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Tragedy on the River

Coast Guard investigates the death of five OSV crewmembers after the OSV LEE III was rammed in dense fog and sunk by ship near Venice, LA. USCG photograph, purposely inverted, shows the extent of the damage. The crumpled OSV was taken to Morgan City where it is being cut up for scrap. (Story on page 5.)



Captain Larry Gwin Goes to Washington

The Coast Guard ignored the problem of oversized and overloaded tows for far too long. One GCMA Mariner finally reached out to TSAC, the Commandant and Congress.

AN HISTORICAL NOTE

Alexander Hamilton's, statesman and the nation's first Secretary of the Treasury under President Washington in 1789, left his thoughts on the qualities he believed an officer of the Revenue Service should possess. The Treasury Department's "revenue cutters" would, during a later period in our history, become part of the organization we now call the U.S. Coast Guard.

"They will always keep in mind that their countrymen are freemen, and, as such, are impatient of everything that bears the least mark of a domineering spirit. They will, therefore, refrain, with the most guarded circumspection, from whatever has the semblance of haughtiness, rudeness, or insult." *[Excerpt of a Letter of Instructions to the Commanding Officers of the Revenue Cutters. Treasury Department, June 4, 1791.]*

Have the public servants in the Coast Guard's Regional Exam Centers forgotten that our mariners are "freemen." As such they have always thrived in the freedoms of the seas, lakes, bays and rivers. Our mariners especially resent being treated as second-class citizens by their government. They are impatient of the arrogance and "domineering spirit" they encounter while conducting their occasional routine business at the Regional Exam Centers. As taxpayers who support these government employees, our mariners are weary of the "haughtiness, rudeness, or insult" they often encounter. The needless and excessive bureaucracy that turns their simplest request into protracted delays and the sea of impenetrable paperwork and administrative gibberish repels them. *[For more on this subject read GCMA Report #R-393, USCG Licensing Procedures: An Affront to Lower-Level Mariners.]*

Remarks of Captain Larry P. Gwin

**At the Towing Safety Advisory Committee Meeting
United States Coast Guard Headquarters, Washington, D.C. March 17, 2004**

Ladies and Gentlemen, Members, and Guests:

My name is Larry Gwin. I have been a licensed mariner for the last 33 years sailing on the inland rivers. I have worked for several different companies, and have seen many changes during these 33 years. However, certain changes that I was expected to participate in went beyond the bounds of safety to the point where they presented a clear and present danger to other mariners, to other waterway users, to the general public and the environment.

Thank you for allowing me to speak to you today. Based on my experience, I will discuss a situation on the river and other inland waterways that has become a severe problem. I believe it is important enough to travel from my home in Illinois to be with you today. The problem concerns **oversized and overloaded tows**.

One major carrier, and my former employer, insisted upon moving **oversized and overloaded tows**. They own five boats that are in a unique class based on their size and horsepower. They are the largest towboats on the Mississippi River.

"**Oversized**" means that this company dispatches more barges than these large and powerful towboats were designed for and can adequately control or handle safely based on their available horsepower, the experience of their licensed officers, and full consideration of the changeable operating conditions such as river stages, weather conditions and the ever-present danger of mechanical failure. I will limit my definition of an oversized tow for such a vessel as being any tow that consists of more than 40 barges dispatched in a downstream direction. Specifically, "oversized" refers to any number of barges between 41 and 48 on any southbound trip from Cairo, Illinois to the Gulf of Mexico. Such a load could hold as much as 100,000 tons of cargo or more depending on the draft of its barges.

"**Over-loaded**" refers to a situation where the standard barges we normally pushed for years had an average loaded draft of 9 feet carrying a load of approximately 1,500 tons per barge. The Army Corps of Engineers only guarantees a 9-foot deep channel maintained by dredging where necessary north of Baton Rouge, Louisiana to Cairo, Illinois during low water. Newly constructed barges are now loaded to a 12' draft with an average of 2,130 tons per barge. These new 14-foot hull barges that draw 12 feet of water are replacing the old 12-foot hull barges that drew 9 feet of water and sufficed for many years. To the general public, these new barges may "look" the same, but there is a noticeable difference in the ability of a towboat to handle them. In order to carry the equivalent tonnage in 9-foot-draft barges a towboat would have to push more than 68 barges.

As a "heavy tow pilot" I have pushed 40 barge tows of standard 195'x 35'x 9'-draft barges down river with the most powerful towboats on the river that have three twenty-cylinder, turbocharged Electromotive Diesel (EMD) engines totaling 10,500 horsepower. While downbound tows are the most difficult to handle, I have also pushed as many as 56 barges up river. While most of the barges were in the grain trade, we also integrated other loads including denatured alcohol, coal and caustic soda in these tows. We call this class of exceptionally powerful towboats the "ten-fives."

I have always believed that this was "honest horsepower" although I have watched one industry publication "increase" the paper horsepower on some 8,400 horsepower boats to 9,000 horsepower without a commensurate mechanical upgrade of any sort. I have seen similar increases in "paper-" or "sales-horsepower" in smaller boats from 5,600 to 6,000hp. This kind of horsepower is of absolutely no value to a pilot whatsoever and simply attracts larger and deeper loading. It is a deceptive practice that can defeat "voluntary" measures taken by joint Coast Guard and river industry committees under high-water emergency conditions. I believe that whatever horsepower this industry uses must be "honest" horsepower based on some measurable standard. Without this, we compare apples to oranges leaving the industry and the Coast Guard as a regulatory agency with neither reliable nor meaningful standard horsepower figures to base tow handling and maneuverability on. Yet, in this case, I speak of unquestionably the largest and most powerful of river towboats and seek only a safe and reasonable "upper limit" for vessels of this size.

I have pushed 40-barge southbound tows with these large towboats that are twenty years old or older that were designed to handle standard 9-foot draft barges. Normally, for the past few years, we pushed 40 barges configured as 8 barges wide by 5 barges long. Up until about two years ago my former employer started asking for "volunteers" to move 6 to 8 extra barges downstream to New Orleans. With the addition of an extra 1 to 8 barges, the length of the tow is extended by about 200 feet. With this configuration you lose the vital

room necessary to negotiate bridges, traffic, and close turns when you are southbound with the current. I find that this lost room is critical in just about every case. I consider this room as a reasonable buffer to correct for normally acceptable navigational clearances, small errors and mechanical malfunctions when the machinery is performing reliably.

While extending the length of a southbound tow is a major problem for river pilots, the eight-barge width of existing tows provides problems for other river users. Inland Rule 14(d) gives a southbound vessel the right-of-way over an upbound vessel as well as the obligation to propose the manner of passage in all cases. This allows the downbound vessel to legally and effectively control traffic at certain times and places. Keep in mind that the width of the channel from Baton Rouge to Cairo and on to St. Louis (UMR Mile 191) as published in the Corps of Engineers "map book" is only 300 feet. A tow eight barges wide takes up 280 of the available 300 feet leaving nothing for other vessels except to try to find a spot to push into and wait. Waiting for an oversized or overloaded tow to pass can take hours and cause significant delays to both upbound and downbound traffic – especially as the tow proceeds cautiously or runs aground for any reason. In addition, threading a 280-foot wide tow through a 300-foot wide buoyed channel is not an exact science. The Coast Guard and its buoy tenders must do the work and bear the expense of constantly replacing buoys.

The company began to move beyond "volunteers" to insist that their experienced mariners "advance" within the company by accepting oversized tows of more than 40 barges and/or by inserting the new oversized barges into the tow. The company appeared to be willing to accept the risk of damage but simply assumed their licensed officers would assume whatever risk accrued to their own licenses. In return for this assumption, they compensated their masters with an additional \$50 per day and their pilots with \$45 per day.

I want to introduce GCMA **Report #R-340** as a report on oversized and overloaded tows that was put together with the input from a number of experienced mariners. I participated in preparing several areas of this report. The report provides a good summary of what can be expected with this type of **oversized and overloaded** towing on the Lower Mississippi River and other waters including the Gulf Intracoastal Waterway and Illinois River. Briefly, the size and composition of handling of these **oversized and overloaded tows** changes their handling characteristics dramatically.

Oversized tows are more susceptible to unseen eddies or other conditions. Overloaded barges within the tow adversely affect backing and swinging the tow and make its handling unpredictable. It makes bridges harder to transit. There is a loss of distance perception when a tow expands from 1,000 to 1,200 feet in length. This makes it hard for the pilot to judge his navigation moves. This places a tremendous amount of added stress upon the master or pilot. This stress is well known to cause severe health problems with a number of pilots who I know personally have died or became permanently disabled from heart attacks or strokes. These huge tows disrupt other river traffic by creating hold ups that can last for hours and clog the traffic pattern. On these tows there is absolutely no room for error. If you don't make a turn or a bridge the first time there is no second chance and you are helpless to watch the disaster unfold in slow motion right before your eyes.

Over the years I regularly moved 40 barges from Cairo, Illinois to the New Orleans area. During this time, I never broke a tow or scattered its barges. I am proud of my reputation as a responsible and careful Coast Guard-licensed towing vessel officer. Yet, I had the distinct impression that as the years passed that the company I worked for became increasingly lax in carrying out its vessel maintenance. I continually reported problems, such as propulsion and steering difficulties to company personnel with mixed results.

Many members of the public unfamiliar with the industry judge the "power" of a towboat by how many barges it can push upstream against the current. The real test, as we in the industry know, comes in being able to stop, hold, and maneuver a large tow moving downstream.

My greatest fear occurred when I was pushing just 35 barges at a medium to low river stage. I found that I simply could not stop my tow when fog unexpectedly set in. I backed my

10,500-horsepower vessel full astern at maximum power with all three engines turning at the full 900 rpm for between two and three miles realizing within the next mile that there was a state ferry docked at St. Francisville, Louisiana, which carried both vehicles and passengers across the river. I backed at full power with the engines screaming and the whole boat shuddering for a full fifty (50) minutes. However, I was unable to stop the tow completely unless and until I dragged the barges to a stop down along the bank or dragged a string down a sand bar to finish stopping it. I mowed down several hundred yards of young willow trees in doing this and had difficulty even holding the tow dead in the water until the fog cleared and I could proceed safely.



The St. Francisville, LA, ferry crossing the Mississippi River at LMR Mile 266 as mentioned in Captain Gwin's remarks. The emphasis on handling a large tow should always be on safety first and foremost. Inland Rule 15(b) requires a ferry crossing a river to keep out of the way of a power-driven vessel ascending or descending the river. On October 26, 1976 the Ferry GEORGE PRINCE was struck and sunk by an upbound ship at Luling, LA, LMR Mile 120.8 with the loss of 76 lives.

I immediately reported this to the company. I advised them that based upon my riding this boat constantly for five years the vessel needed immediate repair. To their credit, they did put the vessel on dry dock. Upon inspecting the underwater propulsion gear, we found the two outside flanking rudders were bent out and back toward the Kort nozzle. The inside port flanking rudder was bent across in a manner that blocked water from reaching the propeller. All three propellers were in dire need of replacement. The center Kort nozzle surrounding the center wheel had large chunks of metal gouged out of it. The vessel had a keel cooler leak that the company did not hesitate to fix.

As for the rest of the repairs, the company representative at the shipyard told me that they would have to be done at some later date. At this point, I advised the company official that unless the vessel propulsion was acceptably repaired I could not bring full tows out of St. Louis. In other words, I could not handle 25 to 30 barges from St. Louis to Cairo and 40 barges from Cairo south. I told them that I would only bring the number of barges I felt the vessel could safely handle. That figure was 30 barges of 9-foot draft or only 25 overloaded barges. This estimate evidently infuriated the company officials enough to make a quick fix instead of making complete and thorough repairs.

The company exerted pressure in a number of ways to coerce some towing vessel officers to accept **oversized and overloaded** tows. The typical approach to many of its senior Captains is "If you won't do the job, we will get someone that will." However, finding a person with comparable experience does not appear to be very high on their priority list. However, it does open up a slot for "advancement" for a pliable individual willing to step up as master of one of the nine largest and most powerful towboats in the country and take his chances with the risk. I don't want to be known as a towboat captain who, like the railroad

engineer Casey Jones, became known for one of the most spectacular pile-ups of the century!

A mariner and his license coupled with his experience can earn the company a profit. Unfortunately, a less-experienced pilot can be exploited or coerced into accepting risks that more experienced mariners will not accept because of the potential damage that can result. The company demonstrated that it was willing to use personal ego, family, or financial issues as pressure tactics to move their **oversized and overloaded tows**.

I made an important decision not to move **oversized and overloaded tows** that cost me my job. My decision came after long and careful consideration. I asked for a transfer to a smaller boat pushing smaller tows. After I was terminated, I found that I was not the only mariner that made this same decision. I personally know of at least six others that made a comparable decision and lost their jobs. The company says our loss of jobs was a result of the "economy", work force cutbacks, and seasonal. Yet, less experienced mariners were hired within hours of our termination? That is clearly an "employment" issue and cannot concern us here today. But, as one of a group of mariners, I took legal action for unfair labor practices where each of us was wrongfully discharged for refusing to commit unsafe acts that placed us in jeopardy of losing our reputations, our licenses, our careers, and had the potential to cause untold damage on our waterways. We also seek an award of \$60,000,000 in punitive damages to remove the financial incentives that unfairly accrue to a large corporation that crowds and clogs the public waterways with its oversized and overloaded tows. As pilots, we tried reasoning with the company. We tried to invoke common sense to no avail. Perhaps tying dollars to common sense will change their mind about taking unnecessary risks!

Our waterways' infrastructure is supported by the American taxpayers and policed by the Coast Guard. I urge the Coast Guard, the American Waterways Operators, the National Transportation Safety Board and this Committee to focus on the problem of **oversized and overloaded tows** and provide a reasonable solution that protects the interests of the taxpayers, the industry and the mariners that serve in this industry.

The record shows a number of accidents since the introduction of these **oversized and overloaded tows**. One accident that approached million-dollars in damage happened near the Upper Baton Rouge Bridge and is cited in GCMA **Report #R-340**. This accident happened to a mariner who was well posted and had navigated the area many times in almost all conditions. The question that investigators should ask under these circumstances is: "What happened, and what changed?"

My answer in consultation with other officers was that the oversized and overloaded nature of the tow was the root cause of the accident. Strangely, the Coast Guard investigator never reached that conclusion or offered any suggestions as how to avoid similar accidents. We can forgive him if he lacked the background of a river pilot approaching this bridge with 42 barges in tow – a place where other pilots previously came to grief. What will it take before the Coast Guard understands the problem posed by these huge tows and acts to protect the other waterway users and the infrastructure on our waterways?



You may ask, "Why am I here, today?" I want to tell you that river pilots have tried for years to get someone in authority to listen to problems that are well known in this industry, only to fall upon deaf ears. American Inland Mariners tried in the mid-1990s to bring our issues to the attention of the Coast Guard. In 1998 river pilots tried to unionize hoping that this would give us a strong voice. Unfortunately, mariners met with very strong threats, intimidation, and resistance by the companies. The "Pilots Agree" movement was not successful and caused many experienced mariners to be black listed so that they could no longer work for the better companies. Others were driven from the industry.

There is little motivation for experienced mariners to work at a job that may kill or disable them years before their normal retirement age. There is even less motivation to commit

unsafe and reckless acts or to break existing laws or regulations in an honest attempt to provide for their families.

A mariner that stands the front watch as Master of the vessel is now caught in a situation where he almost certainly must violate the existing 12 hour rule in light of the time he must spend doing reports, holding safety drills, and other duties managing the crew and shepherding a large number of barges. He must continue to stand his six-hour watch no matter how much time he spends doing these other necessary things instead of resting during his "off-duty" hours. Add this to the stress of an **oversized and overloaded tow** and you will see why the determination by the American Inland Mariners Association that the average life span for river pilots is only 57 years worries many mariners. Thus, the matter of **oversized and overloaded tows** that developed in the pressure of corporate "business competition" has turned into unbridled greed and has caused a significant safety problem with a measurable human toll.

Will it take another tragic and catastrophic event for the Coast Guard to act? A one-barge tow took out the Judge Seeber Bridge in New Orleans; a two-barge empty tow took down the I-40 bridge at Webbers Falls; a four-barge tow brought down the Queen Isabella Causeway in Texas; six-barges caused the Amtrak disaster at Bayou Canot. Just imagine what a 48 barge tow traveling at 10 to 12 miles per hour southbound, at a medium to high river stage with the current, carrying between 70,000 and 100,000 tons of cargo could do to a bridge heavily laden with traffic, to a chemical dock, or to the river infrastructure at Memphis, Baton Rouge or to the chemical corridor down river toward New Orleans? While we are absorbed with guarding against terrorists, we must also guard ourselves against preventable catastrophic accidents.



The Hernando De Soto I-40 Bridge at Memphis, TN, LMR Mile 736.6. Captain Gwin took this picture with the Memphis Gage at 9 feet. At about 20 feet on the gage the main body of the bridge pier footings submerges leaving the smaller circular portion of the bridge support shown in the photograph vulnerable to bridge allisions from tows.

On February 26, 2004 GCMA sought comparative structural information on the vulnerability of these supports from the USCG Bridge Administration Branch in St. Louis in light of the May 2002 barge allision that collapsed the I-40 bridge at Webbers Falls, OK, with the loss of 14 lives.

The barge and temporary sheet piling shown in the photo are part of a \$170,000,000 seismic reconditioning program to protect the 30-year old structure from earthquakes resulting from the New Madrid fault line.

Picture Missing

The Harahan Railroad Bridge, Memphis, TN, LMR mile 734.7. On December 7, 2002 the M/V Andrew Cargill MacMillan pushing 46 barges misjudged how fast her tow was flanking and struck the bridge with her starboard string of barges breaking up the tow sinking one barge, grounding two others.

As members of the Towing Safety Advisory Committee, I ask you to consider what actions by the towing industry or even regulations it would take to resolve this aspect of the **oversized and overloaded tow** problem. If it is an "industry problem," the industry should step in and solve it. If it becomes a "regulatory problem," then the Coast Guard must step in and solve it.

I did my best to present this problem as a person with experience handling one of the largest and most powerful towboats on the river. This is just the pinnacle of the iceberg and it is in plain view. I respectfully ask you to consider that there is a clear need to define and establish an upper limit for tow size. As an experienced pilot, I recommend that that the upper limit for downbound tow size must be capped at a maximum of 40 barges, 195 ft. x 35 ft. x 9 ft-draft on any southbound tow pushed by a 10,500 horsepower towboat on the free-flowing main stem of the Mississippi River between Cairo, Illinois and the New Orleans area.

I suggest to this Committee, to the Commandant of the Coast Guard, and to the Chairman of the National Transportation Safety Board that any larger tow be recognized and labeled as "an unsafe industry practice."

Thank you for your time and your future consideration of this problem.



A forty-barge tow as seen from the pilothouse of a 10,500-horsepower river towboat, the largest used on America's inland river system. Mariners who push these large tows believe that the Coast Guard, as the responsible regulatory agency, should limit the size of tows pushed downstream by these river towboats to a maximum of 40 barges measuring

195 ft. x 35 ft. x 9.5 foot draft.

**Pilot's view of a 40-barge tow.
Width: 280 ft. - Length w/boat: 1200 ft. - Tonnage: 50,000 plus tns.**

TOWING VESSEL INSPECTION

[Background: A lengthy article appeared in the March 29th issue of The Waterways Journal by Bill Evans titled Inspections May Be Part Of New Towboat Safety Regime. GCMA mariners can request a copy of the article as GCMA Report #R-394. Since the article relies heavily on American Waterways Operators (AWO) and Coast Guard sources, GCMA sent the following letter to The Waterways Journal to balance the coverage to represent the goals that our mariners have worked for ever since GCMA was established.]

Dear Mr. Shoulberg,

I read with great interest Bill Evans' report on the possibility of towing vessel inspections. I would like to add a few points from a mariner's point of view.

The focus of attention really needs to be on the much broader view of adequately "regulating" the towing industry rather than just upon "inspection."

Ever since 1972 when the industry dissuaded Congress from properly regulating towing vessels, a tremendous gap in safety and the protection of the mariners arose between the mariners who serve on uninspected towing vessels and mariners who serve on inspected vessels of comparable size and horsepower.

In March 2001, the Gulf Coast Mariners Association presented the Towing Safety Advisory Committee (TSAC) in **GCMA Report #R-276** a list of approximately 60 "gaps" between the safety regulations that govern inspected vessels such as small passenger vessels and offshore supply vessels and those that govern uninspected towing vessels. A year later, at the request of the member of the TSAC who represents the general public, GCMA compared the features of the Responsible Carrier Program to this list of regulatory shortcomings. GCMA presented the findings in a 204 page book at TSAC's meeting in San Francisco. Since that time, GCMA refined its report to now include 74 regulatory shortcomings.

What we seek for our mariners is very simple. We believe that our government must offer equal protection to all our mariners regardless of whether they work on inspected or uninspected vessels. First, Congress must authorize the Coast Guard to add "towing vessels" to the list containing 14 other classes of vessels that are subject to inspection. This is already in the works. With such authorization in hand, we believe that the Coast Guard must address each and every one of the 74 points cited in **GCMA Report #R-276** in new regulations.

While "inspection" of towing vessels is part of the issue, we believe that Congress should examine the matter of how this industry and its 5,200 vessels and its horrific record of accidents was able to remain under the Coast Guard's radar for so long.

Very truly yours,

Richard A. Block
Master #1014425, Issue #8
Secretary, Gulf Coast Mariners Association

CREW LOST AS SHIP CRASHES INTO OFFSHORE SUPPLY VESSEL IN FOG

Following the collision between offshore supply vessel LEE III and the ZIM MEXICO III on February 21, 2004 that left five OSV crewmembers dead, GCMA addressed this letter to LCDR William Drelling, the Coast Guard officer that is investigating the accident:

"The Gulf Coast Mariners Association requests to be named as a "Party in Interest" in the above-captioned matter. Our Association represents the interests of many mariners serving

in the offshore mineral and oil industry and regularly reports to our members on significant events such as the above-captioned matter.

"Newspaper accounts indicate that there will be a number of "lessons" that will arise from this disaster. We want to be certain that we inform our mariners correctly as to the testimony and the conclusions that you reach and to pass along to our membership either in our newsletter or via our website on the internet any pertinent advisories you may issue that may affect our mariners.

"Although we were unable to attend the hearings, we request permission to review the transcript of the testimony when it becomes available in your office as we may not have the funds to purchase our own copy. We were previously afforded this courtesy in regard to the sinking of the M/V Cheramie Botruc #26 several years ago."

The Coast Guard held extensive hearings on the accident that were reported on in the New Orleans Times Picayune. (GCMA file #M459). While these articles outline some of the testimony, journalism is not a substitute for investigation.

Mariners with any knowledge of the accident or solid background information that might be useful to Commander Drelling in his investigation should contact him directly at the MSO Morgan City Investigations Office at (985) 380-5320.

Some of the answers and possible lessons that newspaper reports lead us to believe we may learn from this tragedy are:

- For what reason did the LEE III leave the safety of Venice at 3:00 AM for a perilous trip downriver in shutdown fog?
- What role did excessive speed in fog play in this accident?
- Why didn't the ship pilot hear the LEE III's repeated radio calls until the disaster became unavoidable?
- Was the accident a result of any shortcomings in the handheld VHF radio the ship pilot used or the improper or imprudent use of a radio by either party?
- Could AIS have saved the day if both vessels had been equipped with it?
- Are adequate provisions being made to train mariners on vessels equipped with AIS?
- How does the new New Orleans VTS system plan to control river traffic near the mouth of the river in foggy conditions when the system is fully functional? When will the Coast Guard close the river to marine traffic?
- What role did insufficient "local knowledge" play in the accident?
- Does the two-watch manning system in place on most OSVs allow for a sufficient number of trained watchstanders to be on duty in restricted visibility? (The LEE III Captain, the vessel's only other trained "radar observer" reportedly was found drowned in his stateroom.)
- In what way did the company operational policies and practices affect the accident?

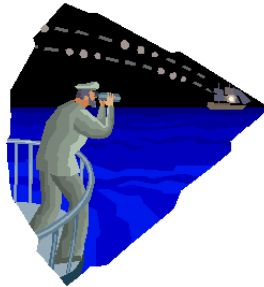
SECURITY TRAINING

In the past, SAFETY was the big "S"-word in the marine industry. Today the new big "S"-word is SECURITY. It's not that "safety" is completely forgotten, but the Coast Guard has its collective mind set on security.

- **TRUE:** There is a requirement that Vessel Security Plans had to be completed by December 31, 2003.
- **TRUE.** The Coast Guard plans to review these security arrangements on or before June 30, 2004 to see if they meet their requirements – and see that they are corrected if they are not satisfactory.
- **FALSE.** Every licensed mariner must complete a Coast Guard-approved vessel security course by June 30th. We want to counteract the rumor that your license will vanish if you don't take a security course! It won't!

Companies will appoint a Company Security Officer (CSO) and Vessel Security Officers (VSO) for each of their vessels. They may well send these officers and other company employees to a security class at company expense. There is a wide assortment of courses "approved" by all sorts of prestigious groups. However, there are no "Coast Guard-approved" security classes offered and none that are planned in the foreseeable future!

In the meantime, licensed officers are expected to read and ask any necessary questions to understand the vessel security plans your company prepares to meet USCG requirements. Each individual mariner is the most important link in our nation's maritime security chain. Your vigilance is important. Help is as close as your radio. It is as close as your cell phone, too. In an emergency, the number is the same one that is on the pollution signs posted on every vessel: **1-800-424-8802**.



ANOTHER TUG SINKS IN THE GULF

For the past four years, GCMA sought answers to why our mariners serving on uninspected towing vessels do not receive equal protection under existing laws and regulations as mariners who serve aboard inspected vessels such as offshore supply vessels and small passenger vessels.

GCMA Report #R-276 lists 74 specific areas where tug- and towboatmen appear to be discriminated against because no laws or regulations protect them. Item #14 in our report deals with the unsafe movement of damaged vessels and states: "Unlike inspected vessels, a damaged uninspected towing vessel does not require Coast Guard permission to proceed to another port for repairs (CG-948) after an accident."

"It is not only after damage to the vessel but also after extended lay up periods that a vessel needs to be thoroughly checked and restored to top working order before setting out on a voyage. The same is true of "delivery trips" when a vessel is sold to a new owner and moved to a new location. Unsafe movements can result in breakdowns, sinking, damage to the environment, channel blockage, or a host of other unsafe but preventable conditions."

A year ago, we learned from word of mouth that a large tug sank somewhere in the Gulf of Mexico. As is true in most accidents, very little appears in local newspapers and in television reports. There is nothing to see after a boat sinks except an oil slick, and oil slicks from small vessels don't sell newspapers or make the evening TV news. Consequently, GCMA filed a Freedom of Information Act (FOIA) request and finally received a copy of the accident report. With a very sketchy accident report in hand, we still had to dig for additional information.

The M/V CAPT. PECK, a 105-foot, 198 gross register ton uninspected steel towing vessel built in 1957 (i.e., 46 years old) departed from Freeport, TX "light boat" on Monday January 20, 2003 with a crew of six en route to New Orleans, LA. Since the vessel was uninspected and apparently was on some type of "delivery trip" after a long lay-up period, she was not required to seek the Coast Guard's permission (i.e., on form CG-948) to proceed to another port for repairs.

While crossing the Gulf, the owner/operator of the vessel was the only individual aboard

the vessel holding a Coast Guard issued merchant mariner's license which was a 100-ton master's license that clearly did not cover a towing vessel of 198 gross tons. The vessel was underway for several days before the incident, during which time the master was relieved of the wheel on several occasions by unlicensed crewmembers for 2 to 3 hours at a time. Normally, such an arrangement would be illegal – and with other shortcomings reflects poorly upon the judgment of the master who apparently also owned the vessel. During the time that the master was off the wheel he would sleep in a cabin near the pilothouse.

On the night of January 23, 2003 the vessel was eastbound through the Ship Shoal area of the Gulf of Mexico with the master at the helm. Sometime shortly after midnight, the vessel began losing generator power and the Chief Engineer shut down the main engine and generator while he changed the fuel filters. Seas at the time were estimated at 12 to 14 feet as the vessel began drifting toward a platform. When the engineer finally brought the generator back on line and restarted the main engine the master immediately put the engines full astern to avoid striking the nearby platform.

This would have been a successful maneuver. However, as the vessel backed down, a loud noise came from the engine room and the main engine shut down. Water began pouring into the engine room from the vicinity of the stuffing box and began to flood the engine room. Although the engineer attempted to start the main bilge pump, he could not reach it because of the rising water – a common occurrence. As the engine room continued to flood and the master immediately sent out a distress call, to which the M/V SAM MCCALL and a Coast Guard helicopter responded. The M/V SAM MCCALL secured a towline to the M/V CAPT. PECK and pumps were dropped from the Coast Guard helicopter. Nevertheless, the pumping efforts were not successful and the M/V CAPT. PECK was abandoned by her crew and sank. There is no record in the accident report as to whether the vessel was ever salvaged or still graces the seabed of the Ship Shoal area.

A Coast Guard interview with the master subsequently revealed that except for the few instances where he turned the wheel over to unlicensed personnel, he remained on watch from the time the vessel left Freeport, TX, to the time it sank off the central Louisiana coast. Post accident drug testing was performed on the master and chief engineer with negative results.

The dollar amount value of vessel was unknown as a result of the Coast Guard's inability to contact the owner/operator. However, the owner/operator did state that vessel was not insured.

The Coast Guard recommended suspension and revocation action against the Master of the M/V CAPT. PECK. We noted several occasions in recent months where the Coast Guard invoked suspension and revocation (S&R) proceedings where they find a person who is clearly operating a vessel beyond the scope of his license. In this case, the master only had a 100-ton license while operating a vessel of 198 gross tons. So, S&R looked like a slam dunk.

However, Title 46 U.S. Code §2101(40) defines a "towing vessel" as "...a commercial vessel **engaged in or intending to engage in** the service of pulling, pushing, or hauling along side, or any combination of pulling, pushing, or hauling along side." The vessel obviously was a tugboat but it was operating "light boat" and was not engaged in towing at the time of the accident and apparently was not planning to engage in towing on that voyage. A note dated October 23, 2003 in the Coast Guard's accident report indicated that "Subsequent investigation gives no indication that master was operating under the authority of his license under these particular circumstances."

The Coast Guard questioned the master, who was also the boat's owner, in regard to the loss of his vessel. That brought into play another regulation, 46 CFR §5.101(b) that states: "In order to promote full disclosure and facilitate determinations as to the cause of marine casualties, no admission made by a person during an investigation under this part or Part 4 of this title may be used against that person in a proceeding under this part, except for impeachment.

The Coast Guard accident report is very limited in what it tells us but it opens up a much broader area of speculation.

This sinking occurred in mid-winter in the Gulf of Mexico where the water temperature often dips to below 59°F. Estimated in-water survival time hanging on to a life float or similar "in water" device at this temperature is probably no more than 3 hours. In the report, there is no mention as to whether this tugboat carried an inflatable life raft on board and that, if there was one, whether it had been serviced within the past year.

GCMA Report #R-276, Item 35 mentions and GCMA Report #R-354 goes into considerable detail on the shortcomings in lifesaving equipment aboard coastwise uninspected towing vessels. GCMA petitioned Congress to consider the lives of our mariners that are placed at risk by not requiring "out-of-water" lifesaving equipment such as inflatable life rafts on these uninspected vessels.

Mariners who work on uninspected towing vessels should understand that no Coast Guard regulation currently requires an uninspected towing vessel to be outfitted with an inflatable life raft or even an inflatable buoyant apparatus even when traveling on an offshore route.

There is no mention as to whether the M/V CAPTAIN PECK carried any immersion suits for crewmembers. 46 CFR 25.25-5(e) allows the substitution of an immersion suit for a life preserver, buoyant vest, or other marine buoyant device. It is extremely fortunate that there was a source of help from a surface craft and that a Coast Guard helicopter responded to the MAYDAY call under difficult conditions. GCMA notes a real difference between the "seagoing" Coast Guard that is out there with rescue equipment willing to assist our mariners in the most desperate circumstances and the "paper" Coast Guard that hasn't figured out for the past 30 years how to provide the most basic support to seamen serving on seagoing tugs.

When the main engine was re-started, the master backed down hard to avoid a nearby platform. In doing so, he backed over his "...towing line which was secured to wooden platforms on the rear deck (and) floated and fouled the wheel." Apparently the towline wasn't "secured" very well – another screw-up that appeared to plague the whole operation and reflects unfavorably on the master's seamanship and supervision.

Where the Coast Guard accident form calls for the "name, address and telephone number of the operating company" these words appear: "(owner)(operator) was not yet a company but would have been."

This, more than anything else in the report indicates that this was a business enterprise run on a shoestring. The sinking marked a sorry end to a new business venture that cut just one corner too many. Perhaps the master would have been able to think more clearly if he had not been on duty for the better part of three days. Perhaps, as a seaman, he should have checked to see whether his towline was adequately secured on the main deck before running in 12 to 14-foot seas or taken the time to move the towline to the top of the deckhouse or other suitable precaution.

Adequate preparation for a trip across the Gulf in mid-winter should have taken into consideration the condition of his fuel before getting underway.

As a sound business venture he should have thought about insuring the vessel in the event of loss. However, even more important is the need to carry insurance in case some accident befell one of his crewmembers. As it was, crewmembers that survived this accident were lucky that help was available and that they got away with their lives; and, more fortunate yet if they ever received their paycheck after this harrowing experience. The owner/operator, whose name was redacted from the report, lost his vessel – a relatively minor consequence considering the lives of his crewmembers he put at risk.

REPORT TO OUR MARINERS

ON THE TSAC COMMITTEE MEETING IN WASHINGTON MARCH 16 & 17

[GCMA Comment: We urge our mariners to read all the GCMA Reports mentioned in this article. They are available on the internet or from GCMA upon request if you do not have an internet connection.]

Representing GCMA at the latest TSAC meeting was Captain Larry P. Gwin and his wife Brenda and Richard A. Block and his wife Gwen.

OVERSIZED AND OVERLOADED TOWS

Captain Larry Gwin is a heavy tow pilot with 33 years of river experience, much of it upon the largest river towboats of 10,500 horsepower.

GCMA called upon Captain Gwin's experience and excellent safety record to make a formal presentation to the TSAC Committee. His speech to this Federal advisory committee was coupled with a written petition to the Commandant citing his experience operating one of the country's largest river towboats. The petition, citing **GCMA Report #R-340 on Oversized and Overloaded Tows**, asks the Commandant to declare that pushing more than 40 standard 195 ft x 35 ft x 9½ ft draft barges downstream represents an "unsafe industry practice."

GCMA expects the Commandant to take this petition under advisement and speculates that he may "task" TSAC with examining the request or take some other appropriate action.

A number of other mariners with comparable experience on these large towboats are also in the process of signing copies of the same petition to the Commandant.

In his prepared remarks accompanied by color photographs (available as **GCMA Report #R-391**), Captain Gwin discussed a number of other items of importance to river towboat pilots. These remarks were distributed in press releases to many newspapers and trade journals as well as to all Coast Guard Marine Safety Offices on the Western Rivers.

Captain Gwin's remarks were well received by the Committee and brought up lively discussion and considerable interest in the points he discussed.

The Coast Guard is now on notice that some of the most senior mariners they examine and license for service on the Western Rivers express serious concerns about the risks to their health and their livelihood, to other mariners including their crewmembers, to the general public, and to damaging the waterway's infrastructure and its aids to navigation.

Mariners tried to express these concerns to the Coast Guard in the past within the framework of mariner organizations such as the American Inland Mariners Association (AIM) and Pilots Agree. Now that these concerns are out in the open before a Federal advisory committee, in the hands of the Commandant, in the newspapers, and in the hands of members of Congress, it will be much more difficult for the Coast Guard to follow its traditional practice of heaping unlimited amounts of blame on an unfortunate Captain who accepted an oversized or overloaded tow or broke a regulation because his only other alternative was to find another job or go on the unemployment line.

Manure

[Source: Captain Dean Bruch, GCMA's senior unlimited Master, tells us: "This matter has been researched by a close friend of mine (ex-Navy) and he has no doubt that this is a true history of this word. If this is not true, "it's still a damn good sea story!]

In the 16th and 17th centuries before commercial fertilizers were invented, bulk cargoes had to be transported by ship. Large shipments of manure were common.

Manure was shipped dry because, in dry form, it weighed a lot less than when wet. However, once water (at sea) hit it, it not only became heavier, but the process of fermentation began. A by-product of fermentation is methane gas. As the stuff was stored below decks in bundles you can imagine what could and often did happen. Methane

began to build up below decks and the first time someone came below at night with a lantern, BOOOOM!

Several ships were destroyed in this manner before it was determined just what was happening. After that, the bundles of manure were always stamped with the term, "Ship High In Transit" on them. This cautionary marking told the seamen to stow it high enough off the lower decks so that any water that came into the hold would not touch this volatile cargo and start the production of methane.

Thus evolved the term "S.H.I.T.," (Ship High In Transport) which has come down through the centuries and is in use to this very day.

GCMA – THE VOICE FOR MARINERS

GCMA is "The Voice for Mariners." It is your voice when you have some serious thought, problem or project to present to the Coast Guard, other regulatory agency, or to your fellow mariners. Our mariners' cause is well served by those experienced and thoughtful individuals like Captain and Mrs. Gwin who are willing to take the time and effort and, at considerable personal expense, to place their message before an appropriate audience.

The Federal Advisory Committee system is used throughout the Federal government. It brings together representatives from a number of different positions within an industry or profession to present and discuss their problems and perspectives. In order to do this, our mariners who have something to say should take the time to learn how to use this vehicle.

GCMA, with the past support of four maritime unions, sponsored several dozen mariners at meetings in such diverse places as Washington, San Francisco, Seattle, Cleveland, Fort Lauderdale, Houston, Galveston and New Orleans. As an independent and self-supporting Association, we are always looking for mariners to attend TSAC, NAVSAC, NOSAC, MERPAC advisory committee meetings as well as "Industry Day", Corps of Engineers Low Water and High Water meetings at various locations. We depend on their feedback to inform our mariners. Our concerns cover the entire area served by "lower-level" mariners in the Eighth Coast Guard District. To learn more of the background of Federal advisory committee meetings, we refer you to **GCMA Report #R-384** on our web site on the internet or from us in printed form.

"DEADHEAD TRANSPORTATION" AKA "TRAVEL TIME"

In past years, the issues presented to TSAC were generally Coast Guard issues. However, in recent meetings, TSAC took up a number of issues that GCMA asked to be placed on the agenda. The matter of "Deadhead Transportation" or allowing licensed officers to have six hours of rest before taking charge of their watch is a major issue that has deadly implications when a mariner (truck driver, airplane pilot, locomotive engineer) falls asleep on watch.

The task was assigned to TSAC's Regulatory Review Subcommittee headed by Mr. Mario Munoz, Risk Manager for American Commercial Barge Lines. GCMA provided each member of TSAC with **GCMA Report #R-346**, Work-hour Abuse, Whistleblower Protection and Deadhead Transportation. While there are an abundance of "horror stories" of mariners falling asleep on watch, we will review carefully the forthcoming NTSB accident report on the Webbers Falls I-40 bridge allision where the towing vessel's master drove over 1,000 miles with only 3½ hour's sleep before taking over the watch on the M/V ROBERT Y. LOVE. GCMA members report their own "horror stories" in Report #R-346.

We urge our readers to review GCMA Report #R-346 and send us any additional information or experiences that would help us obtain adequate regulations to detail specific problems to help the Coast Guard enforce the provisions of the law that some companies

conveniently choose to overlook.

CREW ENDURANCE MANAGEMENT (CEMS)

Crew Endurance Management is an ongoing experimental program that is funded by the Coast Guard. It seeks to teach both Coast Guard personnel and commercial mariners many of the good habits that can maximize their safe performance aboard ship. As a result of its own shortcomings⁽¹⁾ the Coast Guard carried out experiments on its own cutters and boat stations. [⁽¹⁾ *Discussed in GCMA Report #R-305, Betrayed! A Call for Increased Congressional Oversight of the United States Coast Guard.*]

The American Waterways Operators (representing the tug and barge industry) and the Offshore Marine Service Association (representing the offshore oil industry) asked to participate in what has now become a "demonstration project." The National Transportation Safety Board supports the demonstration project while funding it is the subject of proposed Congressional legislation.

At TSAC, we learned that 8 companies and 37 vessels are currently participating in CEMS. However, within the next year, Kirby Inland Marine is looking toward applying CEMS to approximately 90 vessels and Penn Maritime plans to apply it to all their vessels.

GCMA supports the attempts of the Coast Guard, the NTSB, and industry to circulate the scientific information regarding CEMS widely throughout the industry. We believe that this knowledge is an absolute necessity to survive in an industry that has been allowed to push its mariners beyond reasonable limits of endurance such as we cited in **GCMA Report #R-375, Crew Endurance: The Call-Watch Cover-up**. However, where we draw a line is if some companies intend to use this knowledge to squeeze more work out of their already overburdened employees.

We also point out that the program is very ambitious in that it seeks to change our mariners' habits. It is hard to teach old dogs new tricks, and old habits die hard. However, some habits really need to change.

NIGHTTIME BARGE FATALITIES

TSAC agreed to look into the matter of nighttime barge fatalities as a result of a report presented by LT Brandy Parker at TSAC last September. GCMA wants to publicly recognize that LT Parker demonstrated her understanding, interest and concern for our mariners while serving at MSU Baton Rouge.

The AWO has been looking into this problem since 1996 when they issued an AWO/USCG Joint QAT Report on Deck Crew Safety in the Inland Towing Industry (GCMA File #A-424).

At this TSAC meeting, the AWO's professional statistician Douglas Scheffler presented figures that were cautiously optimistic about what he found as a possible downward trend in the number of fatalities since 1997. Scheffler pointed out this distribution of fatalities:

The largest number of fatalities occurred when the last known mariner activity before his fatality was line handling (29%), followed by walking or standing on the barge (14%), fuel and/or cargo transfer activity (11%), and routine maintenance work (11%) with all other activities accounting for less than 10%. Scheffler pointed out that non-AWO companies appeared to have a greater number of crew fatalities. In light of the honest efforts that many towing companies have exhibited in carrying out AWO's Responsible Carrier Program, we believe that this is a fact our mariners should consider when making future employment choices in the industry.

GCMA pointed out that many fleet boats only have a two-man crew with no equipment on board capable of retrieving a deckhand or other person who falls overboard. Unless and until

some improvements are made in this area (specifically exposure suits in wintertime and **new manning and lifesaving regulations**, requirements for man-overboard drills that make it possible to retrieve a man overboard from cold river waters), we do not expect substantial improvements in the fall-overboard fatality rate.

[GCMA Activity: GCMA is currently working with a team of former Coast Guard search and rescue experts at Lifesafer, Inc. of San Diego, CA, who developed a "Personal Retriever" device we are now testing.]

LICENSING AND TRAINING

The tonnage limit for the new Master of Towing Vessel license when used on near coastal routes is 200 tons. However, this new master or mate of towing vessels license cannot be used on international voyages.

There is a significant training burden for mariners who seek licenses to "work foreign." "Foreign" in this case refers to places as close as Mexico or most islands of the Caribbean. This burden involves anywhere between 10 and 22 weeks of schooling including training and assessment to become qualified as an Officer in Charge of a Navigational Watch.

Captain Jim Daley of Crowley Maritime, one of the industry's most sought-after employers, is in charge of a TSAC working group that is looking into a way to pay for training that can cost as much as \$200 per day. The problem has become so serious that a "training summit" was held in Sacramento, CA, in early April. – as announced by Ms. Marina Secchitano, a member of the Inland Boatman's Union and long-time TSAC member.

REORGANIZING THE RECS

Captain Ernie Fink, Commanding Officer of the Coast Guard's National Maritime Center in Arlington, VA, in his presentation to TSAC announced that his proposals to reorganize the 16 Regional Exam Centers so that they are directly supervised by the National Maritime Center had just received Admiral Gilmour's signature.

Mariners are well aware that the Coast Guard keeps things in a constant state of turmoil with its repeated reorganizations. Captain Fink appears to be a good administrator and a number of his proposed reforms appear to make sense. They include:

- A national toll-free (1-800-) number.
- Centralize all mariner personnel records.
- Keep the existing RECs to accept and process applications for original licenses and MMDs, upgrades and renewals.
- Centralize all license and MMD "evaluations" in one location for consistency.
- Purchase expensive fingerprint scanning equipment for each REC. (Mariners will still have to travel to the REC for fingerprinting. – a real loser!)
- Increase course oversight on over 3,000 USCG "Approved Courses" that has been practically non-existent in some regions for the past several years.
- Complete FBI checks in 24 hours.

In preparing his program, Captain Fink consulted with an impressive list of "stakeholders" in the licensing system before making his recommendations. Unfortunately, his list did not appear to specifically include the lower-level mariners who make up a clear majority of all American mariners. It did not include GCMA.

Lower-level mariners are accustomed to being ignored by both management and the Coast Guard. The recent History of the Coast Guard's licensing and documentation program shows a big **disconnect** between our mariners and the Coast Guard authorities that seek to

regulate us. Consequently, when Captain Fink concluded his presentation, GCMA presented him with **GCMA Report #R-393** for his consideration. GCMA Report #R-393 represents the views of many mariners who find it difficult if not impossible to live with some of the policies currently enforced by the Regional Exam Centers.

Picking up on Captain Fink's admissions that there have been problems with "slow service, inconsistencies, and unresponsiveness" on the part of many RECs, our report brings out many other problems we reported to our mariners in our last two newsletters. GCMA then furnished copies of GCMA Report #R-393 to the Commanding Officers of each of the 16 RECs, to members of TSAC (by mail), and to our Congressional liaison.

Captain Fink hopes to have his reorganization in effect by April 2006. A number of questioners asked why the process could not be moved along faster and received solid answers involving the federal budgeting process and the shortage of funds. One director of a major union school cited chronic under-funding of the Coast Guard's licensing process as one of the system's largest problems. Interesting points that were made was that the RECs process 60,000 applications per year, receive \$8,000,000 in "user fees" and currently believe the list of active mariners totals about 200,000 persons. GCMA and other mariner organizations can document seeking this elusive figure since 1992.

A presentation by Mr. Jim Cavo on the NMC's staff dealt with the towing vessel "Designated Examiner" (DE) program and sought support for requiring newly appointed DEs to keep records of every assessment that they make in case mariners lose copies of their paperwork. He stated that it would be difficult to duplicate lost records if a DE could not recall what he had done. All of this makes sense, but it will add another layer of paperwork to a bureaucracy that already sorely tests our mariners' patience. Currently over 300 designated examiners are approved to perform "assessments" on the new Towing Officer Assessment Records (TOAR) forms used by new Apprentice Mate/Steersmen candidates. The number of Des is not evenly spread throughout the industry.

PUBLIC COMMENT PERIOD

One feature of most advisory committee meetings is the "Public Comment Period" at the end of the session. It is at this point where members of the public can bring their concerns to the attention of the committee. At this point, GCMA presented these points:

1. Sea service letters: Title 46 U.S. Code, §10320 states: "The Secretary shall prescribe regulations requiring vessel owners to maintain records of seamen on matters of engagement, discharge, and service. A vessel owner shall make these records available to the seaman and the Coast Guard on request."

We criticized the National Maritime Center for not answering our questions about why the RECs have never helped mariners obtain their sea service letters when employers refuse to give them. TSAC Member Captain Gerard Maurice suggested that he had success when he called on the Equal Employment Opportunity Commission (EEOC) because such action on the part of an employer is discriminatory because it prevents a mariner from enjoying the fruits of his labor and unfairly prevents him/her from advancing within his profession.

Captain Ernie Fink, Commanding Officer of the National Maritime Center expressed interest in viewing a copy of the GCMA letter and follow-up that his office failed to answer. This matter is currently in the hands of the Coast Guard's Marine Safety Council following a formal request by GCMA to the Coast Guard to develop regulations on this matter to carry out the will of Congress clearly expressed in 46 U.S. Code, §10320.

2. Pilothouse Visibility. Several years ago, Captain David Whitehurst gave a presentation to TSAC on the dangers of trying to push a tow when you cannot see over or around it. This is done so often and so routinely that it has become an accepted practice. However, this does not mean that it is a safe practice.

Captain Whitehurst gave an updated presentation to the Navigation Safety Advisory

Committee (NAVSAC), another Federal advisory committee, in Galveston in March pointing out the dangers of this practice to recreational boaters. A number of recreational boaters have been killed because of the limited visibility issue. His presentation was well received, but it was questioned why TSAC did not take action on the report when it was first presented to them several years earlier.

At the TSAC meeting, GCMA handed out copies of Captain Whitehurst's report (**GCMA Report #R-275**, Revision 2) to the members of the committee and the public attending the meeting. Committee Chairman Jeff Parker pointed out that the American Waterways Operators prepared a report on visibility issues concentrating on issues in New York Harbor in 1996. He made copies of his report available to the TSAC committee as well.

Captain Larry Gwin responded to a question about the difficulty of trying to push a 40-barge tow with limited visibility over barge covers because of insufficient height of eye on the towing vessel. His answer cited the difficulty of steering by radar when the barge covers deflect the radar beam and distort the image on the radar scope. He also brought up the stress upon the pilot who must try to maneuver his tow by radar and an occasional peak along the barge walkways hour after hour.

Pilothouse visibility for towing vessels is part of a much larger problem that will involve a greater effort to bring towing vessels under more effective regulation.

3. Towing Vessel Regulatory Review. The TSAC Regulatory Review Subcommittee spent the past two years examining and evading GCMA Report #R-276. This is the report that deals with the current lack of Coast Guard oversight that gets to the heart of the problems that afflict the entire towing industry.

The Coast Guard resisted GCMA's efforts to make needed changes in the industry claiming that Congress did not give the Coast Guard the authority to make these changes and the ability to create new regulations.

The Supreme Court, in the Mallard Bay Drilling case, appears to leave the matter of regulating uninspected towing vessels on navigable waters up to either the Coast Guard or the Department of Labor (OSHA). To this point, neither agency seems anxious to catch the regulatory football.

While the TSAC Regulatory Review Subcommittee dabbled with the idea of a "non-regulatory" approach, the matter dragged on from one meeting to another. GCMA washed its hands of this approach a year ago and pushed for full regulatory controls. A final report on the "non-regulatory approach" was due at this meeting but never took place.

In the meantime, GCMA revised and updated its report to "Revision #7" and even changed the title of the report to Towing Vessels Need Regulations Comparable to Other Vessels – An Appeal to Congress. As the title indicates, GCMA delivered copies of our report to a large number of Congressmen as an outline of the problems that need to be corrected.

Before the meeting, GCMA learned from Captain Whitehurst who attended the NAVSAC meeting in Galveston that the American Waterways Operators was working along the same lines as GCMA to "inspect" towing vessels. Further checking indicates that Congressional committee staff prepared draft legislation for consideration by Congress. Of course, the same thing happened in 1972 but that was as far as it progressed. This shortcoming has made life much increasingly risky for the mariners who work in the towing industry because of the 74 different areas that have little or no enforceable regulations governing them today.

MSO HOUSTON-GALVESTON COMMENTS ON M/V HOWARD STAPP BOARDING

[Background: In the October issue of GCMA News (page 1) we published and commented upon a letter written by one of our licensed masters who reported the unsafe conditions on the inland towboat HOWARD STAPP. We received the following e-mail from LT Vincent Gamma, Chief, Domestic Vessels Branch, MSO Houston-Galveston on March 17, 2004.]

Dear GCMA News,

As a follow-up to subject letter printed in your October 2003 issue: What was not included was the Coast Guard's response to the letter.

After receiving the letter, dated September 22, 2003, MSO Houston attempted to track down the M/V HOWARD STAPP JR. in the Houston Ship Channel for the purpose of boarding said vessel in response to subject complaints.

After tracking the vessel through the Galveston and Corpus Christi zones, we were finally able to pinpoint the vessel's location in the Port Arthur area, whereby we contacted the MSO there to voice our concerns about the letter and request that they conduct a boarding of the vessel. On September 29, 2003, MSO Port Arthur inspected the vessel, issuing a list of 23 deficiencies, 11 of which were required to be corrected prior to the vessel's departure from the Port Arthur zone. Repairs to the vessel were completed with oversight from MSO Port Arthur Marine Inspectors.

My point? Serious complaints such as those expressed in subject letter will be investigated, and corrective action taken. Furthermore, events such as these are documented in our marine safety data base, and constitute a history for the owner, operator, and the vessel. Likewise, the owners, operators, and vessels that volunteer to participate in the D8 (Eighth District) Cooperative Towing Vessel (Examination) Program and/or complete exams with flying colors, are also documented in our data base, and present another type of history - one of management and maintenance excellence.

[Ed. Comment: Thank you for your e-mail. Point well taken! We also received "scuttlebutt" that the vessel was in such bad shape it cost the owner nearly \$80,000 to restore the vessel to a serviceable condition. The ability of owners to allow vessels to deteriorate to this point is one reason why GCMA urged Congress (in GCMA Report #R-276) to properly regulate and inspect all towing vessels. It is unfortunate that the Coast Guard never properly funded the Cooperative Towing Vessel Examination Program. Lt. Gamma may be reached at 713-671-5188, vgamma@mso.houston.uscg.mil



FATHER SINCLAIR OUBRE SPEAKS FOR ALL MARINERS

Father Sinclair Oubre, President of the Apostleship of the Sea is an active GCMA and SIU member and sails as an Able Seaman. In short, Father Sinclair is "one of us".

Father Sinclair was selected a number of years ago by the Secretary of Transportation to serve as a member of the Merchant Marine Personnel Advisory Committee and served on that Federal advisory committee as a steady and consistent voice that speaks out on behalf of mariner issues. His pastoral duties are as Pastor of the St. James Catholic Church in Port Arthur, TX.

Father Sinclair served offshore supply vessel mariners on the Gulf Coast as head of the Board of Directors of the Gulf Coast Mariners Association Education Fund that distributed U. S. Department of Labor training funds to train hundreds of mariners to meet the requirements of STCW.

Following the recent sinking of the OSV LEE III, a boat from Galveston, TX, he requested that GCMA provide him with full media details of the accident.

Father Sinclair recently met with representatives of Congress, the U.S. Department of

Homeland Security and the labor movement in Washington, D.C. to advance the cause of improving the potentially dangerous and often-unnecessary restrictions on mariners' shore-leave rights that are entangled with new homeland security regulations.

Father Sinclair has a broad view of the maritime industry and its mariners. It is this broad view that our mariners, besieged with their own problems, need to develop and it is to Father Sinclair that our Association has learned to turn for guidance.

Foreign seamen arriving in United States ports are trapped in the middle between security and terrorism.

Father Oubre and his national ministry, the Apostleship of the Sea of the United States of America, is urging Congress to ratify the International Labor Organization's (ILO) Convention 185 "in the most expedient manner possible so that seafarers do not become the latest victims of terrorism."

Our mariners on the Gulf Coast were caught in a repressive squeeze play long before the terrorist attacks of September 11, 2001. During the pre-9/11 period, members of the Offshore Marine Service Association (OMSA) sealed their vessels, closed off access to and egress from every dock, restricted visitors to vessels and held captive-audience meetings to deny access to maritime union members who brought with them the unwelcome message that it was time for mariners to stand up for their rights of free speech and free assembly guaranteed by the United States Constitution. These "lock-down" restrictions blended so easily with the post-9/11 "security" regulations enforced by the Coast Guard for an entirely different reason that mariners have become accustomed to their loss of freedom.

Father Sinclair notes that ILO Convention #185 was unanimously ratified by a vote of 392 to 0 last year by delegates to the International Labor Organization forum in Geneva, Switzerland. ILO Convention 185 calls for a universally recognized mariner identification document. ILO Convention 185 also states the critical need for providing shore leave for mariners and further specifies that "...seafarers shall not be required to hold a visa." ILO-185 also indicates that "any member (nation) which is not in a position to fully implement this requirement shall ensure that its laws and regulations or practice provide arrangements that are substantially equivalent."

For now, however, all foreign mariners must possess "D1" (non-immigration) visas to go ashore in the United States. "After September 11, 2001, the Immigration and Naturalization Service ceased issuing crew list visas," Father Sinclair explained. "It also changed its rules regarding the INS agent issuing waivers for mariners to go ashore if they did not have a D-1 visa. The new regulations only allow a supervisor to waive the D-1 visa requirement and, unlike the airline industry, there is no avenue for appeal."

One consequence is that mariners have been denied shore-side medical care because they lack visas. "They can't get off the ship unless it's a life-threatening condition," he noted. "This has led to mariners sailing from U.S. ports on voyages that are weeks long without necessary health care. We can only hope that by the time the vessel reached its next port, the situation did not evolve into a life-threatening problem."

A recent article in [Professional Mariner](#) magazine⁽¹⁾ highlights this point with the following example:

"This past fall, when a Cypriot-flag bulk carrier called on Portsmouth, NH, to unload salt, the second assistant engineer, a Ukrainian citizen, was suffering from an abscessed tooth and needed to see a doctor. He was in terrible pain and lacked medication. He, like the rest of the crew must stay aboard the ship, he was told, since he did not have a visa. The ship's previous stop was near Pisco, Peru, a desert wasteland lacking basic services, including a phone. The next stop was to be New Orleans, where they could expect a similar greeting."
[⁽¹⁾ April/May 2004, p. 4]

Another concern is that such instances may lead to American mariners unjustly being denied leave in ports overseas.

"The bottom line is we don't see the relationship between the D-1 visa and security," Father Sinclair said. "Our present policies assume that the greatest threat to maritime security comes from mariners leaving the vessels. However, the real threat is a terrorist posing as a mariner and staying on the vessel. He or she could blow up the ship at dock or scuttle it at an important waterway junction. Preventing the seafarer from leaving the vessel because the mariner lacks a visa will not prevent either of these security concerns."

In a recent letter outlining the situation, the Apostleship of the Sea asked Congress to enact Convention 185 on seafarer documents "and let these new documents be accepted as identification for the mariner and in place of the-D-1 visa."

LOCAL NOTICE TO MARINERS (LNM) CHANGE IN DISTRIBUTION METHOD

The Coast Guard changed the way it distributes the Local Notice to Mariners (LNM) from mailing them to using the internet exclusively. This will save the Coast Guard the cost of printing and postage.

In recent months, many of our mariners watched the Coast Guard push the issue of making proper and timely chart corrections much more than they have ever done in the past. To correct your charts and publications such as the Coast Pilot in a timely manner you need to use information provided by each Coast Guard District in its Local Notice to Mariners. The Eighth District has one LNM for the Western Rivers and another for the Gulf of Mexico.

Effective **April 1, 2004** (aka April Fool's Day) the Coast Guard announces it will no longer mail copies of the LNM. Instead, they will rely solely upon the internet to make more efficient and timely and cheaper distribution possible. This should make it possible for most employers to download and forward copies to their boats. At least this is the Coast Guard's theory from Washington.

We do not necessarily agree with their theory. We know from past experience that many of our mariners are not computer geeks and many do not even have internet connections or even a computer.

The USCG notice states that they are not asking for comments from the public but will accept them. This is the same type of arrogant attitude that is quickly estranging lower-level mariners from many Coast Guard programs.

We have prepared a copy of the Federal Register notice containing the necessary internet connections in **GCMA Report #R-392** available upon request and we sent them our unwanted comments.

DEPARTMENT OF JUSTICE INDICTS MASTER

[Edited from IOMM&P Wheelhouse Weekly, Feb. 12, 2004]

The U.S. Department of Justice (DOJ) announced that three senior executives, a marine superintendent and two licensed shipboard officers were indicted by a federal grand jury in Miami for their role in overboard dumping of part of an oil-contaminated grain cargo from the SS JUNEAU, a U.S.-flag vessel, into the waters of the South China Sea in early February 1999 and their alleged efforts to impede the USCG and other authorities from learning of the illegal conduct.

The defendants named in the charges are: Rick Stickle, Chairman and CEO of Sabine Transportation, Inc., a Cedar Rapids, IA based company; Michael Reeve, President of Sabine; John Karayannides, Vice President of Operations; Michael Krider, Port Engineer; George McKay, Master of the vessel, and Philip Hitchens, Chief Officer.

"We are committed to bringing to justice those who seek to pollute our waters, lie to our government and endanger our well-being," said Tom Sansonetti, Assistant Attorney General for the DOJ's Environment and Natural Resources Division. "Companies and individuals who navigate our waters should take note that we are keeping a watchful eye."

A spokesman for the DOJ said that this prosecution reflects the U.S. government's commitment to seek out those who would degrade the environment for profit and hold them accountable. "The use of the oceans as a dumping ground for unscrupulous operators will not be tolerated. The DOJ will aggressively pursue these operators no matter where they are or how long it takes to hold them accountable for their actions."

In an earlier federal trial, Sabine admitted to discharging an oily mixture of approximately 440 tons of diesel oil-contaminated grain and agreed to pay a \$200,000 criminal fine with respect to the dumping incident and an additional \$1.8 million for other charges against it.

The government's investigation began when the SS JUNEAU arrived in Portland, Oregon at the end of her voyage and crewmembers alerted USCG personnel there that a diesel oil leak into one of the vessel's main cargo tanks was discovered while the humanitarian shipment of grain was being off-loaded in Bangladesh in Dec. 1998. According to the information provided, approximately 442 metric tons of wheat became saturated with the oil and could not be off-loaded.

Allegedly, over the course of the following month, while in Bangladeshi waters and later during a dry docking in Singapore, company officials and vessel officers discussed various ways of offloading the cargo legally, but this option was ultimately rejected as too expensive.

Instead, company officials are said to have intentionally misled USCG officers in Singapore and Portland by failing to disclose the true nature of the contaminated residue and seeking authorization to discharge the residue at sea under the guise of it merely being an oily waste.

Such wastes can ordinarily be processed through an oil pollution prevention device on a ship, which would limit any oily waste discharge to the standards set by US and international law.

The Sabine officers and employees were well aware, according to court documents, that discharging the oil-laden mixture in this fashion from the SS JUNEAU was not feasible since the monitoring system was designed to handle liquids and not solids.

Although concealed from the USCG at the time, Sabine's executives allegedly decided to hire a team of 15 Bulgarian nationals and several technicians to board the SS JUNEAU in Singapore and directly discharge the contaminated wheat into the ocean during the return voyage to the U.S. During the first week of February 1999, the SS JUNEAU, while transiting the South China Sea, emptied the contaminated cargo tank and failed to report the discharge to the USCG as required by law.

The indictment alleges that the defendants engaged in a multi-purpose conspiracy to illegally discharge the oil-contaminated grain at sea; to obstruct a proceeding initiated by the USCG by presenting the USCG false and misleading statements and records; and to defraud the U.S. by hampering and impeding the USCG and the Dept. of Agriculture in their efforts to enforce environmental laws and the laws and regulations governing the carriage and delivery of donated agricultural commodities.

Counts 1 and 2 of the indictment charge felony violations of U.S. law, each of which carries possible penalties of up to five years imprisonment and a criminal fine of the greater of \$250,000 per count or twice the gain or loss caused by the relevant conduct. Count 3, charging Michael Krider with false pretenses, carries a possible penalty of up to one-year imprisonment and a fine of the greater of \$100,000, or twice the gain or loss caused by the relevant conduct.

SINKING OF THE TUG THOMAS HEBERT

[Source: Edited from USCG Case #MC93003918]

On March 7, 1993, the New York Marine Inspection Office was notified by USCG Group Sandy Hook that the tug THOMAS HEBERT, owned by S.C. Loveland Co, Inc., had sunk 35 nautical miles south east of Manasquan Inlet, NJ. The incident took place sometime between 0300 and 0400 hours. The casualty was reported to the Coast Guard at approximately 0915.

Personnel data: There were seven people on board the tug. Two were rescued and five perished. The survivors were transported to Jersey Shore Medical Center, Neptune NJ. The survivors from the tug were the master, Captain ■■■ and one mate, Mr. ■■■■ whose names were redacted from the report. Crewmembers who perished were: George Washington Coram, Mate; Vincent Blanks, Assistant Engineer; Mabuary George Hatch, deckhand; Charles Lander, Engineer/Deckhand; and James Westmoreland, Cook/Deckhand.

Vessel data: The tugboat M/V THOMAS HEBERT, whose homeport was Philadelphia, PA, was an **uninspected towing vessel** whose official number was 570117. She was built in 1975 at Orange, Texas and was 98 gross tons, 67 net tons, 89 feet in length with a beam of 27.2 feet and a depth of 11 feet. She was powered by a 2-1200 horsepower diesel engines. The tug had a Sperry automatic pilot at two control stations in the pilothouse and one on top of main deck house that would play a prominent role in the accident.

The THOMAS HEBERT was towing LOVELAND 3403, a loaded 3,747 gross-ton coal barge, O/N 290771 built in Orange, Texas in 1963. Both vessels were owned and operated by S.C. Loveland of Pennsville, PA.

Because the tug THOMAS HEBERT was a seagoing motor vessel of less than 300 gross tons, she was not subject to USCG construction and inspection regulations. Because she was seagoing vessel over 79 feet in length, she was subject to USCG Load Line regulations of 46 CFR Subchapter E, that required that a review of the vessel's stability and the vessel's structural integrity be conducted by the American Bureau of Shipping (ABS). The Load Line Certificate was issued on 28 February 1989 and was valid until February 28, 1994 with annual surveys required. The vessel had an ABS machinery survey conducted April 14, 1992 and ABS hull survey conducted April 25, 1992. The vessel was constructed in accordance with ABS classification standards applicable to anchor handling tugs operating in the North Sea. However, ABS has no classification standards for towing systems and towing equipment.

The Accident: The THOMAS HEBERT picked up the barge LOVELAND 3403 at the Newport News coal piers on March 5, 1993. The barge was loaded with 8,500 tons of coal. The tug and barge set out en route to Portland, Maine.

According to an interview with Captain ■■■, he had made the journey from Virginia to Maine several times. The journey normally takes 4 days and was repeated every 8 to 10 days. On this occasion, they expected to arrive in Portland on March 8,

At approximately 2000 hours on March 6th, when the tug and barge were approximately 30 miles south of the Barnegat Light Inlet sea buoy, they altered course to 045 degrees true heading for Buzzard's Bay Light. The vessel's speed was approximately 5.6 knots.

The weather was clear with the temperature about 40 degrees and the wind 10 to 15 knots out of the southwest. The seas were calm with approximately 3 to 4 foot swells.

According to the post-accident interview of the survivors, on March 6th, the Captain and Mr. ■■■■ were on watch from 1730 to 2400. Charles Landers had the engineroom watch. Charles Landers was the Captain's brother. The watches were normally scheduled for 6 hours on and 6 hours off.

The Captain stated that he checked all of the navigation lights prior to being relieved and that they were all operating properly. The vessel was on automatic pilot with a course of 045 degrees true.

George Coram, Mabuary Hatch, and Vincent Blanks were the relief watch. George Coram was the mate, Mabuary Hatch was the engineer and Vincent Blanks was the deckhand. These men were supposed to be on watch at the time of the accident.

The Captain stated that, when he was relieved, the barge was towing easily at the end of 1,200 feet of 2 inch steel wire. The catenary was approximately 50 feet.

The surviving mate stated that, after being relieved, he cleaned the head and mopped the pilothouse. He stated that at about 0100 he went to sleep. Both the Captain and the

surviving mate were asleep when the incident occurred. Their cabins were located just below the pilothouse. According to the survivors, the incident took place between 0300 and 0400, on March 7th.

According to the surviving mate, he was awakened when books from the shelf started falling on him. He noticed a 15-degree starboard list. He yelled, "What's going on?" and ran to the pilothouse.

The Captain was also awakened at this time. The surviving mate and the Captain stepped into the passageway just below the pilothouse. According to the surviving mate, the Captain ordered him to take the engine out of gear. When he did so, he felt some of the strain ease. However, the vessel did not level out completely. The surviving mate found no one in the wheelhouse and did not know where the other mate who was on watch was at the time. He stated that, while in the pilothouse, he never saw the barge. He was not able to say what the position of the barge was.

According to the surviving mate he then went down for his survival suit. After he grabbed his suit, he was going to go up to the pilothouse to make a "May Day" call. However, as he was going up the stairs, the vessel lost generator power and the lights went out. He felt the stern going down.

At this point, both the surviving mate and the Captain were standing in the companionway in front of the Captain's cabin. This companionway is located below the pilothouse but above the galley and the crew cabins. The surviving mate was about to go up to the pilothouse to make a "May Day" call, and the Captain was about to go to the lower cabins to check on the crew. They were standing directly behind each other and facing opposite directions when the surviving mate heard George Coram, who was supposed to be standing watch, trying to go up the stairs saying, "Get out of the way". However, the Coast Guard investigators noted that this conflicts with the Captain's statement that believed that Coram was in the pilothouse and was coming down the stairs to the companionway. Neither the Captain nor the surviving mate reported that they actually saw Coram. The lights were out at the time.

According to the surviving mate, the lights went out and the back windows in the pilothouse blew out. Within seconds he was in the water. The vessel went down stern first with no "May Day" call ever being made.

According to the Captain's written statement, he went to sleep at approximately 0045. "The next thing I remember I heard (the surviving mate) yell out "What the hell is going on?" Then I heard something fall in the head. I jumped up and realized that the boat had a starboard list. I ran out of the room and I told George (Coram) to slow down the throttles." Apparently, the Captain was not aware that Coram was not at the helm. The Captain stated that he thought the steering had malfunctioned again. This is why he ran out of his cabin and yelled "Slow down".

The hydraulic steering system used two (2) solenoids per steering pump. If one solenoid failed the rudder would go hard the opposite way. The problem could be corrected by switching to the other steering pump, and this could be done in the pilothouse. According to the Captain a solenoid would fail approximately twice per year. Consequently, the THOMAS HEBERT carried 10 spare solenoids on board. Both survivors stated that the solenoid in the hydraulic steering system had failed on the previous voyage. The Captain stated that the generator and the main engines were functioning properly but that the engines sounded as though they were straining. However, when the engines were put in neutral, the boat seemed to partially straighten up.

The Captain stated that when he stepped into the companionway, he saw two silhouettes in the pilothouse one by the throttle and one by the door. He also reported hearing Vincent Blanks yell. The surviving mate turned to go to the galley to see what Vincent Blanks wanted. That is when he heard mate George Coram say "get out of the way."

The Captain stated that before he hit the second step, "All hell broke loose". The lights

went out and he felt a sudden gust of wind. The Captain believes that water rushing into the hull had caused the sudden gust of wind. He stated that a wall of water knocked him into the pilothouse and then out of the vessel into the ocean. The tug quickly sank stern first.

The Captain. Reported during a follow up telephone interview that although he never saw George Coram, he swears that he was in the pilothouse although this contradicts the statements of the surviving mate and later reports from divers. The Captain bases his assertion that Coram was in the pilothouse on the fact that he saw two silhouettes in the pilothouse. Additionally, when he later heard Mr. Coram say, "Get out of the way", the voice came from behind him. The Captain was standing in the companion way in front of his cabin and was about to go down the stairs to the galley when he heard the voice of Mr. Coram. However, neither the Captain nor his surviving mate actually made a positive visual identification of Mr. Coram.

The loss was sudden. Both the survivors estimate that it was approximately one minute from the time they noticed the list to when the tug sank. According to the survivors, they did not hear the bilge alarm go off. The Captain stated that the electronic flood detection system would go off when there was 2 feet of water in the bilges but did not know why the bilge alarm failed to sound. Neither of the survivors sounded the general alarm nor heard it activated. The general alarm contactor was located in the pilothouse.

The inflatable liferaft floated free, inflated automatically and both survivors were able to board it. The mate reported that once in the raft, it seemed that the barge had some headway. He saw the barge about 300 feet away. First he saw the red and green lights and then only the stern light.

The mate stated that he saw no large vessel that could have run over his towline. The towline was 1,200 feet long with a catenary (i.e., dip) of approximately 50 feet. He did see three (3) fishing vessels northwest of them, however.

The Rescue: The Captain stated that when he reached the surface, he saw the mate 50 to 100 feet away. They both swam towards the life raft. Inside the raft, the mate put on his survival suit that he had gotten from the tug. When the Captain looked at his watch, it was 0448 although he does not know the exactly time the tug sank. He did not look at his watch immediately upon entering the raft. He may have been in the raft for over an hour by the time he looked at his watch.

Both survivors stated that the raft was being dragged by the tug. The raft remained tethered to the tug and was pulled approximately 30 yards toward the sinking tug until the 100-foot sea painter snapped. Apparently the weak link did not break as it should have done. There was a knife in the raft next to the sea painter attachment but neither man was aware of it at the time.

The life raft was an Elliot 12-man raft. Although EPIRBs were not required on this type of raft, two were placed in the raft. The survivors stated that they could not find the EPIRBs packed in the raft. They were found unpacked in the raft after the rescue. The life raft was inspected on February 19, 1993 and found to be in satisfactory condition.

Although EPIRBs were not required on board uninspected tugs,⁽¹⁾ the survivors stated that there was an EPIRB on board. Because all the EPIRBs both on board the THOMAS HEBERT and in the raft, needed to be manually activated and the survivors were not able to locate any of them, no EPIRBs were activated. Although EPIRBs would not have changed the outcome of this casualty, the survivors would have been rescued much more quickly if the EPIRBs had been activated. ⁽¹⁾ *Category 1, 406 MHz self-activating EPIRBs are now required by 46 CFR §25.26-20 on seagoing uninspected commercial vessels over 36 feet in length.*

The Captain and his mate attempted to paddle the twelve-man life raft toward the barge. They were unsuccessful due to a combination of their own physical fatigue and the wind blowing the raft away from the barge. The mate shot off the raft's hand flares in order to attract attention. However, sparks from the hand flares deflated the raft canopy. They spotted

a scallop boat but could not find the parachute flares to signal them. They were afraid to light any more hand flares for fear that the raft would be further damaged. The vessel continued to drift.

The Captain, who had had no time to dress, was kept warm by the deflated canopy of the raft. Because the mate could not put on the survival suit until he was in the raft, a considerable amount of water was inside the survival suit. However, the mate was instrumental in keeping the Captain alive. He ensured that the Captain was kept warm by wrapping scraps of loose material and cardboard around him. He ensured that water was constantly bailed out of the raft. Because the Captain was exhausted, the mate took charge of their efforts to spot passing vessels for assistance.

At approximately 0930 the mate spotted a ship and started to wave the oar back and forth. However, the other vessel passed without noticing the two stranded crewmembers. At approximately 1100, the fishing vessel MISS MANDY reported that a life raft with two people on board was spotted in position 39°48.8'N 73°13.0'W. The crew helped the two survivors on board and called the Coast Guard. The survivors had drifted five to seven miles from the location of the barge before being rescued.

The F/V MISS MANDY was cod fishing when the rescue was made. A crewman said the pair told them the last thing they remembered was the tug listing heavily, then seeing its windows blow out. According to the crewman the survivors claimed that the tug went down in about two minutes. The crew of the MISS MANDY went back to the location of the barge and searched for a good three hours looking for more survivors.

A Coast Guard helicopter evacuated the two survivors to Jersey Shore Medical Center in Neptune City, New Jersey. They were treated for hypothermia and released.

The Coast Guard sent two helicopters from Air Station Brooklyn and two jets from Air Station Cape Cod to search for the missing men. A broadcast was put out every thirty minutes requesting that all vessels keep a lookout for survivors. Despite the extensive search, no survivors were ever found. The search for the five men was suspended at approximately 2045 on March 7th. The rescue party concluded that the missing crew could not have survived such a prolonged period of exposure to 38°F waters.

The salvage: The USCGC MONOMOY was on scene at approximately 1900 and began searching the area. The crew of the cutter boarded the barge. The barge had no unusual dents or scrapes that would indicate that the barge struck the tug. There was no water in any of the bilges of the wing tanks or in the forward or aft rakes. The crew of the cutter noticed that the bridle went almost straight down just forward of the barge with a moderate to heavy strain and the barge was listing slightly to port. They concluded that this was probably a result of a shift in its cargo. The boarding team entered the barge's generator room and found the navigation lights were energized and burning brightly. Other than the towline, nothing unusual was noted. The cutter remained on scene through out the night.

On the following morning, the tug AMY MORAN and the barge ITCO XII were on scene to pick up the barge LOVELAND 3403 and take it to Portland, Maine. The towing wire was still going straight down, and despite the blowing wind, the barge was not moving. With 1,200 feet of wire out, it was as though the barge were anchored. Dive reports indicated that the line was not tangled in the tug. This raised suspicions that the wire may have been caught on something. The weight of the line itself may have anchored the barge.

The same day, March 8th, the M/V DIVERSION II arrived to conduct a dive survey. They found the THOMAS HEBERT heeled over on her starboard side approximately 110 degrees. Apparently, the vessel landed upside down. The superstructure was in the sand. The mast was bent 45 degrees toward the stern. There was no damage to the hull noted. A small amount of chain and fishing line was found wrapped around the port propeller. This chain appeared to have been there for some time. The divers reported that the port rudder was turned 15 degrees towards port but could not see the starboard rudder because it was buried in the sand. Divers entered the pilothouse. Broken glass and splintered wood, along with

papers and charts were scattered about. The control panel showed the port engine control was in the neutral position, and the starboard control was in reverse. The throttles were in the mid position. One of the two pilot's chairs was knocked loose from its base. A long-range sonar survey, conducted by the dive crew, did not reveal any targets that could have snagged the tow wire. Additionally, none of the divers found anything in the area that could have snagged the wire's catenary.

On March 12th the F/V DEEP ADVENTURES of Brielle, NJ, arrived on scene to conduct a dive survey. The primary focus of the dive was to find the bodies of the missing crew. The engineroom door forward of the winch was found in the open position. It was kept permanently open according to statements from the survivors. The engineroom was in complete chaos with cables, tools, lines and general debris littering the area. A full sized toolbox was wedged between the galley door and the towing winch motor. This made access to the galley impossible. The divers then tried to gain access through the pilothouse. Except for the first window on the port side, all the bridge windows were broken. The port bridge door was dogged shut. A Furuno radar set was hanging out of the bridge window held by a cable. A stopped clock in the pilothouse indicated 5:24. Once the divers accessed the pilothouse they proceeded aft into the passageway. The locker in the passageway below the pilothouse where the survival suits and the gyrocompass were kept was open. The divers closed this door to gain access to the passageway. No survival suits were found in this area.⁽¹⁾ After removing debris, a diver was able to access the Captain's cabin. The head was not accessible because of debris. *[⁽¹⁾A survival suit, now known as an "immersion suit," may substitute for a life preserver, buoyant vest or marine buoyant device on an uninspected vessel that does not carry passengers for hire according to 46 CFR §25.25-5(e). Also refer to NVIC 7-91 that describes the "cold water" areas where this equipment should be used.]*

On March 21st, the M/V VENTURE 3 returned to the wreck site to resume recovery efforts. A storm with gale force winds precluded any diving efforts since March 12th. The plan was for two divers to gain access to the galley via the stairwell behind the pilothouse. At the time, this was the only way into the galley. Two other divers removed the large Craftsman toolbox obstructing the galley door with a come-along. Their next dive would focus on inspecting the tow cable.

The wreck sustains further damage. On a subsequent dive, the diver discovered that the pilothouse had sustained a direct hit by what was believed to be a dragger. The bridge windows were set in and the control panel was smashed. The port pilothouse door was torn off from the hinges and the door rim knocked inward. The Captain's cabin was ripped open approximately three feet and exposed to the open sea. The front part of the pilothouse roof was pushed downward. The searchlights and radar scanners were also torn off. The mast atop the bridge was bent back over the port side. Silt and fine sand were found along the entire length and inside of the wreck. Access through the pilothouse was now impossible. However, the toolbox blocking the engineroom entrance had fallen. The galley was now accessible through the engineroom.

The body of James Westmoreland was located in the head on the galley deck. His sweatpants were still around his knees. This confirms the statements of the survivors that the THOMAS HEBERT went down very quickly. His body was brought to the surface.

The body of Charles Landers was extracted from the crew's cabin. He was wearing a survival suit. According to the relief Captain of the THOMAS HEBERT, Mr. Landers practiced getting in and out of his survival suit and kept it by the side of his bunk at all times. The cabin where Charles Landers was found was not his cabin. It belonged to Mabuary Hatch. Apparently, Charles Landers was trying to tell Hatch that the vessel was in danger of sinking.

Vincent Blanks was discovered face down in the engineroom in front of the hatch leading to the galley. He was dressed in jeans and work boots. From the waist up his body was covered with debris. It appeared that the toolbox had fallen on him.

The divers then focused on removing one body at a time because excessive movement

within the narrow confines of the debris-riddled wreck would have further clouded the waters and reduced visibility. The search for bodies continued and included the main engine room, galley, forward port bunkroom, and starboard bunkroom, and the head on the galley deck. All divers were using standard air, with exposure times between one hour and one and one half hours.

On March 23rd, the divers returned on the M/V DEEP ADVENTURERS 3 to resume recovery efforts. Donjon's 85-foot tug, 200-foot barge, and 200-ton crane with a decompression chamber, and hardhat divers were on site with a four-point mooring. At this time the M/V DEEP ADVENTURERS 3 was informed that a Donjon diver had been lost while diving on the wreck site.

The divers from the M/V DEEP ADVENTURERS 3 proceeded with the body recovery efforts and found the body of Mabuary Hatch in the forward starboard bunkroom where Charles Landers had been found. They searched the port and starboard bunkrooms but the results were inconclusive as a result of low visibility and debris. The bridge, deck mate's room and passageway were also searched. However, the head could only be partially seen.

An attempt was made to inspect the tow cable. Visibility, however, was less than 6 feet. The diver propulsion vehicle was abandoned and the decision was made to swim out the cable. The first fifty yards of the cable from the tug was examined with no abnormal findings.

On March 31st, the dive team departed from Belmar, NJ on the M/V VENTURE 3. The dive plan was to check the passage from the stairwell behind the bridge to verify whether the galley was accessible as an alternate exit. Divers would then try to access the two cabins on the bridge deck.

Entrance to the Captain's cabin was aborted when the diver ran out of room shortly past the doorway. The dragger had damaged the room making the passageway smaller. Two other divers documented the area of the search on film. They made video recordings of every room accessed.

A diver on a propulsion vehicle tried to follow the tow cable from the barge end of the cable to the tug. A buoy had marked the barge-end of the cable before being cut free from the barge. The diver followed the cable out for approximately 50 feet. At this point, however, the cable disappeared into the sand. So as not to lose his bearings, the diver attached a 250-foot line reel and followed the reel out to the end. It was estimated that he covered 300 feet of cable. From what he observed, the cable did not appear to be kinked, worn, bent, or damaged in any way. It was laying on the bottom in a serpentine fashion.

On April 30th the dive team, from the M/V WHITE STAR IV, recovered the body of the missing mate George Coram in the starboard bunkroom. His body was turned over to the Ocean County Coroner's office.

The THOMAS HEBERT sank in sufficiently deep waters to render salvage impractical. The vessel's value was estimated at \$800,000.

The Towing Wire. According to the Captain the barge was towing at the end of a 1,200-foot long tow wire. The tow wire weighed 7.65 pounds per foot. The Captain estimates that there were approximately three wraps of wire still on the towing drum. A towing bridle was attached to prevent the tow wire from riding to port or starboard. The maximum it would ride to either side was one foot. The towing controls were located on the stern of the tug just above the towing winch.

There was a brake release that could have released the tow from the THOMAS HEBERT. However, the mate would have had to proceed from the pilothouse to the first deck to operate the mechanical override. The towing wire was retrieved from the wreck on May 8th. It was rolled up from the bottom on a towing winch. When all the cable that could be reeled by the towing winch was recovered, the line was cut, at the surface. The remaining line would be the distance from the surface to the tug and what was on the winch drum, approximately 150 feet.

The hull and cargo surveyors examined the towing wire. The cable measured approximately 1,038 feet. The cable was relatively new and had been installed on February 15, 1993. However, inspection of the towing line revealed significant damage to the cable. From the socket end that attaches to the tow, to approximately 40 feet, the tow wire shows light wear. At 90 feet, the tow wire shows signs of being opened up. At 140 feet, the tow wire begins to gradually show more pronounced wear. At 190 feet, the strands on the wire are separated $\frac{1}{4}$ to $\frac{1}{2}$ -inch apart. From 240 to 340 feet, the cable is opened up and kinked to such an extent that the wire will not lay flat on the deck.

The area of damage to the tow wire suggests that the tow tripped the THOMAS HEBERT. The area of damage is exactly where the tow wire would experience the greatest strain if such an event took place. The hull and cargo surveyors noted gray paint residue on the outer layer of the cable. This paint residue was found on the most severely damaged portion of the towing wire. The LOVELAND 3403 is painted gray.



Submarine Theory: Rumors of possible submarine involvement surfaced immediately after accounts of the incident hit the media. According to the chief financial officer of the S.C. Loveland Co, "past experience, discussions with the tow surviving crew members and the speed with which the THOMAS HEBERT went down all point to a submarine." Suspicions were strengthened when the USS NEWPORT NEWS reportedly came into port the week of the casualty with damage to the conning tower and electronics.

Throughout the investigation, the Navy denied any submarine or vessel activity in the area of the casualty. The Department of the Navy was contacted by the investigators from the USCG Headquarters staff in order to request information concerning reports of potential submarine involvement particularly, concerning damage, that the submarine USS NEWPORT NEWS allegedly sustained while on a mission.

The Navy reported that the submarine did enter Newport News Shipbuilding and Drydock after returning to homeport. However, this was for normally scheduled maintenance. The Navy reported that there was no damage to the sail and electronics. Furthermore, the Navy reported that the submarine was operating south of the Chesapeake at the time of the incident.

A Navy spokesman said that no submarines were operating in that area at that time and that fleet submarines would not normally travel beneath the ocean's surface in such shallow water. Although the region where the THOMAS HEBERT sank is used for training by submarines, no U.S. or foreign submarines were in the vicinity at the time of the incident.

The probability of submarine involvement was diminished by the location of the damage to the towing wire. If a submarine were involved, the most severely damaged portion of the towing wire would most likely have been along the center of the towing wire rather than near the barge end of the wire.

Conclusions: In investigating the realm of possibilities that could have caused this tragic accident the steering solenoid failure, causing the vessel THOMAS HEBERT to circumvent its tow, the barge LOVELAND 3403, is the most probable. There are several facts that indicate that this is what most likely happened. The suddenness of the 15-degree starboard list suggests that its towing hawser tending sharply to starboard tripped the tug. The fact that the vessel continued to heel despite the fact that the engines were in neutral suggests that the towing hawser continued to exert a continuous overturning force on the vessel's starboard side.

The THOMAS HEBERT had a history of steering failures caused by solenoid problems in the steering system as confirmed by the survivors' statements. It is very possible that the vessel had a steering failure on this occasion. This is what the Captain thought when he first awoke at the time of the incident. The divers found that the rudder was only 15 degrees to port and not hard over. Nevertheless, this does not rule out problems with the steering

system solenoid. The rudders were exposed to tremendous forces during the events surrounding the sinking of the vessel and most likely changed position several times before the vessel came to rest on the bottom.

The damage to the towing wire seems to indicate that, at some point, the towing wire wrapped itself around the barge, which is 340 feet long and 62.6 feet wide. The most severely damaged portion of the towing wire was at approximately 300 feet. With the addition of the 36 foot surge line, this would place the most severely damaged portion of the wire at the aft corner of the barge. If the tug went around its tow, it would have been pulled back quickly by the loaded barge heading in the opposite direction.

It is possible some event other than steering failure may have caused a misalignment of the tow. These include an improper maneuver, inattention to the tow, or unanticipated action of the seas. The stern engine room door was fastened open so that if the stern were submerged at anytime, vast amounts of water would have entered through this large opening. With this main deck exterior door wide open, the tug would have lost reserve buoyancy and stability and would have flooded very rapidly. Anyone who was not near an exit would have had no chance to escape.

The case reopened: The Coast Guard reopened the case in 1995 upon consideration of objections to the investigation raised by attorneys for the owners and operators of the THOMAS HEBERT to allow for further investigation and the designation of parties in interest. Although the Coast Guard reopened the investigation, they did not vacate or retract the investigators' report.

The law firm representing the owner/operator of the vessels involved presented two significant points of argument. The first was where expert witnesses provided by the attorneys stated that the rudders could not automatically "go hard over" when there is a steering system solenoid failure.

The steering system in in this case⁽¹⁾ is designed with two solenoids per steering pump, one for controlling left rudder movements and one for right rudder movements. They indicated that when a given solenoid fails, the steering system could no longer acknowledge rudder commands to the side the solenoid controls. It is then hydraulically locked from moving toward the given side of failure. For example, if the port solenoid fails, the steering system can no longer move the rudder left, regardless of where the rudder is when it fails (i.e., if the rudder was 5 degrees right when the solenoid failed, the rudder could not even be brought back to amidships. However, any command for additional right rudder could still be answered.

[⁽¹⁾Do not assume that every steering system is designed the same way. Take any opportunity to learn how your steering system works from its plans or by asking a knowledgeable hydraulic technician.]

The description of events provided by the expert witnesses conflicts with what the survivors and members of the "relief crew" of the THOMAS HEBERT stated in their interviews both in the initial investigation and during this post casualty analysis. They indicated that when a solenoid fails, the rudders "go hard over". Regardless of this conflict in testimony, it is clear that a solenoid failure severely impairs the steering system and if left unattended or not detected immediately, may have a disastrous result.

Following the example, while the rudder may not "go hard over" automatically, it could be worked hard over to the still functioning side by an unaware and/or panicked operator trying to get rudder response by moving the helm from side to side. With each movement to the still-functioning side, the rudder would be moved just that much more in that direction with no way to bring it back. If the vessel was operating on autopilot, and the operator was unaware of solenoid failure, an equally disastrous result could be achieved as the system tried to correct course with response only to one side.

As stated in depositions, the survivors and members of the relief crew stated that these solenoid failures are not uncommon on this system, occurring approximately twice a year,

and when detected, can be easily corrected by switching steering pumps in the pilothouse.

The second significant point raised by the attorney's representing the owner/operator was that the tug could not have been pulled over on its starboard side immediately prior to sinking (as suggested in the Coast Guard report). During a post casualty dive survey the "guide chains" for the towing hawser on the "Texas bar" of the THOMAS HEBERT were found still intact and attached to the towing hawser. All parties are in agreement that the forces needed to capsize the tug certainly would have easily parted the guide chains. This indicates that any major forces exerted on the hawser would most likely have come from more directly astern of the vessel rather than from sharply off to the starboard side. However, prior to sinking, both survivors testified that the vessel listed to starboard.

Amended Conclusions: The only difference in the conclusions from the previous investigation and from this post casualty analysis is that the tug was more likely dragged backwards rather than being overturned on its starboard side after it circled the barge as the previous report suggests. This in turn most likely forced water into the open engine room door, flooding and sinking the tug.

ALJ REVOKES MARINER'S LICENSE FOR "REFUSAL TO TEST"

By Richard A. Block

Introduction. On Tuesday January 6, 2004 I first learned from his attorney that one of our mariners, Captain ■■■ was scheduled to appear before Administrative Law Judge Peter Fitzpatrick (ALJ) the following day at MSO Morgan City, LA. He filled me in on essential details of the case.

I arrived in the courtroom at 0900 and met Captain ■■■ and his wife. Judge Fitzpatrick arrived from Norfolk, VA, to handle the case. The purpose of this article is to discuss and pass on to our mariners some of the "lessons learned" from a full day of testimony and the ALJ's decision.

Background. Captain ■■■ was the master of a 99 GT, 145 foot, Offshore Supply Vessel, the M/V PETER CALLAIS operated by Abdon Callais Offshore. The vessel's Certificate of Inspection (COI) calls for the vessel, when in 24-hour service, to be manned by one licensed master, one licensed mate and two ordinary seamen. In fact, there were three seamen assigned to the vessel on the days in question – May 20 and 21, 2003. Since the vessel is less than 100 gross tons, none of the unlicensed seaman was required to hold a z-card.

The tour of duty on this vessel is 28 days on duty and 14 days off duty. Company policy calls for both licensed officers to hold masters licenses although the Certificate of Inspection calls for a master and a mate. Captain ■■■ was the senior captain on the vessel, was "in charge" of the vessel, and received slightly higher pay as a result of his position. On conclusion of his tour of duty, Captain ■■■'s "mate" was scheduled to step up to the top slot as the "relief master" and work for the next two weeks in command of the vessel. At the end of two weeks, Captain ■■■ was scheduled to return to the vessel as master.

The company Human Resources Director testified over the speakerphone while the company's former Safety Director appeared in court. In his testimony, the Human Resources Director stated that the Master of the vessel was responsible for setting the vessel's watch schedule that, for the period in question, was 12 hours on watch followed by 12 hours off watch. In fact, Captain ■■■ held the 0600 to 1800 hour (day) watch on May 20th while his relief held the 1800 to 0600 (night) watch. He also testified that the Captain was responsible for conducting the details of the scheduled crew change on the vessel on crew-change day (May 21st) and that the company did not become involved in the details of the crew change. There was no disagreement on this point.

The vessel arrived in Port Fourchon on May 20, 2002. Captain ■■■ stood his watch from 0600 to 1800 during which time he closed out his paperwork for the past month, made arrangements for technicians to service the vessel, supervised the crew and performed all

other duties required of him. He telephoned the relief mate and learned he was en route to the vessel from his home in the Houston area. The Captain remained on the vessel until about 1930 when his wife arrived to pick him up to drive him home located approximately 45 minutes away. He shook hands with his relief as he left stating that he would return for crew change at about 0730 the next morning. In addition, Captain ■■■ spoke with the charterer of the vessel (i.e., the "company man"), double-checked to be sure the boat was not scheduled to leave port, advised him that he was going home, left his phone number with his mate, and then left the boat with his wife and drove home. He arrived home shortly thereafter.

The relief captain (i.e., "mate") testified by speakerphone that he was an experienced mariner with 21 years service and a master's license. He reported that he assumed the 1800 to 0600 watch and awaited crew change at 0730 the following morning. As a matter of professional courtesy, Captain ■■■ assumed that his relief would "cover" the additional 90 minutes until his relief mate arrived. All of this planning was routine and represented a customary practice – and went exactly as planned.

The fly in the ointment. Unknown to Captain ■■■ and the crew, Abdon Callais Offshore arranged with Lafourche Services to conduct a random drug and alcohol test of the vessel. Although the boat spent the entire day in port, the test took place at about 2200 hours at night.

Apparently the urine collector and Abdon Callais' human resources duty clerk showed up on the vessel at about the same time. The relief captain called Captain ■■■ at home and informed him of the random drug and alcohol test.

The company's human resources duty clerk ordered him to report back to the boat to be tested. It is at this point where things became very technical. The direct result of these technicalities led to two separate problems the court was called upon to judge – that we will call 1) "Unexcused Absence" and 2) "Refusal to Test":

UNEXCUSED ABSENCE

Captain ■■■ and his wife were at home and in bed when the first call came. After 28 days at sea and away from home and after completing a full 12-hour day on duty, Captain ■■■ and his wife had several glasses of wine and went to bed. Captain ■■■ was relaxed, fully convinced he was off duty, and told his relief that he would not return to the boat. He confirmed the boat was in good hands and that there was no emergency...nor was there any hitch in the plans for crew change as the boat was going nowhere. In fact, the boat did not leave port for several days thereafter.

Then the human resources duty clerk, representing the company, called and insisted that Captain ■■■ return to the boat at once. He refused stating emphatically that he had completed his watch, was off-duty, had handed the boat over to his relief. After drinking several glasses of wine, he stated that he would not risk losing his license by failing an alcohol test.

The human resources duty clerk decided to push the matter. He informed the urine collector of Captain ■■■'s name and social security number and stated that he had "refused" to return to be tested over the telephone. The collector testified that it was his job to test only those individuals who were physically present on the boat at the time. Since Captain ■■■ was not on the boat he could not test him. However, since the human resources duty clerk furnished his name and social security number and stated that he "refused" to be tested, the urine collector filled out a blank form, put Captain ■■■'s name on it with the word "refused" and sent it to the SAMSHA-approved drug lab. At the same time, one of the three deckhands who was on the boat earlier in the day, was also off the boat and unavailable for testing. However, no "refusal to test" report was ever filed against him.

The following morning, Captain ■■■ returned to the boat. At that point, he heard from a crewmember that the "relief captain" had been promoted to senior captain. Captain ■■■ then removed all his belongings accumulated over two years service on the boat and prepared a brief letter of resignation effective the preceding evening at the end of the last watch he

served. The following day, he turned in his resignation to the office and picked up his paycheck.

The Abdon Callais Human Resources Manager testified that, even though the company left the crew change up to the crew, Captain ■■■ left the boat before crew change without being properly relieved. He complained that the vessel could not go to sea in an emergency without its four-man crew – even though there were no plans for the vessel to leave port and there was no emergency. The "relief captain," who now serves as the vessel's master, testified telephonically from the pilothouse of the same boat as it was underway in the Gulf of Mexico that he was "not properly relieved." While this might have been technically correct, it appeared as a fragile, transparent and self-serving technicality.

Nevertheless, before Captain ■■■'s attorney could summarize his testimony in a closing statement, Judge Fitzpatrick said that Captain ■■■ had made a very serious error and that he "did not buy" that he was properly relieved. However, this effectively stifled the argument that the vessel's Certificate of Inspection only requires two licensed officers when the boat is in 24-hour service.

As a direct result, Judge Fitzpatrick ordered the Coast Guard to lock Captain ■■■'s license in their safe until such time as he could decide the matter of what "sanction" (penalty) to apply to Captain ■■■'s "Refusal to Test."

REFUSAL TO TEST

Over the past four years, GCMA went to great lengths to study and report on the problems that our lower-level mariners face. In doing so, we have written letters, asked questions, solicited advice from many different sources, attended conferences, visited Coast Guard Headquarters and contacted members of Congress on numerous occasions. In May 2002, after a group of our mariners discussed drug problems with the Coast Guard's "Drug Czar" we prepared **GCMA Report #R-315** titled Drug Testing: Urine Specimen Collection. We announced this report in our newsletter and posted it on our website. Here is what the rules say and what we said about "Refusal to Test."

49 CFR §40.191

What Is A Refusal To Take A DOT Drug Test, And What Are The Consequences?

[GCMA WARNING: Be careful! The Coast Guard interpretation of "refusal" to test covers a wide assortment of cases settled by Commandant Decisions on Appeal (CDOA) that have closed just about every possible loophole. Dozens of failed legal opinions advanced by lawyers at great expense to mariners and decided years ago litter the landscape! At least three separate cases are pertinent: 1) Appeal Decision #2624 (Downs) (2001); 2) Appeal Decision #2578 (Callahan) (1996); and 3) Appeal Decision #2641 (Jones) (2002).]

(a) As an employee, you have refused⁽¹⁾ to take a drug test if you:

(a)(1) **Fail to appear for any test** (except a pre-employment test) within a reasonable time, as determined by the employer, consistent with applicable DOT agency regulations, after being directed to do so by the employer. This includes the failure of an employee (including an owner-operator) to appear for a test when called by a C/TPA (see §40.61(a));

(a)(2) **Fail to remain at the testing site** until the testing process is complete; Provided, That an employee who leaves the testing site before the testing process commences (see §40.63(c)) for a pre-employment test is not deemed to have refused to test;

(a)(3) **Fail to provide a urine specimen** for any drug test required by this part or DOT agency regulations;⁽¹⁾ Provided, That an employee who does not provide a urine specimen because he or she has left the testing site before the testing process commences (see §40.63(c)) for a pre-employment test is not deemed to have refused to test;

[⁽¹⁾GCMA Comment: The reference is to USCG "Chemical Testing" regulations in 46 CFR Part 16 or 33 CFR Part 95.]

(a)(4) In the case of a directly observed or monitored collection in a drug test, fail to permit the observation or monitoring of your provision of a specimen (see §§40.67(l) and 40.69(g));

(a)(5) **Fail to provide a sufficient amount of urine** when directed, and it has been determined, through a required medical evaluation, that there was no adequate medical explanation for the failure (see §40.193(d)(2));

(a)(6) **Fail or decline to take a second test** the employer or collector has directed you to take;

(a)(7) Fail to undergo a medical examination or evaluation, as directed by the MRO as part of the verification process, or as directed by the DER under §40.193(d). In the case of a pre-employment drug test, the employee is deemed to have refused to test on this basis only if the pre-employment test is conducted following a contingent offer of employment; or

(a)(8) **Fail to cooperate with any part of the testing process** (e.g., refuse to empty pockets when so directed by the collector, behave in a confrontational way that disrupts the collection process).

(b) As an employee, if the MRO reports that you have a verified **adulterated or substituted test result**, you have refused to take a drug test.

(c) As an employee, if you refuse to take a drug test, you incur the consequences specified under DOT agency regulations for a violation of those DOT agency regulations.

(d) As a collector or an MRO, when an employee refuses to participate in the part of the testing process in which you are involved, you must terminate the portion of the testing process in which you are involved, document the refusal on the CCF (including, in the case of the collector, printing the employee's name on Copy 2 of the CCF), immediately notify the DER by any means (e.g., telephone or secure fax machine) that ensures that the refusal notification is immediately received. As a referral physician (e.g., physician evaluating a "shy bladder" condition or a claim of a legitimate medical explanation in a validity testing situation), you must notify the MRO, who in turn will notify the DER.

(d)(1) As the collector, you must note the refusal in the "Remarks" line (Step 2), and sign and date the CCF.

(d)(2) As the MRO, you must note the refusal by checking the "refused to test because" box (Step 6) on Copy 2 of the CCF, and add the reason on the "Remarks" line. You must then sign and date the CCF.

(e) As an employee, when you refuse to take a non-DOT test or to sign a non-DOT form, you have **NOT REFUSED** to take a DOT test. There are no consequences under DOT agency regulations for refusing to take a non-DOT test.⁽¹⁾

[65 FR 79462, Dec. 19, 2000; 66 FR 41944, Aug. 9, 2001. ⁽¹⁾ GCMA reported to the Coast Guard that a number of employers use non-SAMSHA laboratories to pre-screen employees and were told that this practice is illegal.]

The Judge did not resolve the matter of what sanctions to apply to the "Refusal to test" at the trial although he stated that the charge was "Proven." He commented that this part of the case was "tragic." He pointed out that one serious error, Captain ■■■'s unexcused absence led to a problem that was potentially more serious. The Coast Guard investigating officer reiterated that he would push for revocation (not just "suspension") of Captain ■■■'s license and z-card.

Judge Fitzpatrick ordered the Coast Guard to hold the mariner's license and z-card. He asked both the Coast Guard Investigating Officer and Captain ■■■'s attorney to research case law to find how other judges handled similar cases of "Refusal to Test" and to report their findings back to him within two weeks.

LICENSE INSURANCE

From our earliest days as an Association, GCMA urged our mariners to set aside money

to buy "license insurance" to cover attorney fees in case some unforeseen event forces you to defend your license or z-card either within the Coast Guard' Administrative Law system or in civil court – and these are two very different things. As a service to our mariners, we prepared **GCMA Report #R-342** titled License Defense and Income Protection Insurance. The cost of a year's worth of basic license defense insurance to pay for a lawyer to defend you at a Coast Guard hearing is a little over \$200. If you have to hire an attorney out-of-pocket, \$200 would probably cover one hour's worth of a maritime lawyer's time. Without insurance, you must pay a lawyer to prepare your case, to meet you in court, to represent you through the court session and, in cases like this, to do any necessary legal research work the judge may order or to file an appeal on your behalf. GCMA is not in the insurance business...we don't make a dime – we just offer the information to our mariners!

Having license insurance, however, does not guarantee that you will win the case. However, without insurance, the cost of hiring an attorney can be prohibitively expensive, especially for a mariner who lives from paycheck to paycheck. In one case, an attorney had no choice but to return to court four times to successfully defend one of our mariners.⁽¹⁾ In fact, the legal fees were well in excess of \$9,000. One attorney quoted a fee of \$6,000 to defend a mariner in a drug case. These fees cover a great deal of work required to prepare a case. Not having license insurance to cover these costs alone, to say nothing about winning or losing, could lead to a personal financial disaster. [⁽¹⁾GCMA Report #R-323]

FIGHTING THE GOVERNMENT

Not only must your lawyer work hard to prepare your case, but the Coast Guard Investigating Officer must work equally hard to prepare his case. If your case ever reaches the trial stage, you had better understand that the Coast Guard represents the power and prestige of the Federal government and that they are there to WIN – as is your lawyer!

Unless you spend time in court, most mariners are not able to adequately understand how to defend themselves without legal assistance. Our Association wants to make it clear that, without legal help, we believe most mariner are faced with no choice but to take whatever "settlement agreement" the Coast Guard is willing to dish out as an alternative to appearing before an Administrative Law Judge. Unfortunately, this case may dictate future "settlement agreements" the Coast Guard can accept in cases of refusal-to-test.

In fact, we need to go even further to say that some attorneys have gone so far as to tell us that they have trouble coping with the Coast Guard's existing Administrative Law system. Freely translated, this means that you may have trouble even finding a lawyer to defend you.

The Coast Guard "owns" its own Administrative Law system with its background of over 2,600 cases available to view on the internet. Captain ■■■ confided that he felt the full weight of the Federal government was turned against him. As the day progressed, the Coast Guard produced a number of witnesses both live in the courtroom and by telephonic testimony. The case proceeded like a well-scripted play with each player primed to hold the right documents in his hand and to refer to them immediately upon call.

Captain ■■■'s experienced maritime attorney ably defended him with what appeared to be reasonable and convincing arguments. Captain ■■■ was forthright and clear in his testimony as were the Coast Guard's witnesses.

It is very difficult, if not impossible, to avoid being crushed by "the system." It is particularly troubling for another mariner to watch events like this unfold...as I watched them occur over the past four years. As a mariner, you must learn "the rules of the game" in much the same way as you learned the "rules of the road." Like the rules of the road, each word you read (as in the regulations cited above) means exactly what it says.

GCMA tries to tell its mariners about the "rules of the game" in every single newsletter and GCMA Report. This information is all available for the asking – but it does require you to read! It may not be interesting or exciting reading, but without the knowledge of the "rules of the game," your career on the water can come to a sudden and screeching halt practically

without warning. Even worse, events like this can ruin your life. This case is a horrible example of what can happen. It is events like this that make many mariners ask whether any job that can have such sweeping consequences possibly can be worth having.

Where does this lead us? The Coast Guard upholds "the law." The law consists of Acts of Congress and many more detailed "rules and regulations" promulgated by the Coast Guard to carry out the expressed wishes of Congress.⁽¹⁾ In addition to this are guidelines and policies that are not laws but simply outline the Coast Guard's way of doing business. While they are not "law" or "regulation" it is often hard to tell the difference. More disturbing, however, is that the Coast Guard also enforces company rules, regulations and policies. This involves much more than just the Company's "Operations Manual" that often appears to be as realistic and practical as Alice in Wonderland. The Coast Guard is willing to enforce company written instructions of all kinds and, as was brought out in this trial, can enforce "oral instructions" as well. That can assure both the Coast Guard and your employer a winning hand. [⁽¹⁾GCMA Report #R-223]

Captain ■■■'s attorney pointed out during the lunch break that this case would have never occurred if the captain were represented by a union. A union, as long as it is strongly supported by its members, has the power to step between a company and its employees, for example, to decide upon the meaning of "on-duty" versus "off-duty" time when a vessel is in port and what activities are and are not permissible. In a union, jobs are based upon a negotiated written contract with duties and obligations binding all parties, with tenure and promotion based upon seniority with an employer – rather than with playing company politics.

THE SANCTION: REVOCATION

The Coast Guard presented its arguments to revoke Captain ■■■'s license and z-card within the required time period. These arguments were summarized in a "Conclusion" that appears (edited with our emphasis) as follows:

Conclusion. Dicta⁽¹⁾ in the Downs case⁽²⁾ discussed "doubt" when a post incident test is refused and "doubt" when a reasonable suspicion test is refused. That dicta appears to be an attempt to put a ranking order on refusals based on the seriousness of the type of test ordered. Such a ranking is inappropriate. All (drug and alcohol) tests are required in order to ensure the safety of life and property at sea.

[⁽¹⁾**Vocabulary: Dicta:** An observation made on a legal opinion. ⁽²⁾One of the three "Appeal Decisions" cited above and available on the internet.]

To make the sanction less for refusing a random (drug Test) than for refusing a post-incident test or a reasonable-cause test is tantamount to stating it is okay to use drugs as long as nothing happens. The issue of "doubt" is the same in all tests. Captain ■■■ stated he did not take the test because he couldn't pass the alcohol screen. That may be true or may not be true. It is just as likely that he refused the test, jeopardizing his income as "First Captain" and his Coast Guard license, because he was using drugs. There is "doubt" – we don't know because Captain ■■■ refused to take the test.

Arguendo,⁽¹⁾ to order a lesser sanction for refusing a random (test) than for refusing a post incident (test) or reasonable cause (test) would appear to say the random is the least important of the tests. In fact, the unannounced random (test) is the heart of the drug testing system. Both the past incident and the reasonable cause tests are done after the fact – after life and property have already been jeopardized. They are both ordered in response to something. On the other hand, the unannounced random (test), is a preventative test. Unannounced random tests remove mariners from the seas before life and property have been jeopardized. Further, it is likely that many mariners refrain from using dangerous drugs because they know that the next unannounced random could happen at any time.

Prevention is always superior to response.

[⁽¹⁾**Vocabulary: Arguendo** = for the sake of argument.]

If a mariner takes a drug test and comes out negative, all is well and good. If a mariner takes a drug test and (it) comes out positive, there is a procedure – although time consuming and expensive – to cure the mariner and return the credentials. If a mariner refuses to take a drug test, there is no procedure available (and) the system fails. It is irrational to offer a drug cure without knowing whether or not the mariner uses drugs. The refusing mariner of course cannot be treated as a clean mariner as if he had taken the test and passed it. So into what category does the mariner that refuses a test fall?

This Court should not set the precedent that a mariner who states he refused the test because he was drinking gets to keep his license yet the mariner who refuses the test but doesn't state he was drinking is revoked. A proven refusal should equal revocation in all cases and for all types of tests. There is always "doubt" when the mariner refuses.

The system cannot stand if it is ignored. The system is being ignored if mariners can refuse to test and receive a sanction of anything less than revocation.

The Commandant looked favorably on the ALJ's decision to revoke credentials, despite clean records:

- In 1996 concerning a post incident drug test refusal (Callahan).
- In 2000 concerning a reasonable cause drug test refusal (Downs); and
- In 2003 concerning a random drug test refusal (Jones).

GCMA BROWN LISTS THIS COMPANY



The foregoing is an objective view of the events that occurred from the eyes of a mariner who observed them in the courtroom. They provide a hard lesson of what can and probably will happen if you "refuse" to take a drug test for any reason. The "lesson" is now set in stone! The lesson is don't ever refuse to take a drug test when your employer orders you to do so. Unfortunately, this is the same lesson that GCMA tried to put across to our members in GCMA Report #R-315, Drug Testing: Urine Specimen Collection, where, among other things, we recited the regulations on "Refusal to Test." It is, however, only part of this story.

I am convinced in talking with Captain ■■■ and his attorney that Captain ■■■ is a professional mariner and did his best to perform his job to the best of his ability for the company he worked for several years. In this matter, he may have cut a corner or two, but with a background of several years of service with the same employer, he could reasonably expect them to "cut him some slack." The problem, however, is that his employer acted like a snake in the grass. What they did to destroy Captain ■■■ and his wife is simply unforgivable!

I also believe that this case had nothing to do with drugs. Unfortunately, I, like the Coast Guard investigators, am left without a scrap of test evidence to support my opinion that is nothing more than a gut feeling.

It seems that if a company like Abdon Callais was displeased with Captain ■■■ for any reason, they company could have terminated him at any time and for any reason whatsoever. His employment was not protected by a union contract. For example, even though Abdon Callais took exception to his leaving his post as master and "going home" 6 hours early they chose not to consider that he left their boat under the capable control of another person with a master's license and with 21-years experience. In fact, the company turned around and promoted the mate – who was also a licensed master – the following day.

The mate apparently found nothing wrong with Captain ■■■'s early departure and gave no sign of protest until he stated that he was not properly relieved over the speakerphone in the courtroom. If there ever was a self-serving "low blow", that was it.

As his employer, the company could have fired, demoted or taken a number of other meaningful actions on their own against Captain ■■■ without ever involving the Coast Guard. They could have asked him to take a drug test the next morning to resolve any questions they might have had about drug use!

If a serious event, such as a fire or accident had occurred during his absence, then the Coast Guard could have acted on a charge of "unexcused absence" if the company pushed the issue. In either case, short of a major accident, resorting to the Coast Guard to punish Captain ■■■ is like shooting a squirrel with an elephant gun!

As a mariner, you must always remember that your license or z-card is an easy target because it is closely tied to your ability to make a living.

What is so disturbing is that the management of this company failed to use any of the tools readily available to discipline an employee for infractions of their "company rules." From the beginning, they chose to escalate this problem beyond the company level and dropped it into the Coast Guard's lap. They chose not to give a trusted employee the benefit of the doubt. Without strong and active union representation, there was no buffer between the mariner and the Coast Guard to urge that calmer minds prevail in the several days before the company finally reported the incident to the Coast Guard.

There appears to be little rapport between the company "human affairs" department and the Captain they placed in charge of a multi-million dollar vessel and who appears to have served them well in that position.

Based on what occurred, we would be hard-pressed to encourage any other employee of this company at any level to ever trust their livelihood to this employer again?

Two years of service with this company apparently meant so little to company management that they were willing and determined to destroy Captain ■■■'s career and disrupt his and his wife's domestic life over a matter that could and should have been handled within the company at a much lower level.

The "Human Resources Clerk," who to the best of our knowledge was neither a licensed nor a documented mariner, apparently was given the freedom to act on his own. This person volunteered Captain ■■■'s name and social security number in the middle of the night to the urine collector from Lafourche Services who was only under instructions to test only those persons present on the boat. This betrayal is either a case of exalted self-importance, aggressive stupidity, or concealed intent to carry out some intra-company political feud.

If that was the case, Captain ■■■ got the message the next morning when he returned to the boat and found that his former mate had been "promoted" to "First Captain."

Captain ■■■ "resigned" in writing as of the time he left the boat and, when he returned several days later let the Human Resources Manager know that his decision was final and that he would not to consider returning to work for the company. It was at this point where the Human Resources Manager sent a letter to the Coast Guard formally stating Captain ■■■'s "Refusal to Test." It was this letter that the Coast Guard acted upon and set the wheels of revocation in motion.

Captain ■■■ was not fired. Rather, he submitted his resignation because he believed the company harassed him on his off-duty time after he had already completed 12-hours on watch as well as every other duty except for the final formality of a routine crew change. He even checked out with the "company man" who represented the vessel's charterer before going home.

If this is an example of the way that Abdon Callais treats its employees, this is certainly one company that any of our mariners looking to make an upward career move needs to avoid like the plague.

There are only a limited number of licensed and experienced personnel available in the job market and the situation shows signs of getting worse before it gets better. In a competitive marketplace stories spread very quickly. This company was willing to persecute

a skilled and experienced mariner is, therefore, a company that our mariners ought to avoid recommending to any fellow mariner under any circumstances.

As a licensed mariner, I would never work for a company that I knew would sell me out as was done here. Consequently, I nominate Abdon Callais Boat Rentals for GCMA to add to our "Brown List" of employers.

FREE CHOICE ACT GAINS SUPPORT IN CONGRESS

Even though the National Labor Relations Act which established the legal right to form unions and negotiate for better benefits, pay, safety standards and working conditions-was enacted in 1935, employers across the country continue to use threats, coercion and intimidation to block workers' efforts to unionize.

For that reason, Senator. Edward Kennedy (D-Mass.) and Representative George Miller (D-Calif.) on Nov. 21, 2003 introduced the Employee Free Choice Act (S.1925 and H.R. 3619). The proposed legislation would ensure that when a majority of employees in a workplace decide to form a union, they can do so without the debilitating obstacles used by employers to block their workers' free choice.

"We like to think that workers are free to join a union," Kennedy stated. "But too often that basic aspect of freedom is denied in our modern society because hard-line corporate managers succeed in denying a fair choice by workers."

[GCMA Comment: Offshore Mariners on the Gulf Coast discovered the truth of this statement in the past three years as did mariners who joined Pilots Agree in 1998.]

Miller added, "We are here ... to demand for workers in America the basic legal, labor and human rights by which we judge other nations around the world: the freedom of association and the right to collectively bargain."

The AFL-CIO picked December 10th, International Human Rights Day, to highlight the fact that U.S.-labor laws not only do not protect workers who want to organize' unions, but in many cases facilitate employers' efforts to block them. Civil rights leaders, Democratic presidential candidates and major labor advocates stood with tens of thousands of workers at 90 events in 37 states that day to ask that their rights be recognized.

Workers at many of the marches, press conferences, hearings and other venues spoke about the opposition they have faced in attempting to exercise their right to form a union.

"Behind the closed doors of the workplaces of America, workers face incredible, often ruthless, opposition when they try to come together in a union," said AFL-CIO President John Sweeney. "These employers are literally robbing working people and their communities of better lives. At a time in our nation when the middle class is shrinking, when the gap between the rich and poor is growing, workers deserve the right to form a union to win a real voice on the job through collective bargaining."

Federal labor law protects workers' freedom to form unions-in theory. In reality, employers' most powerful tactics to suppress workers' freedom to form unions are legal under U.S. law. Others, such as firing workers for union activity, are technically illegal-but are penalized so lightly or enforced so poorly that the law is no deterrent.

The Employee Free Choice Act will:

- Allow employees to freely choose whether to form unions by signing cards authorizing union representation.
- Provide mediation and arbitration for first contact disputes.
- Establish stronger penalties for violation of employee rights when workers seek to form a union and during first contract negotiations.

Members of Congress appear to be listening to the workers. In less than three months, 155 members of the House and 27 senators had agreed to co-sponsor the bill. Mariners are

encouraged to get involved with the nationwide campaign by calling their U.S. Senators (202) 224-3121 and Representatives (202) 225-3121, and urging them to co-sponsor the Employee Free Choice Act.

[Source: *Seafarers Log*, March 2004]

ACCEPTING RESPONSIBILITY FOR SENDING AN UNSEAWORTHY VESSEL TO SEA

It is very troubling when a company is willing to send the crew of a vessel as well as other offshore workers to sea in an old and unseaworthy vessel by purposely ignoring unsafe conditions, failing to perform necessary repairs and maintenance and then covering up the deed by paint and plastic putty. ("Red Hand")

GCMA's primary concern is to protect our mariners from the preventable dangers that this seagoing occupation presents including greed and stupidity. However, investigation of complaints and enforcement of regulations clearly lies in the province of the Coast Guard and not GCMA.

Yet, the consequences of complacency and ignoring safety procedures are played out in family tragedies such as many of our Association members witnessed after the sinking of the M/V CHERAMIE BOTRUC 26 and in the Reyburn family's presentation before the National Offshore Safety Advisory Committee and its sponsor, Admiral Pluta, in Washington.

Our mariners and their families don't need additional examples of sending unseaworthy offshore supply vessels to sea!!! We want to make it clear that we will not be a party to sending our mariners to sea in unsafe ships!

IT'S A CRIME

46 U.S.C. 10908, **Penalty for Sending Unseaworthy Vessel to Sea**, states: "A person that knowingly sends or attempts to send, or that is a party to sending or attempting to send, a vessel of the United States to sea, in an unseaworthy state that is likely to endanger the life of an individual, shall be fined not more than \$1,000, imprisoned for not more than 5 years, or both."

While \$1,000 is just a "drop in the bucket" and can be rationalized by some company officials as "the cost of doing business" we believe the criminal penalty of 5 years in jail more closely fits what is clearly a crime. We plan to ask Congress to consider raising the monetary penalty to \$100,000 or some figure that would deter a business enterprise, especially a publicly-held corporation from ever considering sending an unseaworthy vessel to sea.

THE STINGRAY CASE

On February 6, 2004 the Captain of the M/V STINGRAY, a Coast Guard-inspected self-elevating "liftboat" reportedly entered the rudder room of the vessel to determine the source of a persistent leak. He found a small hole and then pulled off a piece of rust that formed an even larger hole in the bottom of the rudder room.

The Captain's was aboard the liftboat at Port O'Connor, Texas, when he made the discovery. Although the boat did not have a job at the time, he failed to report the incident to the Coast Guard as he should have done under 46 CFR §4.05-1(a)(4). This discovery was clearly "an occurrence materially and adversely affecting the vessel's seaworthiness or fitness for service or route..." as stated in the regulation. Since the M/V STINGRAY is a self-elevating "liftboat", it does not need a shipyard haulout to make repairs involving welding. However, such repairs must be made with the knowledge, consent and oversight of the Coast Guard.

Since the Captain did not contact the Coast Guard and seek a "Permit to Proceed" he continued to use poor judgment by taking the boat offshore from Port O'Connor to Freeport, Texas. He planned to continue on to Cameron, LA even after he knew of the hull's deteriorated condition. En route, throughout an offshore trip that lasted for approximately 13 hours, he ordered his crew to pump the rudder room once every hour. By doing this, the

master put his life and the life of the crew at risk.

The M/V STINGRAY set out from Freeport en route to Cameron on Tuesday February 10th but was forced to return to Freeport because of bad weather.

Leaks in steel-hull vessels have a tendency to get worse rather than improve. The situation was a source of worry to crewmembers even if it did not appear to bother the Captain who had been assigned to the same boat for a number of years. Nor did it appear to concern the vessel's operations manager. Between them they decided to patch the underwater portion of the hull with "Red Hand" and to continue to carry offshore contract workers on the boat until its scheduled drydocking and Coast Guard inspection several months later. In the meantime, the company reportedly lined up another offshore charter job for the boat that involved carrying and accommodating about a dozen offshore workers on the lifeboat at an offshore job site.

When our mariners reported the incident and the proposed patch job to GCMA, we reported the incident to the proper authorities at Coast Guard District Headquarters and Coast Guard inspectors were promptly dispatched from Galveston to Freeport. They inspected the vessel and ordered that a substantial and immediate permanent repair be performed on the liftboat before it left port including cutting out and replacing an area of approximately 18" x 20" of rotten steel plating. Substantial evidence of complicity between the Captain of the vessel and the company operations manager to make unauthorized repairs to an inspected offshore supply vessel prohibited by 46 CFR §126.150(a) exists.

When the M/V STINGRAY left port after repairs three days later, it carried 10 construction workers, 1 production worker, and its crew of 3 to the job site at High Island Block 154. These people were carried on board the vessel and were not flown to the job site. Consequently, if left to their own devices, the owners would have placed the lives of 14 persons at risk if the vessel had left port in an unseaworthy condition and before necessary steel replacement repairs could have been made.

The Captain made crew change in Freeport leaving the putty-patch problem in the hands of his relief Captain who, by the arrival of the Coast Guard inspectors was spared from making a hard choice between breaking the law and endangering his passengers and crew and keeping his job.

The leak in the M/V STINGRAY was quite serious as is indicated. The starboard side had the leak that took 17 minutes to pump out each hour while the port side took 5 minutes to pump each hour – as long as the pumps remain operable. However, the water from both sides of the rudder room can run together, and only the starboard side had a high water level alarm. However, the audible alarm reportedly stopped working while the visual alarm still came on.

Although a vessel of this type may have the flexibility to drop its legs to the sea floor and jack up to drain a flooded space, this depends upon a number of factors that are not always predictable. The record of liftboat sinkings in the Gulf of Mexico became so alarming in the mid-1980s that the Coast Guard brought the entire class of vessels under inspection by the end of the decade.

Inspection of liftboats appears to have had a positive effect on the safety of our mariners – but problems remain. The Coast Guard and the offshore industry thoroughly examined the causes of major liftboat accidents in 2002 and 2003 and submitted its report to the National Offshore Safety Advisory Committee (NOSAC) on April 3, 2003. The report from their Subcommittee on Liftboat Operations is available to our mariners as **GCMA Report #R-363** and is recommended reading. However, the report deals with technical matters and, while "human factors" were discussed, the report steers clear of human shortcomings of greed, arrogance and stupidity that, when exposed, must be subject to appropriate sanctions..

Following the detention of the M/V STINGRAY, the company terminated one of the vessel's deckhands and reassigned another to work under close supervision in the shipyard. Both actions appear to be retaliatory in nature.

LICENSED OFFICERS MUST REPORT DEFECTS TO INSPECTORS

This incident brought out other examples of the company using cosmetic "red-hand" to avoid making expensive repairs on their vessels in the past. In Spring 2002 when a Coast Guard inspector was on another company boat and was finishing his inspection he reportedly asked another Captain to report whether there was anything that he knew of that was wrong with the vessel. At that point, in the presence of the Operations Manager's brother who was supervising the job at the shipyard, the Captain stated that "Red Hand" had been used to patch the hull of the vessel. The inspector then asked the Captain to show him the area and ordered the necessary repairs. The Company Operations Manager expressed his unhappiness the following morning at the safety meeting after the Captain was sent offshore on another boat. He said he had contacted his office and that they didn't need anyone reporting things to the Coast Guard, and that such action could possibly lead to termination of their employment.

This brings up the requirement in Title 46, U.S. Code §3315(a) of "each licensed individual" to "assist in the inspection or examination ... of the vessel on which the individual is serving, and shall point out defects and imperfections known to the individual in matters subject to regulation and inspection. The individual also shall make known to officials designated to enforce this part, at the earliest opportunity, any marine casualty producing serious injury to the vessel, its equipment, or individuals on the vessel."

The Captain of the M/V STINGRAY clearly did not live up to this responsibility and endangered all on board by disregarding his responsibilities and shifting the burden to his relief Captain who had just arrived on board.

Our mariners' observations of this company's past actions indicate that they are not trustworthy and are willing to cut corners without regard to the welfare of their employees or their customers. We asked the Coast Guard whether it is wise to entrust them with the safety of others in a hostile offshore environment.

RE-THINK LIFESAVING EQUIPMENT ON SMALL VESSELS



If the "unthinkable" had happened and this liftboat suddenly sank with 14 persons on board, they would have been left in the waters of the Gulf of Mexico that in mid-February are about 59°F.

Survival time in these waters without an immersion suit (that are not required) averages less than three (3) hours. Unfortunately, the Coast Guard still allows small passenger vessels and offshore supply vessels (as well as tugs) to go to sea carrying **life floats rather than inflatable liferafts**. Life floats require each survivor to remain in the water and hang on to either the lifeline around the periphery of the life float (if there are not too many other people trying to reach the lifeline) or on to one of the life-float's 1/4-inch polypropylene pendants until you are rescued. In fact, the capacity of a life float is really based upon the number of these slippery pendants it has. This, restated, means that your life is worth only the cost of a 6-foot piece of quarter-inch poly-pro line⁽¹⁾ and depends on your ability to hang on to it until you are rescued. This isn't much of an investment and isn't a pretty picture in 59°F water! These pendants don't even have a loop to hang onto! We believe that our mariners as well as passengers and persons in addition to the crew deserve a higher standard of care! ⁽¹⁾*Illustrated at 46 CFR Figure 160.010-3(i), Acceptable method of rigging a pendant.*

A person immersed in cold water loses body heat 25 times faster if a person remains in the water rather than out of the water and in air of the same temperature. We believe that the Coast Guard should move to replace all existing life floats with either inflatable life rafts or, in protected waters, with inflatable buoyant apparatus that will keep survivors out of the cold water.

"Life floats" have a notoriously poor record going back to their use in World War II on merchant ships. The errors of the past are being perpetrated today in little more than a regulatory conspiracy of boat owners who are unwilling to pay for the safety of their crews and passengers.

To their great credit, the National Transportation Safety Board in their report on the M/V PILGRIM BELLE accident on July 28, 1985 concluded in part that "Sufficient lifesaving equipment should be provided on all passenger vessels to keep all passengers and crew out of the water to reduce the effects of hypothermia and to make it easier to locate persons abandoning a vessel." They have consistently supported this view for the past 20 years⁽¹⁾ as the Coast Guard has taken the public in a different direction. We see no difference between the mariners who serve as the crew on a small passenger vessel or on any other type of small vessel and a "passenger" as far as the standard of care owed to them.

Although the "life float" is a primitive and outmoded device, it is even harder to believe that the Coast Guard doesn't even require a primitive life float as a survival craft on uninspected towing vessels operating offshore. **Shame!** [⁽¹⁾NTSB/MAR-86/08, *Conclusions*. #20.]

Tummy Trouble

[Source: [Pacific Maritime Magazine](#).

By Kelly Sweeney. April 2003]

Four years ago I took a Chief Mate's job on an oceanographic ship here on the West Coast. One day, after a chicken lunch, I became sick, and it was apparent to me that the food had something to do with it. After a night of extreme discomfort, I was talking with one of the able-seamen. He told me, "I don't know what was wrong with the food yesterday, but I got really sick last night." Later, another AB told me the same thing. The three of us each spent a couple of days running to the head every half hour or so, and I had to postpone some planned maintenance as a result. Ultimately, six crewmembers and scientists were ill after that lunch meal.

The Captain and I decided to confront the Steward. He laughed and said, "What's the problem? Maybe it's good for you, it'll clean your pipes out!" I was incredulous that he responded that way. Afterward, because I was the Medical Officer onboard, I decided to check things in the galley more closely. What I found was that the Steward kept leftovers in the refrigerator for up to two weeks, served canned juice that was expired, and put out potato chips that were long past their freshness date and had gone rancid. As the work tour continued, I noticed fewer and fewer people eating meals. Some of the scientists seemed to be existing on fruit and a cup of instant noodles. The dry stores were kept in a room near the ship's laundry, which was normally unlocked. Interestingly, canned goods began disappearing off the shelves - until the day when the Steward announced that he would be keeping the door locked. The morale on the ship seemed to be declining daily, and the Steward acted like he really couldn't care less whether tasty, healthy food was served. A lot of us were wishing we could just go out to a decent restaurant ashore!

Last summer I decided to take a short relief job on that same ship - after I first verified a different Steward would be making the trip! As the Chief Mate I was again the Medical Person in Charge, and one day while looking through the Medical Log I was amazed to find that a few months earlier yet another bout of food poisoning had hit the ship. A number of people onboard including engineers, mates, and sailors were all logged as having been afflicted. The First Engineer, a friend of mine, was one of them and I asked him about it. He

told me, "For two days I was so sick that I really felt I wouldn't make it to my next watch."

The Steward on that ship was responsible for feeding nearly sixty people three times a day - an operation similar to a restaurant ashore. The big difference between a ship's steward and a cook ashore is a cook ashore actually has to receive training in food safety and what causes food-borne illness. In fact, public health authorities require that a food handler's card, involving classroom work and testing, be obtained before someone can even wash dishes in a restaurant - much less cook the food. Unbelievably, a person with no specialized training in galley sanitation or proper food-handling can be Coast Guard certified to work on a ship as a dishwasher, cook, or steward. The only specific requirement to be a Coast Guard certified food-handler is a physical attesting that the person is free of communicable diseases. (46 CFR 12.25-20).

There are, however, cooks and stewards at sea who have training far beyond the basic requirements. For example, the Seafarers International Union requires that a 20-hour shipboard sanitation class and a 20-hour galley familiarization class be completed before a man or woman can even apprentice in the galley on a SIU-contracted ship. To actually become a Chief Steward, 33 weeks of classes and more than two years working in the galley are required. Over the years I have sailed on 11 ships whose steward's department was manned by the SIU, and have been impressed with the cleanliness and attention to proper food handling. I've personally never seen nor heard of a case of food poisoning on those vessels.

There are also quality companies that take their responsibility to serve clean, healthful food seriously. After my bad experience on the oceanographic ship four years ago, I was skeptical about accepting a relief Chief Mate's job with an East coast based outfit that operates oceanographic ships. Nevertheless, I took the job, and was pleasantly surprised that the galley crew was one of the best I've ever sailed with. I had to go on a diet after that work tour! Later, I found out why the galley operation ran so well. The company sought out applicants who had a degree from an accredited culinary school, and at least three years of experience as a steward or cook on other vessels. Considering the specialized training regulations to which many in the industry must now adhere in the era of STCW, I think that the requirement to become a Coast Guard certified food handler should be re-examined and updated. It's time to mandate that all those working in the galley demonstrate competence in the safe handling of food. I believe that, as a minimum, in addition to the current physical requirement, a course similar to a food handler's certification ashore should be mandatory to obtain a food handler's endorsement on a merchant mariner's document. 46 U.S.C., Part G, Chapter 109, Section 10902 states that if the food onboard is determined to be "unfit for use," then the ship can be declared unseaworthy. For years that law has focused on the quality of the food itself. If the improper handling and preparation of the food causes people onboard to become sick, shouldn't it be considered "unfit for use?"

Till next time.. smooth sailin'.

Kelly can be reached at kelly@pacmar.com

<p style="text-align: center;">NTSB CHAIRMAN NOTES PROGRESS IN REDUCING OPERATOR FATIGUE BUT MORE NEEDS TO BE DONE</p>

Washington D.C. (March 29, 2004) National Transportation Safety Board Chairman Ellen Engleman-Conners today praised the Federal Motor Carrier Safety Administration for making progress in reducing fatigue related accidents by issuing updated hours-of-service regulations last year. The revised regulations limit the number of hours that truck drivers can operate and set minimum off-duty periods for drivers to obtain much needed rest. The Chairman's remarks come at the beginning of National Sleep Awareness Week (March 29 - April 4), during which the NTSB hopes to raise public awareness of its ongoing concern about fatigue related safety issues.

Chairman Engleman-Conners noted that the new hours-of-service regulations represent "an important first step in reducing fatigue related accidents on our nation's highways," but acknowledged that there is more work to be done. She challenged other modal administrations to implement Safety Board recommendations and make necessary changes to hours-of-service regulations to ensure that all vehicle operators receive enough rest.

Tired vehicle operators are not a new concern for the Safety Board. Human fatigue and hours of work have been on the Board's Most Wanted list since its inception in 1990. As early as 1972 the Board made recommendations to the Federal Aviation Administration concerning pilot rest and duty limitations. In 1989 the Board issued a series of inter-modal safety recommendations to the Department of Transportation calling for aggressive federal programs. to address fatigue issues in all sectors of the transportation industry. Many of those recommendations remain open and in some cases have been classified, "open unacceptable action."

During National Sleep Awareness week the NTSB Chairman called on the DOT and the transportation industry to address the Board's remaining outstanding recommendations. Chairman Engleman-Conners also noted the need for enforcement of new hours-of-service regulations. "Rules without enforcement are useless. We must all work together to aggressively pursue the safety of our transportation system. Everyone, whether a pilot, truck driver, ship's officer, train engineer or private citizen should make sure they are well rested before operating a vehicle."

In an effort to further highlight and share information on the significant role fatigue plays in transportation safety, the Safety Board has developed a two-day course on the subject to be delivered in Fall 2004 at the NTSB Academy.

[GCMA Comment: The Coast Guard ignored numerous GCMA mariner complaints set out in May 2000 in our book titled Mariners Speak Out On Violation Of The 12-Hour Workday pdf. distributed to many government officials and other concerned individuals. The USCG saw their past inaction labeled as "Open – Unacceptable Action" by the NTSB.]

GOING ON AN INTERNATIONAL VOYAGE? MARPOL ANNEX IV (SEWAGE) IS IN FORCE. GET YOUR PAPER!

And we don't mean toilet paper!

MARPOL 73/78, Annex IV (Sewage) of the International Convention for the Prevention of Pollution from Ships, entered into force internationally last September. The United States, however, has not yet ratified the Annex. However, Port State Control Officers in foreign countries will be checking all types of vessels to see that they are in compliance. By "checking" we mean that they will be looking for your "paperwork" showing you are in compliance.

This leads to a very interesting "paper chase" that officers on any/all U.S.-flag vessels should look into. The letter is G-MOC Policy Letter #03-03 titled Guidelines for Equivalent Compliance With (Revised) MARPOL 73/78 Annex IV (Sewage). It is available on the internet or from GCMA.