enclosure2.pdf>

- <http://www.uscg.mil/hq/g-m/marpers/pag/16-02.pdf> on the internet.

A Mate 500/1600 GRT now requires 3 not 2 years of service (which must include 6 months of bridge watchkeeping under the direct supervision of the Master),

completion of the practical assessments (enclosures 1 and 2 above) and completion of 18 formal training courses (over 100 classroom days at approximately \$17,000) not the 4 - 5 previously required.

[GCMA Comment: Only a few years ago the cost of a 500/1,600 ton mate's license was less than \$1,000. In 1999, GCMA unsuccessfully fought against the changes that drove the cost of training to this level.]

For most mariners, receiving the Mate (OSV) license is a more practical alternative, if being limited to serving on OSVs of up to 3000 GT (International Tonnage) is acceptable. Details on the requirements for a Mate OSV are contained in NMC Policy Letter 7-00 at:

- <http://www.uscg.mil/hq/g-m/marpers/pag/700.pdf> and
- <http://www.uscg.mil/hq/g-m/marpers/pag/7-00ch1.pdf> on the internet. As noted in enclosures 1 and 2, only 2 years of deck service are required (with a year on a vessel over 50 GRT and 3 months as able seaman (A/B) while holding an A/B Merchant Mariner's Document). The assessments are tailored to smaller (under 1,600 GRT) vessel's equipment, and training is reduced to 4 - 5 courses. For details on the OSV programs, including any cost of participating, contact either your company personnel office, or the owners of these programs; the Offshore Marine Services Association (OMSA), or Sea School. OMSA may be contacted at (504) 734-7622, Sea School at (727) 577-3992.

[GCMA Comment: Since this and other OSV trade-restricted license programs are special USCG approved programs owned and controlled by OMSA, an industry trade association, GCMA declines to comment on them. If you have questions or experience problems while participating in this special OSV program, we advise you to contact OMSA directly.]

WHY OUR MARINERS DON'T GET THE MESSAGE

By Richard A. Block

What message?

Well, you name it!

Several weeks ago, I received a call from an up-and-coming marine contractor with a small fleet of tugs and barges. He heard some of his Captains talking about some new license regulations that would cut them out of a job.

A few minutes into the discussion, I realized that he was not aware of the towing vessel officer licensing regulations kicking around for the past 10 years that finally went into effect on May 21, 2001. Apparently his employees weren't either!

It would be laughable if it wasn't so sad.

If the “management” of some companies doesn’t understand what is happening around them, its no wonder that their mariners are confused.

Part of the problem is that the Coast Guard expects companies to inform their employees. But, does this really happen and, if not, why not?

On December 17, 1997 (i.e., 6 years ago), I brought this matter to the attention of Coast Guard Headquarters and explained the root of the problem was a breakdown in communications. Unfortunately, the people at Headquarters are so far removed from our working “lower-level” mariners that the letter flew over their heads.

Every licensed and documented mariner works under two masters – his employer and the Coast Guard. The Coast Guard choses to work through the “companies” and seldom touches the individual mariner unless or until he applies or renews his license and/or z-card or breaks the law.

The Coast Guard does not become involved in relations between an employer and his employee (i.e., a “labor dispute”) so don’t expect to tell them your sad story whatever it may be. This often leads mariners to believe that the company “bought off” the Coast Guard. Such claims are difficult if not impossible to prove.

The fact is that the Coast Guard consistently fails to get a clear message out to the working mariner on any subject. The reasons appear in **GCMA Report #R-382** Why Our Mariners Don’t Get The Message. Call or write us for a copy of the report or pick it off the GCMA website at www.gulfcostmariners.org.

GETTING THE REC MESSAGE ACROSS

Admiral Pluta (Ret.) gave **LCDR Danny LeBlanc** the task of serving as the liaison between the Gulf Coast Mariners Association and the Eighth District. He is an outstanding Coast Guard officer and has done this job well...and at times it was not an easy job. Unfortunately, as with all Coast Guard officers, his time for reassignment is approaching.

One of his other tasks for the past several years was to coordinate the District’s four RECs – New Orleans, Memphis, Houston and St. Louis.

In an off-the-cuff remark, he opined that the RECs might consider using something like a videotape to explain the license application to mariners.

Over the past few years, the National Maritime Center has cleaned up its “Application Package” so that it no longer looks like a refugee from a trashcan. However, the neater and clearer it looks, the longer it becomes.

As we told the Coast Guard, the majority our “lower-level” mariners are NOT college freshmen completing a course in Bureaucracy 101. Almost any passage you encounter in the Code of Federal Regulations is written at the 12th grade level ... far above the reading level (or comfort level) of many of our mariners. This has always been the case. Unfortunately, things haven’t changed a great deal in the past 30 years.

“...The analysis proves that the (license) application process is too confusing and is in need of improvements.” This comment was attributed to the officer in charge of the REC in Memphis as quoted in The Waterways Journal. The challenge is to simplify and improve it – but until that is done, something at least must be done to explain it effectively. Here is where the Coast Guard could use videotape and/or a videodisk to explain in a clear and comprehensive manner exactly how to submit an application correctly. If the job is worth doing, it’s worth doing well! To do it well means preparing an accurate script or scripts and have it professionally done. Sure, it will cost money. But, compared to the anger and frustration generated by the existing dysfunctional system, this could be money well spent!

Copies could be made available to individual mariners, schools, and companies. There is no reason why the script could not include all of the Top Ten Reasons Why CG Licensing Applications Are Delayed and much more to overcome many mariners’ discomfort with the whole application process. Yet we have reached the point where “explanation” no longer can substitute for simplification.

The “message” we want to send the Coast Guard is this: “Our mariners have reached the end of the line...we are fed up! We are tired of being “dumped on” by the existing inefficient REC bureaucracy. We are mad as hell about the way we “lower-level” mariners are treated.”

SO YOU WANT TO BECOME A DESIGNATED EXAMINER

What are the qualifications for becoming a “Designated Examiner” that now must certify an Apprentice Mate or Steersman’s Towing Officer Assessment Record (TOAR) as a requirement for a raise of grade to Mate/ Pilot of Towing Vessels? So far, about 252 mariners have decided to qualify ... although the procedure remains a mystery to many other mariners. So, we asked the National Maritime Center a number of basic questions under FOIA and received (and paid for) the answers that we include in **GCMA Report #R-383**, “Designated Examiner Qualifications.”

As previously announced, **GCMA Report #R-372**, “Questions About Towing Vessel Officer Licensing and Manning” answers a number of frequently asked questions of interest to our mariners.

Captain David Miller, GCMA’s webmaster, posted both reports on our website. Call us at (985) 879-3866 for printed copies if the Internet isn’t your “thing.”

CREWMAN LOSES LIFE IN DOWNSTREAMING ACCIDENT

[Source: USCG Accident Report]

The M/V Thoroughbred (Official #D543278), an uninspected towing vessel, was proceeding downstream on

the San Jacinto River towards the confluence with the Houston Ship Channel when the vessel capsized and sank while attempting a downstream landing on the port bow of the tank barge HINES-435B (D955272). The incident occurred at approximately 1040 (CST) on November 6, 2002. There were 4 people on board at the time of the incident.

The M/V Thoroughbred was owned and operated by Kirby Inland Marine, LP. The estimated damage to the vessel, based on surveys, was \$342,325. The vessel was subsequently salvaged, sold, rebuilt and placed back in service as UTV Caroline Guidry. There is no evidence that drugs, alcohol, fatigue and/or equipment failure played any role in the casualty.

One crewmember, Steven D. Counts, 30, drowned as a result of the sinking. The other 3 persons on board were rescued by UTV Mustang (D638135). Mr. Counts' body was recovered on November 18, 2002. The Harris County Medical Examiner listed the official cause of death as drowning. There was no evidence of drugs or alcohol found in deceased's blood.

River and weather conditions: The river flow was over 30,000 cubic feet per minute as a result of heavy rains before the incident. Based on the past 17 years of USGS data, this was more than 300 times the median daily stream flow. This excessive rate resulted in a 3 to 4 knot current in the location of the incident. The weather at the time of the incident was clear with good visibility, and there was no wind of any significance reported.

There was a safety zone in place 500 feet above and below the I-10 bridge on the San Jacinto River at the time of incident because of the excessive discharge flow rate of the water. The safety zone was initiated in accordance with the Captain of the Port (COTP) Houston-Galveston High Water Crisis Action Plan. The safety zone required all vessels with loaded barges to utilize at least one assist boat when transiting through the safety zone, and it required that all vessels utilize the I-10 bridge as an additional Vessel Traffic Service (VTS) reporting and check-in point. The safety zone also cautioned that all vessels should consider the special hazards posed by the excessive discharge flow rate of the water in this area before beginning or continuing their transits.

This safety zone was continually broadcast every hour on VHF channels 13, 16 and 05A by VTS Houston-Galveston from November 4 at 1500 until after the incident occurred, when a more restrictive safety zone was effectuated in support of the salvage/rescue operations. Written notification of this safety zone was also faxed in mass to all known waterways users by VTS Houston-Galveston at 1500 on November 4th.

The M/V Thoroughbred is a 1,000 HP twin-screw towboat. Each shaft has its own propeller and rudder. However, she does not have flanking rudders (a second set of rudders located forward of each propeller for use when the engine is operating astern), which limits her maneuverability when backing. Her draft was approximately 7 feet at the time of the incident.

As per our interview of the captain and relief captain of the M/V Thoroughbred, she had about 1' forward freeboard from her deck to the waterline at the time of incident. There were approximately 4,000 gallons of fuel onboard the

vessel at the time of the incident.

Sequence of events: The M/V Thoroughbred was transiting "light boat" (i.e., not pushing any barges) downstream from Equistar to Kirby-Western fleeting area at time of incident. The M/V Thoroughbred encountered UTV Capt. Bill Mantle (D565331) (henceforth "UTV Mantle"), which was pushing the tank barge HINES-435B, crossways partially blocking the navigable channel just downstream of the I-10 bridge. UTV Mustang was assisting the UTV Mantle by pushing on starboard stern of barge to straighten out the tow and direct it downstream.

According to the captain of the UTV Mantle, Captain ■■■■■■ of M/V Thoroughbred, offered unsolicited assistance to the UTV Mantle who accepted the M/V Thoroughbred's offer. M/V Thoroughbred headed underneath the I-10 bridge towards the UTV Mantle but turned to port about 30 feet from the barge, with her starboard side facing the port side of the barge. M/V Thoroughbred's stern subsequently hit forward amidships of port side of barge, immediately followed by her starboard bow hitting further forward pointed towards port bow of barge. Water started rushing over the M/V Thoroughbred's port side bulwark and she then rolled under the barge.

According to Captain ■■■■■■, he found UTV Mantle's tow with the stern of barge pointing upstream angled towards west bank of river (IVO Southwest Shipyard) and the bow of barge pointed downstream angled toward east bank of river. There appeared to be an upstream eddy current from the east bank pushing the bow of barge back upstream, so Captain ■■■■■■ offered to push downstream on the port side bow of the barge to overcome the eddy and right the UTV Mantle's tow. The first contact he made was amidships on port side of barge with the starboard stern of the M/V Thoroughbred.

He reportedly transited back upstream and circled around by making a port turn towards the barge about 100' away. The second contact was the starboard bow of the M/V Thoroughbred further forward near the port bow of the barge. As the current pushed him in this direction, he tried to engage astern propulsion but his port bow touched the barge, with his starboard stern quickly following suit by veering into the barge, laying the entire starboard side of the M/V Thoroughbred flush against the port side of the barge about 75' from the barge's port bow. Water started rushing over the M/V Thoroughbred's port side bulwark and the vessel rolled under the barge with her port side submerged before her starboard side.

According to the crewmembers onboard the UTV Mantle whom we interviewed, and based upon our own observation on scene after the incident, the barge appeared to be empty. Her draft was only 2 feet, with her freeboard being approximately 10 feet above the waterline.

According to the CG-2692 (accident report), and based upon our interviews of the crewmembers onboard M/V Thoroughbred, her draft was approximately 7 feet at the time of incident, and she had very little freeboard above the waterline.

Since the M/V Thoroughbred had a much deeper draft with significantly less freeboard than the barge, it appears that the strong downstream current caused the M/V Thoroughbred to list to port and push under the barge within minutes after she came to lay against the barge. Water entered into the

hull through the engine room door on the port side of the vessel that was open at time of the incident. The only other means of ingress into the hull were a few hatches on deck, but these hatches were all watertight and shut at time of incident.

After the M/V Thoroughbred rolled under the barge, 3 of 4 crewmembers emerged downstream on other side of barge; however, Mr. Counts did not make it. The sunken vessel lodged under the barge, which was eventually pushed onto the east bank of the San Jacinto River near an area frequented by local recreational fisherman and crabbers.

According to the captain of the UTV Mantle, he had started backing the bow of the barge off the east bank while the UTV Mustang was pushing on the starboard stern of the barge as the M/V Thoroughbred approached. The bow of the barge was completely off the bank when the M/V Thoroughbred made contact with the barge. The UTV Mantle pushed the bow of the barge back onto the east bank after the M/V Thoroughbred sank. The captain of the UTV Mantle advised that there was approximately 75 feet between his stern and a barge tied up at Southwest Shipyard on the west bank of the river for the M/V Thoroughbred to pass if she so desired – instead of attempting to assist in righting the UTV Mantle tow's.

The captain of the UTV Mustang largely corroborated the M/V Thoroughbred and UTV Mantle's version of events with the exception of a couple discrepancies. According to the captain of the UTV Mustang, the bow of the barge was pushed into the east bank of the river at the time the M/V Thoroughbred approached and ultimately sank. The captain of UTV Mantle stated that the bow was pushed off the bank as the M/V Thoroughbred approached and made contact with the barge, and that he did not push it back into the bank until after the M/V Thoroughbred sank.

According to the captain of UTV Mustang, his boat was pushing on the starboard quarter of the barge, about 30 feet from the stern of the barge, while the UTV Mantle attempted to use the east bank as a "pivot point" to rotate the bow of the barge downstream against an eddy off the bank that was pushing it upstream.

As the M/V Thoroughbred approached, the captain of UTV Mustang, who was seated in the wheelhouse approximately 20 feet high with an excellent vantage point of the entire incident, saw the M/V Thoroughbred attempt to turn back upstream away from the barge when it was approximately 50 feet from the barge; however, the current shoved her stern into the starboard side of the barge, followed quickly by her starboard bow. He did not see the M/V Thoroughbred make any prior contact with the barge nor did he see it successfully circle around upstream and come back towards the barge as Captain ■■■■■ stated that he did. A subsequent re-interview of the captain of the UTV Mantle confirmed that the M/V Thoroughbred did not make any prior contact with the barge nor did she successfully circle around upstream and come back towards the barge before the sinking.

The captain of the UTV Mustang advised that he did not stop pushing on the starboard quarter of barge until after the M/V Thoroughbred listed to port and sank; however, he was more or less just holding the stern in place due to the downstream current. The UTVs Mantle and Mustang were in constant radio contact during the entire evolution. UTV Mustang confirmed that the current at the Kirby fleeing

area, which is further downstream and located in a wider area of the river, was approximately 3.1 MPH earlier that morning.

The UTV Mustang promptly retrieved the three M/V Thoroughbred crewmembers from the water and took them back to Kirby. None of the rescued crewmembers sustained any injuries requiring medical attention as a result of incident, although one of the rescued crewmembers was hit in the head by a life ring while the UTV Mustang was picking him up, leaving a small abrasion on the top of his head. An extensive search for Mr. Counts yielded negative results.

The captains of all three tugs involved in this incident indicated that they were fully aware of the San Jacinto River safety zone announced by VTS Houston-Galveston at the time of the incident. The captain of the UTV Mantle advised that he did not initially have an assist tug on the barge because he was only picking it up from Southwest Shipyard, which is on the west bank of the San Jacinto River below the I-10 bridge, and turning it around to head downstream. He was not going to push the barge underneath the bridge, and the barge was not loaded. After he was unable to turn the bow of the barge downstream, he nosed into the east bank of the river and called the UTV Mustang for assistance. This all occurred at approximately 1020 AM.

The M/V Thoroughbred was raised on November 13th after extensive salvage efforts and taken to a local shipyard for survey and repair. The body of the deceased crewmember was found on November 18th.

Cause of the casualty: The primary cause of casualty was Captain ■■■■■'s unsolicited decision to assist with righting of the UTV Mantle's tow in such difficult and dangerous conditions. These dangerous conditions were predicated by the strong current, estimated to be approximately 3 knots at time of incident that ultimately pushed the M/V Thoroughbred into and under the barge as she attempted to assist.

Downstream landing: Attempting to land on a barge with the bow of your towing vessel facing downstream (i.e. with the current) is referred to as a "downstream landing" in local towing industry vernacular. It is defined by the American Waterways Operators (AWO) as: "...a procedure in which a towboat moves downstream with the current in order to approach and land on another object, such as a fleet, dock or another tow."⁽¹⁾ [⁽¹⁾Refer to *Reducing Downstreaming Incidents, Report of the Quality Action Team,* dated September 4, 1998 (hereinafter referred to as "AWO report").]

Downstream landings are expressly prohibited by written Kirby company policy in strong currents and/or high river conditions because they are so dangerous. The prescribed method is to land on the barge and/or vessel with your bow pointing upstream, as the UTV Mustang did in this case when she went to assist the UTV Mantle.

According to the company policy, the only time a downstream landing may be conducted in strong currents and/or high river conditions is with the express approval of the Operations Manager; and even then the wheelman must ensure that certain additional safety precautions are taken prior to attempting the downstream landing, including conducting a critical task conference with the crew.

Captain ■■■■■ made no attempt to contact the Operations Manager to get approval for the downstream

landing he attempted in this case. Nor did he ensure that any of the additional safety precautions required by the company policy were in place before attempting the downstream landing. Therefore, Captain ■■■■■■ was in clear violation of company policy in this case. He was consequently terminated by Kirby on March 13, 2003 as a result of this incident.

The AWO report concludes that smaller towboats operating in swift currents are most at risk when downstreaming. Smaller boats are defined as 1350 horsepower (hp) or less. The M/V Thoroughbred was only 1000 HP, making it clearly at risk given the strong current and high discharge flow rate on the San Jacinto River at the time of the incident.

The AWO report goes on to caution that "...small towboat operators should recognize the risks involved in downstreaming under high current conditions and weigh those risks before attempting to downstream." If a decision is made to downstream with a small towboat under high current conditions, the report recommends that the wheelman must:

- ensure all doors and windows on deck are secured.
- that the boat has adequate freeboard.
- and that all crewmembers are notified and positioned to climb to safety in the event of a downstreaming casualty.

In this case, Captain ■■■■■■ took none of these recommended precautions. The door to the engine room was left open; the vessel had minimal freeboard; and 2 of the 4 crewmembers were asleep in their quarters when Captain ■■■■■■ attempted to downstream.

Furthermore, it is doubtful that Captain ■■■■■■ adequately recognized the risks involved in downstreaming given the fact that there was so little to gain by attempting the maneuver in this case. The UTV Mantle did not ask for his help, and Captain ■■■■■■ had plenty of time and space to hold up until river was clear.

M/V Thoroughbred's relief captain, Mr. ■■, stated that he would not have attempted a downstream landing here. He stated that he would have pushed up on the bank or held up until the UTV Mantle's tow cleared before proceeding under the bridge to the fleeting area. Mr. ■■ pointed out that the absence of flanking rudders on the vessel made it all the more difficult to attempt a downstream landing in this case. The AWO report also emphasizes the importance of flanking rudders to "hold the boat in position" as she approaches her downstream target.

The captain of the UTV Mustang, that was also owned and operated by Kirby at the time of the incident, verified that all tug captains should be aware of the written company policy prohibiting downstream landings because a copy of the ISO Manual is onboard every tugboat that Kirby owns or operates. He pointed out that he was very familiar with the downstream landing policy because it was just revised and re-written on October 15, 2002, and every Kirby tug captain was given a copy of the policy to brief their respective crews on.

The captain of the UTV Mustang advised that, although the term "downstream landing" is not expressly defined in the company policy that prohibits them without prior approval of the Operations Manager, all tug captains commonly understand the term to mean "anytime the current is on your stern." Finally, he stated that in the 6+ years he has held his

towing vessel operator license, he has never once attempted a downstream landing because they are so dangerous. He opined that the attempted downstream landing by the M/V Thoroughbred was extremely dangerous in this case because of the strong current.

The captain of the UTV Mantle confirmed that, in his opinion, the attempted downstream landing in this case was very dangerous in light of the current. Given his experience level, which is about 3 years as a towing vessel operator, he would not have attempted what the M/V Thoroughbred did in this case. He advised that he has never attempted a downstream landing in his career. Furthermore, while there was no specific discussion between the UTV Mantle and the M/V Thoroughbred on this point, the captain of the UTV Mantle assumed that M/V Thoroughbred could clearly see the barge was empty given its high freeboard, making it more dangerous if M/V Thoroughbred's draft was deeper than the barge she was attempting to push in such a strong downstream current.

Conclusion: Captain ■■■■■■'s desire to assist the UTV Mantle may have been commendable; however, the risk he took was unacceptable under the circumstances and was in direct violation of company policy prohibiting downstream landings in strong current without prior Operations Manager approval. The UTV Mantle's tow was already being assisted by the UTV Mustang when the M/V Thoroughbred approached. There was no other vessel traffic in the area and the UTV Mantle was not in any imminent danger when the M/V Thoroughbred offered to assist. The M/V Thoroughbred had plenty of time and space to allow the UTV Mantle to clear before proceeding downstream.

There was little to gain and much to lose by assisting in this case. Unfortunately, the attempted assistance resulted in the sinking of the M/V Thoroughbred and the death of Mr. Counts.

Enforcement action: Captain ■■■■■■ deposited his license with the investigating officer on June 11, 2003, the same date he was personally served with charges alleging **negligence and misconduct** in connection with this casualty. Captain ■■■■■■ admitted all jurisdictional and factual allegations and agreed with a six-month outright suspension. The judge's decision and order were issued on June 18, 2003.

[GCMA Comment: We do not want to heap blame or identify the hapless Captain. While his desire to help may seem "commendable," the outcome brought down upon him charges of negligence and misconduct as defined below.]

46 CFR 5.27-Misconduct

"Misconduct is human behavior which violates some formal, duly established rule. Such rules are found in, among other places, statutes, regulations, the common law, the general maritime law, a ship's regulation or order, or shipping articles and similar sources. It is an act which is forbidden or a failure to do that which is required."

In this case, the captain violated specific company rules on downstreaming. He failed to ask or receive permission from the company's operation manager to make a downstream landing as company directives stated that he must do. The company eventually fired him for this failure. However, the

point we want to make is that the Coast Guard can and does enforce by suspension or revocation the failure to abide by a "ship's regulation or order" (e.g., a company policy) in this case.

Most companies have an Operations Manual that new employees are expected to read when they are hired. It is only reasonable for these companies to have you sign a statement that you read and understood everything in the manual. As you do this, you will be expected to abide by everything that appears in the manual.

Many Operations Manuals are written by lawyers who use their skills to protect their client – your employer (i.e., "the company.") Read the manual and any other directive the company gives you carefully and settle any questions to your satisfaction before "signing on the dotted line" for you are committed to follow these policies as soon as you do. Most individuals without a strong union affiliation find themselves in no position to protest a policy that may not reflect how things are done in the real world.

46 CFR 5.29-Negligence

"Negligence" is the commission of an act which a reasonable and prudent person of the same station, under the same circumstances, would not commit, or the failure to perform an act which a reasonable and prudent person of the same station, under the same circumstances, would not fail to perform."

Captain ■■■■■'s fate was sealed when the captains of both other vessels (as prudent persons) stated that they would not have attempted the downstreaming maneuver. Of course, they could have warned him off and rejected his offer to assist. That might have been "commendable." However, if the accident report is accurate, they chose to sit on the fence and offered their advice only after a grievous mistake was made, a fleet boat was sunk, and a crewman's life was lost. That's sad!

Best Industry Practices. Unfortunately, downstreaming accidents are not rare. In fact, in the mid-1990s the American Waterways Operators (AWO), an industry trade association, and the Coast Guard jointly performed a study, issued a report, and produced a vivid videotape demonstrating the dangers of a downstreaming maneuver. This activity was captured in the following article by Bill Evans excerpted from The Waterways Journal.

Industry /CG Team Issues Report On Downstreaming

By Bill Evans, The Waterways Journal

"Downstreaming," the practice of moving downstream with the current to land on a barge, tow or dock, is a common and practical maneuver under normal river conditions, but it can quickly turn killer in high river, an industry/Coast Guard "quality action team" reported recently.

In swift current conditions, downstreaming has resulted in vessel sinkings and crew fatalities, the group said in its report, recommending heightened awareness on the part of wheelhouse personnel to the risks involved and empowerment of boat operators to decide whether or not to downstream based on existing conditions.

"Under normal conditions, downstreaming may be a practical and sometimes necessary operation," the group reported. "However, when casualties do occur, the risk to

the vessel crew is very high and the options for escape are limited...

"Addressing the human-factor causes of these incidents is the most effective prevention approach," the group said in its report. "This involves raising awareness of proper downstreaming techniques and the risks involved in downstreaming under adverse conditions. The towing company must make awareness of downstreaming risks a part of its overall high current/high water operating procedures.

"Ultimately, the decision whether to downstream must rest with the vessel operator, and the company must create an environment in which it is understood that ensuring crew safety is more important than saving time or gaining financial advantage."

The group emphasized the need to focus on smaller towboats, 1,350 hp. or less, operating under high current conditions, primarily on the Lower Mississippi River.

The group's study stemmed from increasing Coast Guard and industry concern over downstreaming accidents resulting in at least 12 deaths since 1982. In July 1997 the Coast Guard/American Waterways Operators Southern Region Quality Steering Committee named a six-member team to study downstreaming and recommend measures to minimize risk....

Practical Usage. Downstreaming is used in barge fleets to remove barges from the upstream end of a tier of barges. In a successful downstreaming maneuver, a towboat moves upstream above the fleet before turning downstream, then moving down toward the fleet, tow, or other intended landing, often with engines in reverse or backing down. The boat faces up to the desired barge, deckhands tie off to the barge and the boat backs the barge out of the fleet or tow.

The maneuver is not without its challenges, however, "If the towboat meets the barge at an angle and if there is a strong enough current," the group reported, "the boat may become pinned sideways against the barge. In these cases, water may rise up onto the deck and enter the vessel...through doors or windows. The vessel may capsize and sink, or if it is pinned under the rakes of the barges, be pulled down under the fleet..."

"Survivors or witnesses have described the incidents as happening with surprising speed, with the vessel sinking in less than one minute. Crewmembers who are not able to climb onto the fleet or rescue vessels are at extreme risk."

The group surveyed the towing and fleet operators and reviewed Coast Guard records seeking data on downstreaming accidents, identifying 16 vessels sinkings related to downstreaming or caused by similar factors between 1982 and 1997. In some of these incidents, the operator was not attempting to downstream, but had "simply ventured too close to the head of a fleet and became pinned." The group suspected there were more such incidents between 1982 and 1992, but said little information was available for that period.

Between 1992 and 1996, 244 towboat sinkings occurred on U.S. navigable waterways including eight related to downstreaming, the group said. Another 27 sinkings occurred in the first nine months of 1997 including three related to downstreaming. The group sent out 100 surveys to towing operators seeking their policies on downstreaming. The group received 32 responses, ranging from prohibition of

downstreaming in high river conditions to policies of leaving the decision to the vessel operator.

Conclusions and Recommendations. The team concluded:

- Downstreaming casualties are infrequent but highly dangerous when they do occur;
- Smaller towboats operating in swift current conditions are most at risk ;
- Human factors, “especially complacency and lack of awareness on the part of vessel operators,” appear to be the most significant causes of downstreaming incidents and represent the best opportunity for prevention;
- The most effective way to reduce downstreaming casualties is to raise awareness of the risks of downstreaming during high current river conditions; and
- Some operational measures, including use of weather tight doors and windows and placement of empty barges with box ends upstream, affect the likelihood and survivability of downstreaming casualties.
- Small towboat operators should recognize the risks involved in downstreaming under high current conditions and weigh those risks before attempting to downstream, approaching downstreaming not as “yes” or “no” decision, “but rather as a process of continual evaluation and...be prepared to abort the attempt if necessary”;
- Prior to downstreaming with small towboats in high current, operators should ensure that first deck doors and windows are closed and secured, ensure the boat has adequate freeboard, notify crewmembers of the operator’s intentions and position crewmembers to climb to safety in event of a casualty; and
- During periods of high current, vessel operators should manage fleets so as to minimize the need to downstream, including fleet width and placement of empties with the

box end upstream when practical.

- Companies should support vessel operators’ judgment and not encourage them to perform any maneuver they are not comfortable with, including downstreaming;
- Through policy and action, “the company should convey the message that crew safety is more important than saving time or gaining financial advantage”;
- For fleeting companies, a senior captain or “other licensed, knowledgeable supervisory employee” should evaluate newly hired towboat operators to ensure they recognize downstreaming risk factors and understand proper downstreaming procedures for their specific area of operation;
- If outside towing companies are used in a fleet, the operators of those vessels should be similarly evaluated before being allowed to downstream;
- Companies should stress the need for safe operations during periods of high water/high current, including raising awareness of downstreaming risks and frequent communication with vessel personnel before during high water;
- Daily crew meetings and communications should be used to identify and discuss downstreaming “close calls” and to determine whether downstreaming should be prohibited at specific river stages, drawing on the expertise of operators with the best judgment and working knowledge of the area of operation;
- High water procedures should address the need to close and secure first deck doors and windows and the need to ensure adequate freeboard; and
- Companies should consider conducting periodic drills to ensure that crewmembers understand assigned positions and proper alarms...

IN THE GALLEY DIET AND FOOD PREPARATION

[By Captain David Whitehurst]

A proper diet is very important to everyone and especially for a mariner with diabetes or a heart condition. For many of these mariners, it is essential to maintain a strict special diet. Unfortunately, this is very hard to do on a vessel that has no assigned cook

A large number of towing companies took cooks off their vessels to save money. Consequently, on such a vessel the crew has to prepare its own meals. Most of the time the job is left to one of the deckhands. Since there is such a high turnover rate in this industry, many of the deckhands are just out of high school and have little decking experience. Some companies do send these “green” deckhands to deckhand school where they learn the basics of how to tie a line, lay rigging, how to put barges together and face the vessel to the barges. Most retain very little else.

Unfortunately, there are no classes on the proper way to handle food and prepare meals. This leaves Pandora's box open for unsafe handling of meats, high risk for food contamination, and transmitting communicable diseases to the crew and then on to their families. No gloves are ever used since they are never supplied. Many times I have seen a deckhand come in off the tow pick up a spoon lying on a dirty dish towel and put it in a pot on the stove and stir away without washing either his hands or the spoon.

Many Captains and Pilots have diabetes. If they don't eat a special diet to keep their diabetes in check they can pass out while operating the vessel. This is also true for a person with a heart condition. The Captain that passed out and hit the I-40 bridge at Webber Falls, OK, reportedly had a heart problem and was operated on shortly after the accident. However, whether that was the cause of the accident or whether it was fatigue or exhaustion remains to be seen.

I recently made a trip as Pilot on a vessel with a crew of 8 that once had a cook. Unfortunately, the company no longer employs cooks. It was Thanksgiving day and I ended up being thankful for eating a can of chicken noodle soup. I wrote the following complaint to the company faxed it in with the logs, and received no reply.

“It is Thanksgiving Day and there was no meal at noon. It is now 17:00 and there is still no turkey. I was told that the turkey was ready, so I went and pulled the bird out of the oven that was turned off. I cut into the turkey to remove a drumstick and the blood ran out. I was very disappointed that it is Thanksgiving and that there is no meal to sit down to enjoy. Not only was the turkey uncooked but there was no stuffing in it.

“The cooks were taken off these vessels, so now the crew must do all the cooking. I been on this vessel since ■■■■ and in that time all that was cooked on board was a roast. I lived off canned soup, cereal and milk. The crew, it seems, does not know a great deal about cooking. I am from south Louisiana where we pride ourselves in our food and where

the men cook as good as the women. You don't find this in some other states.

"If a deckhand is expected to prepare meals, then the company that employs them should require that he knows basic sanitation and how to cook.⁽¹⁾ The Coast Guard and AWO are now looking into "crew endurance" where proper nutrition is supposed to play an important supporting role in this program. A proper diet is essential to good health and avoiding fatigue." [⁽¹⁾Why is it that mariners in other sectors of the merchant marine are protected by 46 CFR §12.25-20 and towboatmen working on the rivers and inland waters are not? 46 CFR §12.25-20 states: "No applicant for a rating authorizing the handling of food will be certificated unless he produces a certificate from a medical officer of the United States Public Health Service, or other reputable physician stating that the applicant is free from communicable disease." This is just one additional government protection that is not available to our mariners.]

I placed my letter on the counter for the crew to read and one deckhand took offense to it. He put out some chopped lettuce in a ziploc bag and a apple with a small can of V-8 juice with a note that said, "Your Proper Diet Per Your Request."

That evening I told the deckhand that the salad was cool and started to explain my letter but he cut me off. He didn't want to hear any of it. I told him that this vessel should have a cook and that with further cuts in the size of the crew (that can occur at any time on an uninspected towing vessel) the next to go will be the boat's Engineer. He told me that he did not care and that he would take care of the engine room if he had to...and if I did not like how things were done on the boat, I could call the office and get a relief. This is the first time I was ever "fired" by a deckhand. I guess this will give him free rein to be not only the Cook and Engineer but also the Captain if he chooses.

This is an AWO member company operating under the Responsible Carrier Program (RCP). The fact that each Captain and Pilot is expected to maintain his good health in order to pass the required physical examination each time they renew their licenses should be of greater importance to the towing companies so that they can retain experienced personnel.

BUOY BASHERS

The Gulf Intracoastal Canal Association (GICA), a group that promotes and defends the use of this valuable waterway, recently reported a record low reporting rate in the month of November 2003 for USCG aids to navigation that were knocked off station in the Houston area. The "year to date" figure according to GICA indicated that only 41 of 180 or 23% of these "knockdowns" were ever reported to the Coast Guard.

The Master's Duty. 33 CFR §70.05-20 states in part: "Whenever any vessel collides with an aid to navigation established and maintained by the United States...or is connected with any such collision,⁽²⁾ it shall be the duty of that person in charge⁽¹⁾ of such vessel to report the accident to the nearest Officer-in Charge Marine Inspection in accordance with 46 CFR 4."

[GCMA Interpretation:⁽¹⁾ It is the Master's duty to notify the USCG Marine Safety Office by phone or radio. ⁽²⁾If the Mate/Pilot is on duty, he should notify the Master who must then make the report.]

Specifically, 46 CFR §4.05-20 states: "Whenever a vessel collides with a buoy or other aid to navigation under the jurisdiction of the Coast Guard or is connected with any such collision, it shall be the duty of the person in charge of such vessel to report the accident to the nearest Officer in Charge Marine Inspection. No report on form CG-2692⁽¹⁾ is required unless one or more of the results listed in §4.05-1 occurred.⁽²⁾

[GCMA Interpretation: ⁽¹⁾ The report does not have to be in writing; a telephone or radio call to the nearest MSO will cover you. ⁽²⁾46 CFR §4.05-1 specifies groundings, allisions with bridges, loss of main propulsion or steering, serious damage to your vessel, loss of life, injury beyond first aid, or property damage of over \$25,000 where Masters must submit a written accident report on form CG-2692 within 5 days.]

[GCMA Comment: If your company policy requires you to notify the company first, the regulations also require the Coast Guard be notified by "the person in charge of the vessel." After you notify a responsible person at your company, make and sign a log entry describing the accident and name the person in the company you notified. Recite any understanding that person gave you that he/she would notify the Coast Guard. CYA.]

Buoys, lights and day beacons are put in place and maintained at considerable public expense to serve ALL shipping interests and all mariners. GCMA assumes that no licensed mariner would purposely "mow down" a buoy or other navigation mark. However, considering the way that both employers and the Coast Guard manage to heap every possible burden on the master of the vessel, it doesn't take a rocket scientist to understand why so many of these accidents are unreported. However, here are some of the risks you may face by not reporting these accidents:

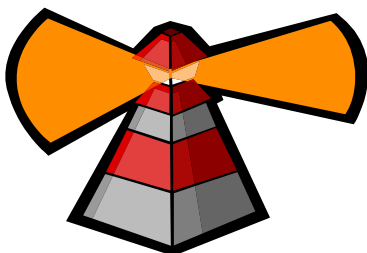
The Coast Guard assumes that each licensed Master or Pilot has access to all the tools necessary to locate buoys by day or night including charts, searchlights, lookouts, radar, etc. and is fully capable of using these tools. Mariners know that this is not always a true picture. Bulbs burn out, radar fails, lookouts watch TV and not the progress of the vessel, etc. However, you will face this picture if "things get out of hand" and an investigation by the local MSO results.

So, if an accident with an aid to navigation occurs, the regulations require that you report it as an accident and specify to whom you should report it. Depending upon the circumstances, the Coast Guard may ask you to explain how the accident happened; or perhaps they won't. In any event, if you make the report, the Coast Guard has the information it needs to report the aid to navigation as damaged, destroyed, or off station and will warn other mariners on the Broadcast Notice to Mariners. This is their principal concern. They also know that you reported the accident as required by law.

In the event you don't report it, you already violated one regulation. However, there are **other regulations** waiting in the wings that can be used for "hit-and-run" violators. For example:

- **33 CFR 70.05-5** contains penalties ranging from \$500 to \$2,500 or 30 to 365 days in jail for knowingly aiding, abetting, or authorizing a violation that altered, defaced, destroyed, moved, injured, obstructed or impaired the usefulness of an aid to navigation. In addition, one-half of the fine will be paid to any person or persons giving information leading to the conviction. Under these conditions, bashing a buoy may be a hard secret to keep.
- **33 CFR 70.05-10** allows an Administrative Law Judge to suspend or revoke your license for willfully injuring or destroying an aid to navigation. If you didn't report the accident, the assumption is that you "willfully" damaged it. Of course, you can tell your story to the judge or, more likely, sign some sort of "settlement agreement." Neither result will help your career.
- **33 CFR 70.05-15** assigns liability to pay for the damage the collision caused to the vessel. If it is a genuine accident, this is just the company's "cost of doing business" and may be covered by insurance. The burden falls on them and not the taxpayer.

After spending large sums for constantly replacing the same aids to navigation time after time, the day may come when the Coast Guard considers how difficult it is to handle many oversize and underpowered tows as they cross open bodies of water on windy days. Many of our mariners reported these problems to us and we report them in GCMA Report #R-340 and will continue to do so.



APPLYING STABILITY LESSONS LEARNED FROM A CANADIAN ACCIDENT

Maritime accidents occur and are investigated in Canada much as in the United States. The Transportation Safety Board of Canada (TSB) recently investigated the capsizing of the small fishing vessel CAP ROUGE II and loss of five lives off the entrance to the Fraser River in British Columbia on August 13, 2002. The following lessons are easily adapted to American uninspected vessels and our mariners that serve on them – **with emphasis on uninspected towing vessels.**

WE NEED MARINERS TO ATTEND FEDERAL ADVISORY COMMITTEE MEETINGS

Since its founding in April 1999, Directors and members of our Association attended many scheduled meetings of these Federal Advisory Committees sponsored by the Coast Guard:

- Towing Safety Advisory Committee (TSAC)
- National Offshore Safety Advisory Committee (NOSAC)
- Merchant Marine Personnel Advisory Committee (MERPAC)

Unless working mariners attend these meetings, the Coast Guard will only obtain the "management" point of view that is neatly and persuasively packaged by industry trade associations like OMSA and AWO.

We want to encourage our mariners with the longest and broadest range of experience to attend these advisory committee meetings as members of the public. It is only by attending these meetings that we can bring **mariners' issues** to the attention of the Coast Guard and all segments of the maritime industry.

What Mariner Issues? GCMA outlined **sixteen** (16) major issues in **GCMA Report #R-350** – one of our major functions. Many, but not necessarily all, of these issues may affect you as a working mariner. Choose the ones you believe are the most important to you and "bring your experience to the table." We need **your support** on each of these issues. It's not rocket science; it's what happens to you and around you each and every day.

Many branches of the federal government use Federal Advisory Committees to solicit information, opinions, and guidance from members of the public with expertise in different areas. As a mariner, we believe you may be an expert in the tasks you perform every day and may know more about what you do than some guy sitting behind a desk in an office who has never performed your job.

As the name implies, the purpose of a Federal Advisory Committee is to give advice to a government agency such as the Coast Guard.

We prepared **GCMA Report #R-384** to provides our mariners with more information on how these Federal Advisory Committees operate and how to participate in them.

We originally prepared **GCMA Report #R-276** in March 2001 to point out the unregulated workplace dangers that our mariners on many of our 5,200+ uninspected towing vessels face. One of our concerns was and is towing vessel stability.

The CAP ROUGE II is a 45-foot aluminum fishing boat with a single 275 horsepower Caterpillar engine. On the day of the accident she was returning from an offshore fishing trip in the Strait of Juan De Fuca carrying a load of about 20 tons of salmon in 3 of her 4 fishing holds. The summer weather was clear, the wind at about 17 knots, and the seas about 3 to 4 feet. The vessel carried a crew of 5 and two children who apparently were on board for the ride.

At 0902 a sailing vessel reported to the Vessel Traffic Center in Victoria that a fishing boat had just capsized less

than two miles off the Steveston Jetty. Within minutes, the BC passenger ferry QUEEN OF NEW WESTMINSTER, a Canadian Coast Guard Hovercraft with divers on board, a freighter, several fishing boats, and a CCG Auxiliary patrol boat converged on the scene. Canadian Forces Squadron 442 with additional divers and a commercial crane barge were also dispatched to the scene. In spite of the spectacular and virtually flawless response, it was not enough to save five people, including the two children that drowned inside the boat.

Stability problems. Pictures of the CAP ROUGE II taken in the shipyard 10 days after the accident show a neat, well-equipped aluminum hull that appears virtually undamaged. Recounting some of the key problems leading to these fatalities may serve as a useful lesson to us all.

- The lazarette and the two after fishing holds were fitted with manhole covers. Working offshore, these manhole covers were often under water. Unfortunately, the gaskets needed to be renewed. They leaked and allowed large quantities of water to gradually fill the holds. With water covering the manhole covers, the crew could not open them and check the water level.
- Both forward holds (i.e., port and starboard) were partially filled with salmon immersed in a slurry of ice and seawater. One of the two after hold carried a small amount of fish, ice and seawater. The vessel was not overloaded. However, a major cause of the accident was the free surface area caused by these three partially filled holds as well as the free surface from the water sloshing around in the lazarette.
- While the two forward fish holds with most of the fish and ice had a centerline bulkhead, the bulkhead did not reach to the underside of the deck. When the vessel heeled, contents from one hold flowed freely over the top of the bulkhead into the adjoining fish hold.
- The vessel had two fuel tanks that were connected together and the fuel was free to flow from one tank into the other. Since the tanks were only partially filled, it allowed for additional free surface to affect the vessel's stability. When the boat was recovered, one tank had considerably more fuel than the other. The fuel presumably flowed "down" from the high side to the low side as the boat began to list.

The vessel was modified a number of times since it was used to serve several different purposes. A full width stern seining ramp, a net roller, and a seine net powered drum with hydraulic package were added. The drum was raised off the deck about a foot to allow under-net clearance. The net, neatly spooled onto the drum weighed about 15,000 lbs. But its height above the deck was high above the boat's center of gravity. A heavy-duty domestic deep-freezer unit was mounted on top of the deckhouse. The vessel had a main cargo boom, winches, rigging, an additional radar mast, scanner, and fishing lights as well as a six-person life raft that were also high above the main deck. All this equipment, while necessary in its own way, did not improve the vessel's stability – in fact, these items all detracted from it to the point where the vessel had a definite stability

problem. However, the problem was not visible to a casual observer.

Unfortunately, unless you have had the opportunity to study stability, all of these warning signs can slip by easily. The Captain, who also owned the boat, had 31 years experience in the fishing industry yet was caught in a trap he never saw closing. The difficulty with understanding vessel stability is that its problems are not clearly visible. It's what you don't see that will nail you!

Closer to home, GCMA continues to question the continued "uninspected" status of towing vessels. As we reported in **GCMA Report #R-276** (Page 9): "Unlike inspected vessels, uninspected towing vessels have no regulations that require stability testing and do not have to meet rigorous stability requirements that other vessels do. Some towing vessel owners have added raised pilothouses and made other major structural conversions without having the vessel undergo a basic stability review by a naval architect. Unlike inspected vessels, the Coast Guard is not required and does not issue a stability letter, stability booklet or other stability advice to direct most uninspected towing vessel officers." Other examples include adding towing winches, cranes, open rescue boats that can trap spray and rainfall if left uncovered, elevating pilothouses in the raised position, etc.

The importance of drills. There was no record that the crew or passengers ever participated in a drill of any sort. TSB records:

"One of the crewmembers woke the skipper to inform him that the (boat) had a starboard list which he might want to assess and correct. In response, the skipper left his cabin and made his way aft to the galley door, which was secured in the open position. This door led to the main working deck. He observed seawater on the starboard side of the deck, but due to the obstruction caused by the seine net wrapped on the net drum, he was unable to see the stern of the vessel or the skiff (it was towing).⁽¹⁾ [⁽¹⁾*The line towing the skiff passed over the top of the net drum about 8 feet above the deck adding to the overturning moment of an already dangerously unstable vessel.*]

"The skipper descended a ladder into the engineroom and started an auxiliary engine used to power the vessel's bilge pumps. He then proceeded aft along the starboard side of the engine. To correct the list, he adjusted the valves necessary to pump overboard water in the starboard after fish hold. Pumping had just begun when the vessel heeled heavily to starboard, causing unsecured equipment to fall from the top of the port side main fuel tank. The skipper made his way up the ladder into the interior companionway of the main deck and shouted to those in the wheelhouse to "take the engine out of gear."

"The skipper made his way forward to the wheelhouse. By this time, the vessel was listing so severely that the starboard side of its superstructure was touching the surface of the sea..."

As part of its analysis, the TSB stated: "The situation involving the CAP ROUGE II demonstrates that crews of ...small vessels may have little time to assess the severity of an emergency situation and formulate a plan of action.

Where a vessel is listing heavily and may be in danger of capsizing, the amount of time available for an orderly abandonment is limited.

“Emergency situations are inherently stressful. Individuals may selectively focus on information and not accurately assess the probability of adverse events.⁽¹⁾ This could lead to an overestimation of a positive outcome. Such a bias has the potential to delay a decision to abandon the vessel until it is too late. [⁽¹⁾*The skipper underestimated the danger by thinking he could solve the problem by taking the engine out of gear – where he should have called for the crew to don lifejackets and prepare to abandon ship.*]

“Training and practice serve to reduce this potential for error by providing crews with an opportunity to practice their response to emergency situations prior to an actual emergency. In this way, when faced with emergencies, crew response will be more automatic and require less interpretation and decision-making. To have this effect, any training received must be regularly reinforced by using a combination of recurrent training and ongoing practice...”

“The capsizing sequence of the CAP ROUGE II underscores the importance of emergency abandonment drills and procedures. Unless the decision to prepare for abandoning the vessel is made before the problem has become critical, the crew may not have sufficient time to leave the vessel. Emergency training and the reinforcement of such training are critical to making timely decisions with respect to abandoning a vessel.”

Closer to home, **GCMA Report #R-276** (page 10) makes this point on drills: “Fire drills were not required to be held aboard towing vessels until January 19, 2000. Unlike inspected vessels, uninspected towing vessels do not require “man overboard” drills or “abandon ship” drills and instruction. In fact, in the absence of a safe manning document on uninspected towing vessels, there is no assurance that a towing vessel manned with only two crewmembers (i.e., a master and a deckhand) is properly

equipped to successfully recover the deckhand if that person falls overboard...”

Recently, one of our mariners reported that he served on a vessel where he was asked to sign a false statement that he participated in a fire drill aboard his vessel. After he refused to do so and reported the incident to his supervisor, the company could no longer find need for his services.

Adequate means of escape. Five people in the pilothouse and below decks drowned because there were inadequate means of escape. The vessel was built with a pilothouse door on one side only and with a hatch leading to the top of the deckhouse that was difficult to use. The only two people to escape managed to escape through that hatch.

Closer to home, **GCMA Report #R-276** (page 11) discusses “Means of Escape” on uninspected towing vessels as follows: “Unlike inspected vessels, there is no assurance on an uninspected towing vessel that there are two adequate, workable, and unlocked means of escape from all compartments normally occupied by or worked in by vessel personnel. This is simply because there are no governing regulations requiring such a safety feature...”

What does it take for the Coast Guard to take concrete steps to improve safety on uninspected towing vessels?

When you are afloat, your “ship” is your home, the crew is your family, and, at least for the time being, your entire world. When your ship suddenly goes ass-over-tea-kettle or sinks into the sunset you may have a severely traumatic experience. Your “ship” doesn’t have to be the RMS Titanic to etch the disaster into your memory for the rest of your life. We have spoken with “survivors” of the M/V Navigator, the M/V Mathilde, the M/V Fritz Cenac, the ENSCO Kodiak II and with the Reyburn family who lost their son, Greg, on the M/V Cheramie Botruc #26. All are in our family of “lower-level” mariners. All are survivors or relatives of mariners that had the trauma of their boats slipping beneath the waves. The message is that this is an experience that they can never forget and have trouble reconciling even years later.

CHANGES IN THE COLREGS

Local Notice to Mariners (LNM) #46/03 announced several changes in the International Rules of the Road.

- Colregs 3(m) announces a new term: “The term “Wing in Ground” (WIG) craft” means a multimodal craft which, in its main operational mode, flies in proximity to the surface by utilizing surface-effect action.” The definition also affects Colregs 3(a) and 18(f) dealing with WIG craft much as with seaplanes.” So what, you say!
- Colregs 23(c) was renumbered to 23(d) to cram in the information that a WIG craft when taking off, landing or flying near the surface exhibits a high intensity all-round flashing red light. Some new lights to remember!
- Colregs 31 was adjusted to allow a WIG craft to exhibit lights and shapes as closely similar to characteristics and position to other craft as possible. So now you know that a WIG is more than a hairpiece!

- In international waters (only), bells are no longer required on vessels between 12 and 20 meters. That affects Colregs 33(a) and inserts a new Colregs 35(i) – causing the renumbering of old 35(i) to become 35(k) and old 35(j) to become 35(k). Portions of Annex I and Annex III are also amended. So far, that’s international only...don’t let someone steal your fog bell!

We received no word that any of these changes affect the Inland Rules. This means that several additional points of difference now separate the International and Inland Rules – and will remain until adjusted at some later date.

When the Coast Guard boards vessels, they often ask to see your copy of the Rules of the Road. The book you show them should be the latest CORRECTED copy. Ask for **GCMA Report #R-385** that contains a copy of the full notice that appeared in the recent Local Notice to Mariners and is **Effective Nov. 29, 2003**. The full notice will help to update your copy of the rules.