



[Formerly Gulf Coast Mariners Association]

NEWSLETTER

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WE DON'T NEED MORE LAWS ... JUST ENFORCE THOSE WE HAVE

[Source: *Waterways Journal*, Aug. 15, 2008, Letter to Editor. *Emphasis is ours!*]
 The July 28 issue of the WJ reported the details of an accident that will make a very strong impact on the inland towing industry for years to come. It will also result in changes in the way the industry operates that some people will not like, but it is very evident that they are needed. This accident resulted in a massive oil spill that stretched for more than 95 miles. It was reported that the person in charge of the M/V Mel Oliver, operated by DRD Towing, was holding only a steersman's license at the time of the accident. While this did not surprise me, I was shocked to learn that he was the only license holder on the boat. It has been my experience, having been licensed and operating boats for more than 30 years, that it is not unusual for some boats that operate in this region to have only one properly licensed operator on board. From time to time you would hear about a minor accident that resulted in an investigation where it was discovered that this was the case. Usually the company or persons involved would receive a slap on the wrist and then it would be back to "business as usual." Well, I have a very strange feeling that this "policy" suddenly changed on the morning of July 23, 2008.

[NMA Comment: Congressman Elijah Cummings, Chairman of the Coast Guard and Maritime Transportation Subcommittee has scheduled a Congressional hearing on the New Orleans oil spill for Sept. 16, 2008.]

As a result of the accident and oil spill that followed, there will surely be

some "knee-jerk" legislation passed that will "prevent this from ever happening again. WE DO NOT NEED MORE LAWS. We need ENFORCEMENT of the laws that already exist, and when violations are found, some very strict punishment for those who disobey the law.

And it must not stop with the mariner. A lot of people are intimidated into doing things that they shouldn't. Let's bring the land-based officers and operators of these vessels into the realm of responsibility, and make them accountable as well. I do feel that as a result of the seriousness of this particular accident and oil spill, there will be people who will be severely punished for this lack of oversight.

The majority of the companies that operate on the inland waterways and Western Rivers are very careful about manning their boats. They require proof that a person who operates their boats is properly licensed and trained. However, there are some who do not do this.

For instance, I read a news story from the July 28 issue of the *Times Picayune* that reported 11 days prior to the Mel Oliver's accident, another DRD boat, the M/V. Ruby E, collided with the M/V. Martin Challenger and sank as a result of that accident. The Ruby E was also being operated by a person who held only a steersman's license. One incident could be an oversight, but two incidents in 11 days is a blatant refusal to obey the laws that are set forth for the mariners to operate by. These are the people who need to be punished, not the ones that are operating in compliance with the law.

Regulations Apply to Both Mariners & Employers
46 CFR Part 15 Subpart C

Manning Requirements; All Vessels

§15.401 Employment and service within restrictions of license or document.

A person may not employ or engage an individual, and an individual may not serve, in a position in which an individual is required by law or regulation to hold a license, certificate of registry, or merchant mariner's document, unless the individual holds a valid license, certificate of registry, or merchant mariner's document, as appropriate, authorizing service in the capacity in which the individual is engaged or employed and the individual serves within any restrictions placed on the license, certificate of registry, or merchant mariner's document.

[CGD 81-059, 54 FR 149, Jan. 4, 1989]

TUGS OPERATE UNDER RADAR ON RIVER

[Source: By Jen DeGregorio, New Orleans Times-Picayune, Aug. 10, 2008. Contact #504-826-3495. Meghan Gordon contributed to this report. Emphasis is ours]

Lack of Checks Allows Problems.

Arriving at the worst oil spill on the lower Mississippi River in nearly a decade, Coast Guard officers found a rookie at the helm of the towboat Mel Oliver, which had put the barge it was pushing on a collision course with an oncoming ship.

The man steering the tug was an **apprentice mate**, the equivalent of a teenage driver with a learner's permit. Coast Guard officers found no trace of master-licensed pilot Terry Carver, who should have been in charge.

On a different vessel, the absence of a master might have come as a shock. But towboats such as the Mel Oliver are considered "uninspected towing vessels," which are not subject to regular Coast Guard inspections. Critics say the lack of oversight has fueled a self-policing towboat culture in which unqualified crew and defective equipment run rampant.

"It's a very unsafe operation," said Richard Block, who has been pressing for towboat industry reform as secretary of the National Mariners Association. "The Coast Guard for years has literally ignored . . . towing vessels."

The Problem is Reputedly Worse in New Orleans.

"It's common knowledge out there that you're not going to get boarded in New Orleans," said David Whitehurst, a licensed captain with 40 years of experience on the river, referring to the random Coast Guard inspections known as boardings.

A Coast Guard hearing scheduled for Tuesday should provide new insight into the circumstances of the July 23 collision, which spilled more than 250,000 gallons of No. 6 fuel and continues to disrupt river traffic.

From what Block can tell, the oil spill embodies larger industry troubles. The Mariners Association blames the prevalence of incompetent crew and lax oversight for scores of marine accidents that have ended in economic and environmental disaster and, in some cases, the death of innocent bystanders.

Two companies involved in last month's spill -- American Commercial Lines of Indiana, owner of the tugboat and barge, and DRD Towing, the Harvey company hired to staff the Mel Oliver ó are also repeat offenders. Like many firms in the industry, they have received little more than slaps on the wrist for their roles in accidents, Block and other critics say.

Checked Track Record.

Congress asked the Coast Guard to begin regular inspections of towing vessels in 2004, and the agency is designing a program to do so. In the meantime, the Mariners Association says a crop of small towing companies has been given free run of waterways regardless of their speckled histories.

In the July 23 oil spill, for example, American Commercial Lines hired DRD Towing to staff its tow and fuel barge despite several infractions by the company. In the span of less than two weeks last month, DRD caused two wrecks on the Mississippi River.

Just 11 days before the Mel Oliver's barge collided with the Tintomara in New Orleans, the Ruby E sank after colliding with Martin Challenger near Westwego. Both times, a DRD-employed **apprentice mate** was at the helm of the vessel instead of a master-licensed pilot.

And in 2004, the company put an improperly licensed pilot at the wheel of the Mr. Craig towboat, which lost control of a barge and punctured the Eagle Memphis, dumping 2,100 gallons of crude oil into the Mississippi near Algiers Point.

In that instance, pilot Richie Zito held a master's license. But he was sanctioned only to steer vessels as heavy as 100 tons, and the Mr. Craig was 129 tons. The Coast Guard recommended a fine of \$3,000, although DRD ultimately paid \$500, said Randy Waits, DRD's attorney. Waits said DRD otherwise has a strong safety record.

Still, the American Waterways Operators, a private association that acts as the de facto regulator of the towing industry, revoked DRD's membership last week after it flunked a May safety audit and failed to submit a letter agreeing to mandatory annual audits.

American Commercial Lines remains in good standing with the waterways association, although the group requires its members to work with partners with good safety records. American Commercial Lines spokesman David Parker said his company has maintained a clean safety record overall, citing a barge transportation injury rate of 1.8 per 200,000 man hours, compared with an industry rate of 2.5 per 200,000 man hours.

Little or No Training.

In the eyes of the Mariners Association, though, American Commercial Lines is part of a class of large barge companies that enlist what Block describes as "subpar" towboat firms because they offer cheaper labor. In fact, documents filed with the mariners group show the Mel Oliver fared no better under the watch of another operator: Versatility Marine.

The association took a statement from Captain Gary Hensley, who recounted serious problems under the watch of Versatility Marine on a trip with the Mel Oliver to Baton Rouge on April 5, 2007.

Hensley wrote that the towboat's "port generator would not

start up, the bilge was full of oily waste and water, there were no flashlights onboard for the crew to use at night or in emergencies, nor was there a green barge navigation light for the vessel to use to operate at night."

Hensley "felt it was unsafe" to operate the Mel Oliver at night and complained to the Coast Guard. Officers responded, boarding the Mel Oliver near Morgan City and terminating the mission.

The bilge had spilled overboard, creating an "oil sheen on the water," Hensley wrote. The freshwater hose was also broken, "causing the crew to be without any way to take a bath . . . or clean the vessel."

In a letter to American Commercial Lines executive Mario Munoz, Block of the Mariners Association criticized the crew aboard the Mel Oliver for having "**little or no training in engine operation and maintenance.**" He urged Munoz, who is also chairman of the Towing Safety Advisory Committee in Washington, D.C., to push Congress for tighter regulations.

[NMA Comment: Refer to our Report #R-401, Rev. 1, Crew Endurance and the Towing Vessel Engineer – A Direct Appeal to Congress and our Report #R-428, Rev. 1. Report to Congress: The Forgotten Mariners. Maritime Education and Training for Entry-Level Deck and Engine Personnel.]

American Commercial Lines cut ties with Versatility Marine "as a result of a follow-up conducted after receipt of the letter," Parker said in an e-mail message.

Texas Bridge Crash

The mariners group's disapproval of American Commercial Lines goes beyond the company's work on the Mississippi. The company had a hand in one of the most notorious marine accidents in recent memory, which has fueled questions about its credibility and choice of contractors, Block said.

In 2001, four American Commercial Lines barges hit the support beams of the Queen Isabella Causeway in South Padre Island, Texas, collapsing the bridge and killing eight people.

The accident spurred several lawsuits against American Commercial Lines, including one by David Fowler, the pilot of the towboat in the causeway crash. The Coast Guard blamed Fowler for the accident, but the pilot sued American Commercial Lines for chartering an unseaworthy vessel. The company was exonerated, according to Parker.

Fowler himself had only a few weeks' experience aboard the towboat and had been involved in one other bridge strike and two other groundings in the 13 months preceding the causeway crash, according to a 2004 Associated Press report.

Two years after the accident, American Commercial Lines filed for bankruptcy. But today, the publicly traded company's fleet of more than 2,800 barges makes it the biggest in the business, according to the American Waterways Operators.

In the past year, American Commercial Lines was party to at least 8 different marine incidents, according to an online Coast Guard database. In September, Coast Guard officers found a mariner without credentials at the helm of a vessel that demolished a pier on the Gulf Intracoastal Waterway.

The database also cites American Commercial Lines' closest peers in the barge industry, listing companies associated with Kirby Corp. of Texas as a party to four

incidents and Ingram Marine Group as a party to seven incidents.

Limited Inspections

Private industry has stepped in to fill the regulatory void for the towing business. The American Waterways Operators touts its Responsible Carrier Program, which requires its roughly 350 members to pass third-party safety audits. The group, which claims to represent as much as 80 percent of the industry, issues certificates to members that pass muster.

"I don't think it's a system that's flawed," said Merritt Lane, the group's chairman and chief executive of Canal Barge Co. of New Orleans. "It may not be fail-safe, but it's not flawed. The important elements are sincere interest by the owner to do it, supported by the third-party audit."

Lynn Muench, a senior vice president of the American Waterways Operators, said the oil spill has made the organization re-examine its handling of companies that fail audits. Carpenter, the group's vice president of national advocacy, said DRD's canceled membership is a sign that the group has its eye on wayward companies **but that only the Coast Guard can truly regulate the industry.**

Last year, the Coast Guard conducted only 291 random on-board inspections of about 7,000 uninspected towing vessels working for the barge industry. Since 2004, such checks led to 1,930 civil penalty cases for unlicensed or under-licensed crew, although only a fraction of those cases have resulted in fines or prosecution. **The Coast Guard also initiated 510 proceedings to suspend or revoke towboat-equivalent mariner licenses from 2004 through 2007.**

"Our relationship with the maritime industry is not meant to be adversarial," Coast Guard spokesman C.T. O'Neil said in an e-mail message. "We apply enforcement actions commensurate with the severity of the violations we encounter."

Still, government auditors have criticized the Coast Guard's policing of marine incidents. In May, a report by the inspector general of the Department of Homeland Security found the Coast Guard was "hindered by unqualified personnel . . . and ineffective management of a substantial backlog of investigations needing review and closure."

Of more than 15,000 investigations between January 2003 and October 2006, the Coast Guard issued 396 recommendations to mariners, industry or other Coast Guard branches.

"Because of these management shortfalls, the Coast Guard may not be able to determine the causal factors of accidents and may miss opportunities to . . . prevent or minimize similar casualties," the report said.

While the Mariners Association says American Waterways Operators has its place, the group has been pushing for more governmental regulation, including better training and more oversight. Whitehurst said towing firms have dramatically cut training regimens to make up for staffing shortages.

"The companies are trying to move these guys through the system as quickly as possible," Whitehurst said. "The training isn't what it should be."

[NMA Comment: Refer to our Report #R-429-N, Rev. 1, Report to the 110th Congress: Maritime Towing Accidents Involving Apprentice Mates/Steersmen.]

TOWBOAT ELIZABETH M SINKING CLAIMED FOUR CREWMEMBERS' LIVES

[Sources: Our file #M-523. Article titled Oversize and Overloaded Tow: Four Dead in Catastrophe on Ohio River, GCMA Newsletter #27, Jan. 2005, pgs.23-26 was based on numerous newspaper reports. We now have several Coast Guard reports in response to our FOIA 05-0644, the latest of which on Mistle Case #215829 is Mistle Activity #2271812 (a "formal" investigation") released to us on July 16, 2008 from which this article is based. Other reports include Mistle Activities #2534925 (pollution) done at the "data collection" level and 2637947, an informal S&R investigation) on "Misconduct" released in Jan. 2007.

Editorial note: *Preparing this article involved extracting data from the primary source. Information is quoted from the report where possible, with approximate page numbers listed and contents were edited where needed for continuity. NMA Comments and emphasis are ours.]*

Summary of the Accident

[Page 2] On Jan. 9, 2005, at approximately 0200, the M/V ELIZABETH M and her six barge tow successfully locked up-bound through the Montgomery Lock and Dam located at mile marker 31.7 on the upper Ohio River below Pittsburgh, PA. The tow included a total of six (6) loaded open hopper coal barges. The lock approach and lockage were uneventful).

While the towboat was exiting the lock chamber and facing up to the tow on the flyö, the barges were set to port towards the center of the river by the current flowing past the lock and over the nearby dam. The set led to an initial allision with the middle lock wall bull nose and the two lead barges at the head of the tow began to break away.

A second allision between the tow and the mooring cells at the end of the riverside lock wall caused the two lead barges to wrap around the end of the riverside lock wall.

A third allision between the stern of the towboat and the landside lock wall caused most of the facing wires between the towboat and the tow to separate.

Efforts to regain control of the barges proved unsuccessful and, at approximately 0220, the ELIZABETH M and two barges went over the Montgomery Dam.

The ELIZABETH M sank and came to rest just below the Montgomery Dam between Gates 5 and 6. A portion of the pilothouse remained above the waterline after the vessel sank. Two of the six barges in the vessel's tow preceded the ELIZABETH M over the dam and continued downstream and subsequently sank. The four remaining barges sank upstream of the dam in the vicinity of Gates 1, 2, 3 and 4.

Subsequent to the sinking of the ELIZABETH M, three crewmembers perished, one crewmember was missing and three crewmembers survived. The three surviving crewmembers suffered various degrees of injury, mostly hypothermia, contusions and lacerations. Rescue/recovery operations were carried out by the M/Vs SANDY DRAKE, LILLIAN G and ROCKET.

The M/V ELIZABETH M was raised on March 4, 2005. After the vessel was raised the missing crewmember was located in the vessel's engineroom. The vessel was transported to, and dry-docked at, C & C Marine Maintenance

Co. in Georgetown, PA located at mile 39 on the Ohio River. The vessel was surveyed, and the owners plan to scrap the vessel after removing serviceable equipment.

Coast Guard Safety Recommendations

[Pages 4-12] **Safety Recommendation #6118: Coast Guard, U.S. Army Corps of Engineers and industry stakeholders charter a working group** Recommend that the U.S. Coast Guard, U.S. Army Corps of Engineers and industry stakeholders:

- a. Develop a single definition of, and a process for determining when, the upper Ohio River is in a state of high water.
- b. Charter a working group to identify known high water hazards associated with vessel operations in the vicinity of the Montgomery Locks and Dam and the upper Ohio River.
- c. Once the hazards in Recommendation b. are identified:
 - (1) Develop methodologies to reduce the hazards associated with high water operations.
 - (2) Establish trigger points to initiate mandatory actions to be taken as the river level rises and falls.
 - (3) Promulgate the required trigger points and actions through a revision of the Ohio River Valley Waterways Management Plan and/or Federal Regulations.

Safety Recommendation #6120: Campbell Transportation Company implements systems and review current policy.

Recommend that Campbell Transportation Company:

- a. Inspect the other vessels in their fleet to ensure all vessel modifications have been completed in accordance with good marine practice and meet or exceed minimum manufacturer's specifications.
- b. Implement a system to ensure their vessel operators are aware of, and comply with, policies and procedures such as the U.S. Corps of Engineers Navigation Notices.
- c. Implement a system to ensure vessel movement orders are clearly articulated and not subject to misinterpretation by (their licensed vessel officers.)
- d. Review and revise company policy for scheduling vessel movements to ensure adequate time is allowed for executing the orders.
- e. Review and revise their Pilot Trainee or Steersman Program policy to reflect commonly used terminology and ensure it is clearly understood, and complied with, by all affected parties.

Safety Recommendation #6124: The U.S. Army Corps of Engineers review and revise policy as needed.

That the U.S. Army Corps of Engineers:

- a. Review, and revise as needed, Navigation Notice No. 1-2004 (or subsequent revisions) to ensure the terms used in the policy are clearly defined (i.e. towboat öset over.ö).
- b. Enforce compliance with the requirements of Navigation Notice No. 1-2004 (or subsequent revisions) by discontinuing the policy of allowing towboats to face up to a tow on the flyö without maintaining some type of positive control over the tow.
- c. Ensure personnel employed at their locks and dams are familiar with, and comply with, all locking procedures.
- d. Ensure commercial vessel compliance with all locking procedures.

Safety Recommendation #6123: Coast Guard Investigative Service review this report for possible criminal action.

Recommend that the Coast Guard Investigative Service review this report for possible criminal action against the Master of the ELIZABETH M and the Pilot of the RICHARD C under 18 U.S. Code §1115 or any other applicable laws and/or regulations.

[NMA Comment: Stupidity is not a crime.]

Safety Recommendation #6130: U.S. Coast Guard seek legislative approval for additional safety standards on commercial towing vessels.

[NMA Comment: Duh!!! This accident occurred 4 months after Congress passed the law requiring towing vessel inspection – something the Coast Guard refused to recommend after the 1993 Amtrak-Sunset Limited accident.]

That the U.S. Coast Guard seek legislation requiring commercial towing vessels comply with certain minimum safety standards for lifesaving, hull condition, stability and machinery installations. This casualty highlighted the following specific areas where legislation could improve maritime safety:

a.Lifesaving. Require primary lifesaving appliances, installed in a float free arrangement, to provide crewmembers egress from a quickly sinking vessel.

[NMA Comment: Duh!!! The NTSB recommended “out-of-water lifesaving equipment as early as 1985. These crewmembers had to enter 34° water in the middle of winter. Our Association traveled to Washington years before this tragic accident to urge the Coast Guard to extend their lifesaving equipment guidelines in NVIC 7-91 to recognize the dangers of cold river water – to no avail.]

b.Emergency Drills. Require crewmembers routinely conduct emergency drills to include abandon ship and man overboard.

[NMA Comment: Duh!!! Current regulations for towing vessels only require fire drills, not man overboard drills. “Man overboard” is the major cause of fatalities in the towing industry on the rivers.]

c.Hull condition. Require scheduled hull inspections (i.e. dry-docking) and testing (i.e. gauging) as needed to prove satisfactory condition.

d.Hull openings. Require all hatches, hull openings and securing gear be maintained in a serviceable condition and openings in the hull to be kept secured except while the vessel is not operating.

e.Stability and subdivision. Require minimum stability and subdivision standards, including the proper installation of ballast.

f.Plan review. Require repairs or alterations to the hull, machinery or equipment that affects the safety of the vessel be submitted to the Coast Guard or a third party for review and approval. Third party review should be restricted to an authorized classification society, naval architect or professional engineer.

Safety Recommendation should be considered as major support documentation in the new regulation development of towing vessels. The Eighth Coast Guard District strongly

supports the inclusion of specific minimum requirements for construction, repair, stability, machinery, and lifesaving in the upcoming towing vessel regulatory project.

Headquarters concurred with this recommendation. Section 415 of the Coast Guard and Maritime Transportation Act of 2004 (Public Law 108-293) added towing vessels to the list of vessels subject to inspection for certification. However, a recent report shows the Coast Guard is only aiming at the year 2014 before it implements towing vessel inspection procedures still on the drawing board.

[NMA Comment: At least Headquarters knew that Congress had acted even if the word had not reached Pittsburgh four months after the Act became law.]

As such, the Coast Guard has sufficient authority to establish minimum safety standards for towing vessels. A regulatory workgroup has been established and a docket opened. The safety areas noted in this recommendation will be considered during the rulemaking process.

Stability Issues: Fixed Ballast

[Page 27] In April 1997 records show that 35 tons of ballast (cement blocks) was installed on the ELIZABETH M in an attempt to trim the vessel to the original waterline after replacement of the vessel's main propulsion engines.

Post casualty analysis completed by the U.S. Coast Guard Marine Safety Center (MSC) indicates that it is likely that the 35 tons is significantly more ballast than the weight difference between the original and final engines and drive trains. The analysis also showed the approximate one-foot increase in draft over the original waterline would have negatively impacted the vessel's survivability during a sinking scenario by increasing the vessel's susceptibility to downflooding through non-watertight doors.

Steersman Training

[Page 28] Campbell Transportation Company has a written policy titled “Pilot Trainee or Steersman Program.” This policy “...describes the qualifications, responsibilities, necessary training, skill requirements, and other criteria for a Pilot Trainee or Steersman...” Among other (company) requirements, “the Steersman shall steer the vessel only under the direct supervision of the Captain of the vessel assigned. Overseeing the training is the responsibility of the vessel Captain.

Rick Conklin was referred to as a “Striker-Pilot” on board the ELIZABETH M in documentation and throughout the testimony provided during the U. S. Coast Guard hearing. Although there is no reference to a “Striker-Pilot” in this policy, Campbell Transportation Company considered this to be the guiding policy for Conklin's training. The company expected the vessel Master (Capt. Zappone) to follow this policy while Conklin was filling the Striker-Pilot position on board the ELIZABETH M. *Captain Zappone testified he was not aware of this policy.*

[NMA Comment: Mariners are required to follow laws, regulations, as well as company policies. Suspension and Revocation (S&R) hearings consider all three of these sources of direction given to mariners.]

Ohio River Valley Waterways Management Plan

[Pages 29 & 30] The plan proved to be *inadequate*. The plan did address high water and was ineffective in protecting against casualties during high water conditions. The plan has specific trigger points and actions to be taken during low water conditions but no trigger points for actions to be taken during high water conditions. For the case at hand, during the high water conditions, inter-pool traffic was only limited by lock outages and inadequate bridge clearances but not by the high river stages resulting from the high water conditions.

Non-Compliance With "Corps" Procedures

[Page 30] There was non-compliance with procedures contained in the U.S. Army Corps of Engineers Navigation Notice No. 1-2004 for a tow leaving a lock in an up bound movement.

For the case at hand, specifically part of paragraph 14 of the Operational Aspects section states "For a single lockage, with a towboat only set over a lock operator walks a line out with the tow until the towboat is again secured to the tow...*That did not happen!*"

Cooperative Towing Vessel Examination Program (CTVEP)

[Page 31] A Campbell Transportation Company representative completed a U.S. Coast Guard cooperative towboat examination (phase II) on the ELIZABETH M utilizing the Eighth Coast Guard District Towing Vessel Boarding form. No deficiencies were noted.

[NMA Comment: CTVEP is a voluntary Coast Guard program that was offered up in the late 1990's as a substitute for a formal vessel inspection. Like other "voluntary" programs planned by Coast Guard officials, this program was inadequately funded, unevenly administered, and contained weak "enforcement" provisions.]

On Oct. 1, 2004, Davis Marine Surveyors, Inc. conducted a dry-dock survey of the ELIZABETH M's hull and noted fractures in way of the port fuel tank. A 4 foot x 4 foot x 1/2-inch section of hull was renewed. On Oct. 12, 2004, Campbell Transportation Company had the ELIZABETH M dry-docked for a survey by Mr. XXX and completed subsequent repairs. Work completed included repairing a hole in the starboard ballast tank, installation of gussets on the bottom of the tow knees, repairing cracks in the headlog, renewal of a 4 foot x 5 foot x 1/4-inch plate in way of the port fuel tank knuckle, replacement of port and starboard rudders and repairing fractures in the Kort nozzles. Hull gauging noted thin spots (under .25 inches). The company decided to defer making the to correct thin spots in the hull to a later date of February 5.

[NMA Comment: This 54-year old relic sank on January 9th – thereby saving Campbell Transportation Company the expense of repairing it. The value of the equipment lost and damaged in the accident was \$1,043,580 including estimates.]

The Elusive Definition of High Water

[Pages 31 & 32] Campbell Transportation Co. considered the river to be in high water conditions when the gates at the Montgomery Locks and Dam were at or above 50 feet. As per the Ohio River Valley Waterways Management Plan, the U.S. Coast Guard Marine Safety Office Pittsburgh considered the

Ohio River to be at high water when the upper gauge at Dashields Lock, located at mile marker 13.3, was at or above 20 feet. The U.S. Army Corps of Engineers considered the river to be in high water conditions when the gates at the Montgomery Locks and Dam were at or above 65 feet.

[NMA Comment: Without an agreed-upon definition of "high water" mariners, employers, and government agencies were free to choose their own definition. This is not satisfactory on a regulated waterway when it leads to unsafe operations and multiple fatalities.]

Unauthorized Entry into Restricted Waters

There are restricted areas above and below the Montgomery dam. Restricted areas are areas designated by the responsible District Engineer of U.S. Army Corps of Engineers. No vessels are supposed to enter any restricted areas at any time.

The restricted area at the Montgomery Locks and Dam extends the entire width of the river up to approximately 1000 feet above the dam and approximately 500 feet below the dam. It was into this area that the Master of the ELIZABETH M ventured while chasing down his lost tow.

Operating Conditions Peculiar to Montgomery L&D

[Page 33] There are five operating conditions that are peculiar to the Montgomery Locks and Dam.

The outdraft at the upper approach. The stronger the current flow over the dam the stronger the outdraft.

The eddy current at the lower approach.

The short lock chamber of the 600 foot main chamber is actually only 592 feet in length.

The constant wind.

Tows may have problems exiting the lock after a down bound lockage when the lock's lower gauge reaches 24 feet.

The current tends to push the tow back into the lock chamber.

The Company Dispatcher Botched the Sailing Orders

[Pages 33-35] [Timeline] Jan. 8 09:34:00 to Jan. 9 03:00:00 (Estimated): Campbell Transportation Company dispatchers issued handwritten sailing orders via fax.. Orders for the M/V ELIZABETH M, M/V RICHARD C and the M/V OLIVER SHEARER were contained on the same fax.

This was *inadequate*. The format and wording of the vessel orders were unclear. The ELIZABETH M orders simply stated "The RICHARD C will help." This order read on its own, without the benefit of reviewing the RICHARD C orders, does not provide enough detail regarding the purpose of the RICHARD C such as what "help" the RICHARD C will provide or when that "help" would be provided.

The orders also were inadequate because the schedule of the RICHARD C did not allow ample time for the RICHARD C to arrive at the Georgetown fleet in time to assist the ELIZABETH M in building the tow and/or to be standing by when the ELIZABETH M was ready to get underway after building the tow.

After receipt of the vessel orders from Campbell Transportation dispatchers, the Master of the M/V ELIZABETH M, Captain Zappone and the Master of the M/V RICHARD C XXX discussed the orders via telephone. They discussed how the tow would be configured and how the towboats would face up to the tow of six loaded coal barges.

High Water on the Ohio River

[Page 36] Timeline 21:30:00 to 02:20:00 (Estimated): The Ohio River was in an extremely high water condition. The Montgomery Dam gates were fluctuating between a low of 83 feet and a high of 95 feet during this time period. The Montgomery Dam was considered to be in high water when the water on the dam gates reached 65 feet.

[NMA Comment: We saw no mention in the accident report that the lock employees ever notified mariners that they were changing the amount of water flowing through the dam gates. We explored the same problem in our Report #R-399, Jun. 14, 2004, "Danger on the Illinois Waterway: Towboat Pilot Loses License After He Accepts High Risk Assignment. Mariners must receive this type of information from lock personnel.]

Approaching Montgomery L&D

[Pages 38-49] Scott Stewart, the ELIZABETH M Pilot, arrived in the pilothouse to relieve Captain Zappone. Zappone and Stewart completed a pre-relief brief discussing known river traffic and cautions about locking through Montgomery Locks in high water conditions. At the time of the watch relief the vessel was located near mile marker 35 on the Ohio River in the vicinity of Phyllis Island. It is unknown when the Striker-Pilot (Conklin) reported to the pilothouse.

The Pilot (Stewart) on the ELIZABETH M and the Pilot on the RICHARD C had a conversation via VHF-FM radio to establish a passing agreement. The vessels safely passed near Shippingport, PA which is at approximate mile marker 34.5 on the Ohio River. The ELIZABETH M was upbound and the RICHARD C was downbound.

The approach and lockage were completed without incident. Lock personnel described this evolution as "picture perfect." The ELIZABETH M and her six (6) barge tow executed a "knockout" lockage. Because of the tow configuration and length, a towboat only set over was utilized during the lockage. The "set over" meant that the ELIZABETH M was moored starboard side to the stern barge on the tow's port string during the lockage.

While the ELIZABETH M was in the lock chamber, the dam gates were raised from 83 feet to 89 feet. An increase in the flow rate over the dam would have increased the outdraft current at the upper approach to the lock.

[NMA Comment: This was a significant change.]

Leaving the Lock

Rick Conklin, the Striker-Pilot (i.e., "steersman"), was operating the ELIZABETH M as she departed the lock chamber. Once the ELIZABETH M and tow were cleared by the lock personnel to exit the lock, the deckhand released the line between the lock and the tow. A line was not maintained between the towboat/tow and the lock.

[NMA Comment: Please read our report #R-429-N Report to the 110th Congress: Maritime Towing Accidents Involving Apprentice Mates/Steersmen for coverage of the Apprentice Mate/Steersman program.]

As the ELIZABETH M began maneuvering to face up to the tow on the fly, she pushed the tow approximately 200 feet out of the lock chamber before releasing the tow and prior to

maneuvering around to the stern of the tow.

While the towboat was maneuvering around to the stern of the tow to face up, the tow was adrift with no positive control. As the ELIZABETH M completed facing up to the tow, the towboat and part of the tow were still within the main lock chamber. This is the approximate time and location where the effects of the outdraft would have been felt at the head of the tow. The tow was out of shape and being set towards the center of the river by the outdraft. Just after the tow was faced up, the lead deckhand noticed "...the head of the tow, it looked weird. It was headed out. The stern of the boat was riding against the land wall."

The tow of the ELIZABETH M first allided with the upstream bull nose at the end of the middle lock wall. The allision caused all the wires at the coupling between the lead and center barges in both the port and starboard strings to separate with the exception of the wires on the port string between the port stern of the lead barge and the port bow of the center barge.

After the (first) allision the towboat and tow continued making headway in an upstream direction angling out towards the center of the river. This was the approximate time that one of the Locksman observed the ELIZABETH M was going "...out toward the center (of the) river a little quicker than what I seen other people do. (and) accelerated."

[Timeline 02:05:30 to 02:20:00 (Estimated)]: Following the initial allision, all deckhands and the Striker-Pilot (Conklin) onboard the ELIZABETH M began making attempts to secure the tow.

The (first) allision parted the line securing the lead barge of the starboard string in the tow. The wire between the starboard bow of the lead barge in the port string and the port bow of the lead barge in the starboard string held. The starboard string lead barge swung around in front of the port string lead barge ending up in a bow to bow configuration. The allision also allowed the two head barges to wrap around the mooring cells and end up facing downstream toward the dam.

The Pilot (Stewart) directed the deckhands to run a line from the tow out to the mooring cell located at the end of the riverside lock wall. The lead deckhand XXX was successful in securing a line between the last upstream mooring cell on the river wall and the tow in the vicinity of the coupling between the center barge and stern barge in the port string.

[Timeline 02:07:30 to 02:08:00 (Estimated)]: The ELIZABETH M's starboard quarter allided with the landside lock wall, (i.e., the second allision).

[Timeline 02:07:45 to 02:08:00 (Estimated)]: Captain Zappone relieved the Pilot (Stewart) and assumed navigational control of the M/V ELIZABETH M.

The Master Takes Charge

[Pages 50-54] The Master, Captain Zappone, maneuvered the ELIZABETH M to the port stern corner of the stern barge in the port string and used a line to secure the bow of the towboat to the tow to try to push the tow upstream out of the locks and towards the mooring cells located above the upper end of the landside lock wall.

[Timeline 02:14 to 02:20 (Estimated)] After successfully pushing the tow up to the 800 foot mark on the landside lockwall, a report was made to the pilothouse that the stern barge in the port string was sinking.

[Timeline 02:18 to 02:19 (Estimated)]: After attempts to release the sinking barge were unsuccessful, the crew of the

ELIZABETH M released the port facing wires and set the tow adrift.

[Timeline 02:18:15 to 02:19:00 (Estimated)] Captain Zappone maneuvered the ELIZABETH M around the starboard side of the tow and placed a line onto a timberhead on the starboard bow of the center barge in the starboard string.

The Catastrophe

[Timeline 02:18:45 to 02:19:00 (Estimated)] Captain Zappone then attempted to back the barges upstream but the ELIZABETH M and tow was not able to make any headway. Captain Zappone gave orders to the crew to release the tow.

[Timeline: 02:19:00 to 02:19:30 (Estimated)] After the tow was released, Captain Zappone then attempted to turn the ELIZABETH M to port to spin the towboat upstream by going full astern on the port engine and greater than clutch ahead on the starboard engines.

The Master decided to swing the ELIZABETH M around to point the head of the towboat upstream before beginning to maneuver away from the tow prior to the tow alliding with the dam, instead of backing the towboat away from the tow. The time taken attempting to execute the maneuver reduced the amount of time available to maneuver the towboat away from the tow and reduced the distance between the towboat and the dam. Based on testimony from the Master, it appears he was predisposed to performing this maneuver because he considered the maneuver to be "...pretty normal..." and had performed the maneuver ..well into the hundreds of times, maybe thousands.ö

[Timeline 02:19:30 to 02:19:45 (Estimated)] While the ELIZABETH M was swinging to port, the starboard side of the vessel collided with the tow causing the bow to be pulled back into the tow and pinning the ELIZABETH M starboard side to the tow.

[Pages 57-62] One of the Locksmen who had just completed opening dam Gate 9, was walking towards Gate 1 when ö...there was a loud bang, a real big crash..." which caused him to lose his balance. At the time, he was standing on the dam in the vicinity of Gate 6 and witnessed two barges start to get jammed in Gate 6. However, the barges quickly dislodged and went over the dam.

Elizabeth M Goes Over the Dam

The Locksman's testimony regarding what he witnessed as the ELIZABETH M approached, allided with and went over the dam was "...before it started going over the rollers, the whole stern was completely submerged, and the rest of the quarter deck and so forth went very fast, and the only part I could physically see was the wheelhouse (and) the tow knees on the bow of the towboat on both sides. I could only see maybe a foot of that."

The ELIZABETH M initially struck the dam "sideways" at a 45 degree angle on the starboard side of the vessel, then spun and went over the dam stern first through the spillway at dam Gate 6.

[Timeline 02:22 (Estimated)] Two of the six barges in the tow preceded the ELIZABETH M over the dam. Four of the six barges in the tow remained in the pool above the dam. After going over the dam, the ELIZABETH M came to rest between dam Gates 5 and 6.

After going over the dam, the stern of the ELIZABETH M submerged then resurfaced and drove the bow of the vessel into the outflow coming through the spillway. The bow then

resurfaced, the stern re-submerged and the ELIZABETH M sank almost immediately. The vessel came to rest between dam Gates 5 and 6.

Crew Thrown into Frigid Waters

[Pages 61-65:] [Timeline 02:22 to 02:40 (Estimated)]: Four of the seven crewmembers were washed/thrown overboard by the violent action of the ELIZABETH M being washed over the dam and the rapidly rising water as the vessel sank. All four of these crewmembers were later recovered by vessels in the vicinity.

[Timeline 02:25:00 to 07:38:00 (Estimated)]: The M/Vs LILLIAN G and SANDY DRAKE recovered three unconscious and one conscious crewmembers. Rescue vessel crews initiated first aid and transported recovered crewmembers to emergency medical service personnel located at the Mansfield Power Plant near mile marker 34 on the Ohio River.

The crew of the M/V ROCKET successfully rescued two crewmembers (Captain Zappone and XXX) from the partially sunken ELIZABETH M using ring life buoys attached to lifelines. Once Captain Zappone and XXX were safely aboard the ROCKET, the crew initiated first aid procedures and transported them to emergency medical service personnel.

[Timeline 03:10 to 03:45:00 (Estimated)]: As a result of the ELIZABETH M sinking, XXX suffered hypothermia and frostbite and Captain Zappone suffered hypothermia, an amputated right hand little finger, lacerations to his feet, bumps and contusions.

Dead or Alive –Don't Forget the Drug Test

[Page 66] [Timeline 08:00:00 to 08:10:00 (Estimated)] Campbell Transportation Co. did not conduct required chemical testing in accordance with 46 CFR Parts 4 and 16. Non-Department of Transportation chemical testing was performed on the Master. Chemical testing was not performed on the two surviving deckhands.

Salvage

[Pages 72-77] The M/V ELIZABETH M was raised without incident and transported to Industry Terminal located at mile marker 33 on the Ohio River. Oil was discharged from the ELIZABETH M during salvage operations. The vessel was ultimately transported to, and secured at, the C&C Marine Maintenance Co. in Georgetown, PA located at mile 39 on the Ohio River. The vessel was a total constructive loss.

A vessel survey was completed after the ELIZABETH M was raised. Pinholes and fractures were noted in the forepeak which appeared to be the result of hull wastage.

Two cutouts approximately 25" x 25" were noted in the main deck below the poop deck in the vicinity of the steering gear. Both cutouts were located on the vessel's centerline (approximately) with one located approximately 10 feet forward of the transom and the other approximately 19 feet forward of the transom.

The poop deck had been modified by installation of open grating which replaced approximately 30 inches of the stern section of the deck. The poop deck modifications compromised the vessel's weather/water tightness. Any water shipped on the poop deck would have drained directly into the interior of the vessel through the grating and the two 25" x 25" cutouts in the main deck. Hatch dogs were also found to be unserviceable.

Post casualty analysis indicated, with the 25" x 25"

openings in the main deck, "...given 60 seconds and some combination of static head and river flow, the aft void could have been mostly (if not completely) full of water.ö The analysis also concluded "...filling (to 100%) the aft void (space) and deck box alone would not have caused the vessel to sink.ö However, it would have trimmed the vessel and made her more susceptible to downflooding.

Inadequate Power and Loss of Power

During the course of this investigation there were indications the ELIZABETH M may have lost main propulsion power before going over the dam. Post-casualty analysis indicates the engines were running at or near full rated power until the vessel sank after going through the dam.

Air was supplied to the main diesel engines (MDEs) from air filter housings located outside the engineroom on the 01 (Texas) deck. The MDEs air supply ran from the air filter housings through reinforced hard rubber elbows and steel piping which terminated approximately 4 feet above the MDEs. There were four sections of 6-foot long (approximately), 8-inch diameter, wire reinforced, thin wall (0.060") flexible PVC duct hose connected between the steel piping located above the MDEs and MDE's turbocharger inlets.

These flexible duct hose sections did *not* meet minimum manufacturer's specifications which "...specify ridged piping and reinforced heavy wall elbows and flexible connections similar to the ELIZABETH M air supply above the PVC hoses."

Air flow to the MDEs was restricted as the air filtering media swelled from being wetted after the vessel went over the dam. The restriction of airflow to the MDEs resulted in an increase of vacuum within the MDE's air intake supply system between the air filter housing and the MDE turbocharger inlets. The high vacuum within the system collapsed the flexible PVC duct hoses. The collapse of the duct hoses caused air starvation of the MDEs and the engines shut down. All four sections of flexible PVC duct hoses collapsed in a similar fashion. No hydraulic lock damage was found in either MDE during the post casualty internal inspections.

Post-casualty analysis also indicated the river velocity approximately 100 feet above the dam at 0230 on Jan. 9, 2005 was approximately 16.2 ft per second which equates to approximately 11.04 miles per hour. River velocity would have increased in the vicinity of the dam gates due to the river restrictions caused by the lock and dam structure. The current near the dam gates could have been as high as 13.2 MPH.

Post-casualty analysis also indicated the ELIZABETH M as a light boat, with the MDEs governors limiting engine speed to 1200 RPM, could not have produced enough propeller RPM to overcome the currents being experienced in the restricted area above the Montgomery Dam on the date of the accident. The analysis indicated the ELIZABETH M, as configured, had a maximum light boat velocity potential of approximately 11 MPH.

[NMA Comment: That would be 11 MPH moving ahead, but not moving astern as the Master first attempted while seeking to retrieve the barges from going over the dam.]

Causal Analysis of Factors Contributing to the Accident

Overconfidence Bias. The Master decided to shove the tow out of the somewhat protected area between the landside lock wall and the riverside lock wall into the open river in an

attempt to reach the mooring cells above the upper end of the landside lock wall after the third allision.

Overconfidence Bias;. The Master decided to pursue the barges into the Corps of Engineers restricted zone above the dam.

Framing Bias. The Master decided to swing the ELIZABETH M around to point the head of the towboat upstream before beginning to maneuver away from the tow just before the tow allided with the dam, instead of backing the towboat away from the tow. The time taken attempting to execute the maneuver reduced the amount of time available to maneuver the towboat away from the tow and reduced the distance between the towboat and the dam. Based on testimony from the Master, it appears he was predisposed to performing this maneuver because he considered the maneuver to be "...pretty normal..." and had performed the maneuver "...well into the hundreds of times, maybe thousands."

Overconfidence Bias. The Striker-Pilot decided to continue shoving the tow out of the lock chamber, towards the open river, after the initial allision and before regaining full control of the barges at the head of the tow.

Non-compliance with procedures contained in the U.S. Corps of Engineers Navigation Notice No. 1-2004 for a tow leaving a lock in an up bound movement. Specifically paragraph 14 of the Operational Aspects section which states "For a single lockage, with a towboat only set over.. a lock operator walks a line out with the tow until the towboat is again secured to the tow..." **This never happened!**

The Striker pilot operated the M/V ELIZABETH M and her tow contrary to company policy. The Striker Pilot was operating under the supervision of the Pilot and not the Captain as required by company policy.

Improper condition of the equipment. Modifications were made to the ELIZABETH M that were not completed in accordance with manufacturer's specifications or good marine practice. The modifications reduced the vessel's survivability and degraded the vessel's propulsion system capabilities.

Mismatch between design use and production activity. Once the six barge tow was out of shape and had drifted into the restricted area above the Montgomery Dam, the ELIZABETH M was not an adequate or suitable vessel for recovery of the tow due to the configuration of the vessel's main diesel engines and river conditions being experienced in the area immediately above the dam at the time of the accident.

Workplace Factors. Inadequate training of line workers. Campbell Transportation Company personnel on the morning of the casualty were not conversant with all U.S. Corps of Engineers locking procedures.

Lock personnel employed at the Montgomery Lock and Dam on the morning of the casualty were not conversant with all U.S. Corps of Engineers locking procedures.

The Striker Pilot (öSteersmanö) was operating the M/V ELIZABETH M and her tow contrary to company policy. The Striker Pilot was operating under supervision of the Pilot and not the Captain as required by company policy..

Operations not in accordance with rules and regulations. The ELIZABETH M personnel failed to follow Army Corps of Engineers locking procedures.

Montgomery Lock and Dam personnel failed to follow Army Corps of Engineers locking procedures.

Organization Factors

Inadequate Training of line managers. Campbell Transportation Company's written policy titled "Pilot Trainee or Steersman Program" was unclear regarding the responsibilities of, and for the ELIZABETH M's Striker-Pilot (Conklin) because their policy does not refer to, or define the term "Striker Pilotö. There is evidence that the policy was not followed by at least two Campbell Transportation Co. employees who operated the ELIZABETH M who allowed the Striker-Pilot to operate the ELIZABETH M on the after watch (Pilot's watch).

Purchase of unsuitable equipment and installation on the main diesel engines air supply system did not meet minimum manufacturer's specifications and degraded the vessel's propulsion system.

Format and wording of the vessel orders issued by the Campbell Transportation Company dispatcher were vague, unclear and easily misinterpreted..

Improper or inadequate schedules. The schedule of the RICHARD C as established by the orders issued by Campbell Transportation Company on Jan. 8, 2005 did not allow ample time for the RICHARD C to arrive at the Georgetown fleet in time to assist the ELIZABETH M in building the tow and/or to be standing by when the ELIZABETH M was ready to get underway after building the tow.

The U.S. Coast Guard, U.S. Army Corps of Engineers and the marine industry were all using different standards for making a determination of when vessels were operating in high water conditions on the upper Ohio River.

The Ohio River Valley Waterways Management Plan is ineffective in protecting against casualties during high water conditions.

Campbell Transportation Company's policy titled "Pilot Trainee or Steersman Program" was unclear regarding the responsibilities of, and for, Striker-Pilots.

Inadequate or absent oversight. There is evidence the Campbell Transportation Company cooperative towboat examination program (CTVEP) is substandard. The last vessel examination under this program was completed while the ELIZABETH M was under a Captain of the Port order suspending operations until the cause of a power loss experienced on Sept. 24, 2004 could be determined and corrective action taken to prevent reoccurrence. The examination was completed by a Campbell Transportation

Co. representative and no deficiencies were noted. However, the vessel was dry-docked on two different occasions within twelve days after completion of the examination and significant deficiencies were noted including cracks in fuel tanks, holed ballast tanks and cracks in the headlog.

Inadequate or absent safety promotion. The ELIZABETH M was experiencing significant downflooding of interior spaces prior to going over the dam. Over-ballasting of the vessel in 1997 would have increased vessel downflooding noted just prior to the vessel going over the dam and quickened the sinking of the ELIZABETH M after going over the dam.

The ELIZABETH M experienced significant downflooding of interior spaces before she went over the dam. The two 25" x 25" cutouts found in the aft main deck, increased vessel downflooding noted just prior to the vessel going over the dam and quickened the sinking of the ELIZABETH M after going over the dam.

The U.S. Coast Guard, U.S. Army Corps of Engineers, and the marine industry all used different standards to determine when vessels were operating in öhigh waterö conditions on the upper Ohio River.

Defenses in Place but Failed due to Inadequacy:

Inadequate defective/problem reporting policies and procedures. Pilot XXX on the RICHARD C failed to take appropriate actions when he knew the ELIZABETH M and tow had departed the Georgetown fleet in violation of company orders. The Pilot on the RICHARD C testified he understood his orders were to get in tow with the ELIZABETH M in Georgetown, but he did not discuss the deviation from the orders with the Pilot (Stewart) on the ELIZABETH M (when the two vessels passed each other). On the morning of the casualty, when asked by a Campbell Transportation Company dispatcher why the ELIZABETH M departed Georgetown without the RICHARD C, said, "He didn't ask." Although the Pilot observed a situation that was contrary to his understanding of his vessel's orders, in addition to not inquiring with the Pilot on ELIZABETH M, he did not notify the RICHARD C's Master or a Campbell Transportation Company representative to inform them of the discrepancy. He just "...was wondering why he left." The President of Campbell Transportation Co. testified that XXX "...should have called the office..." when he knew the ELIZABETH M departed Georgetown without the RICHARD C.ö

Human Failure Planning Errors. The ELIZABETH M and tow departed from the Georgetown fleet without the assigned assist vessel.

Failures of Defense Against the Subsequent Events

Inadequate training. The Striker Pilot was operating under the supervision of the Pilot and not the Master as required by company policy.

[NMA Comment: The lesson here is for mariners to read and understand your company's policies and obey them. You are responsible for doing so.]

Absence of information about potential hazards. The Pilot failed to inquire and recognize the damø increased outdraft effect on the vessel's tow.

Non-compliance with procedures contained in the U.S. Corps of Engineers Navigation Notice No. 1-2004 for a tow leaving a lock in an up bound movement. Specifically paragraph 14 of the Operational Aspects section which states: ðfor a single lockage, with a towboat only set over...a lock operator walks a line out with the tow until the towboat is again secured to the towí ö

The decision of the Pilot to remove the line that had been secured between the riverside lock wall and the tow after the second allision. The line was removed before gaining full control of the tow and could have been used to check the forward momentum of the tow and prevented it from being pulled around the upstream mooring cells on the riverside lock wall.

The Master decided to pursue the barges into the restricted zone above the dam and then operated the ELIZABETH M within the restricted area above the dam while trying to recover the tow. This was a willful violation of regulations.

The decision of the Master to shove the tow out of the, somewhat, protected area between the landside lock wall and the riverside lock wall into the open river in an attempt to reach the mooring cells above the upper end of the landside lock wall after the third allision.

Inattention Error ó Perceptual Confusion; The Master failed to recognize a risk of allision.

- Engineered defenses that could reasonably have been expected but were removed. Ballast and engineering modifications were made to the ELIZABETH M that were not completed in accordance with manufacturers specifications or good marine practices. The modifications

reduced the vessel's survivability and degraded the vessel's propulsion system capabilities.

Excessive ballast was placed on board the ELIZABETH M in April 1997 during re-powering the vessel.

Comment by Attorney Dennis M. O'Bryan, Esq.

[Dennis O'Bryan is a longstanding member of our Association who represents working mariners. Contact him at the O'Bryan Law Center, P.C., 401 S. Old Woodward, Suite 450, Birmingham, MI 48009. Phone: 248-258-6262; Fax: 248-258-6047; E-mail: dob@obryanlaw.net. Client line: 1-800-627-9267.]

Dear Mr. Block:

I represented the Estate of Thomas J. Fisher and crewmember Jacob Wilds, in the ELIZABETH M matter, and would comment as follows:

Attending the Coast Guard hearings on behalf of the Estate of Thomas J. Fisher, and crewmember Jacob Wilds, was an interesting experience. At the time, the Coast Guard was very reluctant to allow in any evidence I presented of fault on behalf of the Corps of Engineers not following their own procedures regarding the handling of tow boat only set overs. In fact, the Commander in charge refused to allow me to illicit any testimony with regard to the matter. Nevertheless, in the underlying court suit, I deposed the lock masters and made it clear that they had violated their own rules and regulations, and sent those transcripts to the Coast Guard for consideration in their investigation. To my surprise, the Coast Guard adopted those same arguments that they precluded me from making during the investigation. I was quite surprised in the comprehensiveness of the Coast Guard report which was much more exhaustive than those generated in other disasters in which I have represented the estates of crewmembers who perished, or surviving crewmembers. Saying that, I totally agree with the Coast Guard report.

Very truly yours,
Dennis O'Bryan, Esq.

MARINERS MUST BE *TRAINED* TO USE MODERN ELECTRONIC NAVIGATION EQUIPMENT

The 1993 Bayou Canot Accident – 47 Lives Lost

Like almost all uninspected towing vessels the M/V MAUVILLA that did have a radar. However, the Pilot of the towboat was not proficient in the use of the vessel's radar.

ðThe National Transportation Safety Board determined that the probable cause of Amtrak Train 2's derailment were the displacement of the Big Bayou Canot Bridge when it was struck by the MAUVILLA and tow as a result of the MAUVILLA's Pilot becoming lost and disoriented in the dense fog because of (1) the Pilot's lack of radar navigation competency; (2) Warrior & Gulf Navigation Company's failure to ensure that its pilot was competent to use radar to navigate his tow during periods of reduced visibility; and (3) the Coast Guard's failure to establish higher standards for inland towing vessel operator licensing.ö⁽¹⁾
[⁽¹⁾NTSB/RAR-94/01]

After the accident, it always appears to be after an accident, the Coast Guard mandated radar training for all licensed towing

vessel officers and required towing vessels to carry appropriate navigational devices, including charts, in the wheelhouse.

The NTSB noted: ðTo require that radars be installed on uninspected towing vessels would be to regulate what is accepted practice and would not be an imposition on the industry, but it would prevent such vessels from operating legally unless their radar was in proper working order and would encourage operator reliance on radars. **Operators trained in radar observation would be more likely to use radar and would know how to use it properly. They would also be less likely to become disoriented in fog.**”

Why couldn't the Coast Guard figure this out on their own and ask Congress for the authority to require radar installation, use, and training before 47 lives were lost in this tragic accident? Could it be that some Coast Guard officers lack sufficient practical, hands-on experience in the areas in which they are expected to have expert knowledge. Don't hold your breath waiting for them to admit it!

Automatic Identification System

The Coast Guard had an ðeasy sellö on requiring vessels to

carry AIS equipment, especially following the events of 9/11. However, in their haste to promote this latest electronic wonder, they completely forgot about requiring mariner raining in how to make the best use of this new tool.

Equipment dealers and their equipment installers are interested in selling and installing new equipment and not in training a mariner how to use it. In fact, many towing vessels never even received a copy of the instruction manual that explained basic equipment use and settings.

We mentioned this to the Coast Guard on several occasions, but they were too busy to respond to our letters and complaints about the lack of response to senior officers at Headquarters received equally cavalier treatment.

The M/V North Service Accident

On Feb. 13, 2003 at 2130, the tug NORTH SERVICE departed Whitestone Anchorage for Long Island Sound, pushing ahead the laden tank barge ENERGY 5501. The Captain was on watch and on the helm. Due to the weather conditions, he followed his foul-weather route and proceeded to transit along the ragged Connecticut shoreline, taking advantage of the lee created by the land. At midnight, Captain ■ was relieved of his watch by the Mate. The tug and barge were located just off Greenwich, CT. Captain ■ instructed the Mate to continue along the foul-weather route until he reached Norwalk, CT. By that time, the Captain believed the winds and seas would have lessened substantially, and they could make their turn to the south to take the barge into Port Jefferson. They were expected to be at the TOSCO facility at 0730. The Captain retired to his stateroom.

The Mate continued the transit, following the foul-weather route as plotted on the chart plotter. He passed south of buoy R"32", just south of Stamford Harbor. This buoy coincided with waypoint 007 in the electronic chart plotter. His heading was 064 degrees true, and he was making 6.6 knots. Using the chart plotter screen image, he noted a boundary circle around Budd Reef, and a second boundary circle around an area of shallow water (22 feet) located east of Budd Reef. He also noted the location of buoy R"26", just south of the Norwalk Islands. He intended to keep the tug and barge an equal distance between these obstructions, then make a gradual turn to the south after passing buoy R"26".

As he reached waypoint 008, just past Budd Reef and south of buoy R"28", he altered his course to 065 degrees true to take him between the 22-foot boundary circle and buoy R"26". However, at waypoint 008, the chart plotter depicted the intended track line making a course change to 067 degrees true to waypoint 009. Waypoint 009 was located south of buoy R"26".

The Mate, Mr. ■■ continued his transit, and at approximately 1:50 a.m., felt the tug and barge strike something. At first he thought he hit ice. He sent his deckhand out of the wheelhouse to investigate. Using the spotlight, he noticed a red sheen coming from the starboard side of the barge and smelled fuel.

The Captain awakened by the noise and came to the wheelhouse. He assumed the helm and directed his crew to secure all vents on the barge as he maneuvered the vessel to a safe location. The tug and barge anchored in a location southwest of the grounding site.

The crew took immediate action to mitigate the discharge in accordance with the vessel's response plan, and notified the Coast Guard and their operating company, Hornbeck Offshore Transportation. The tankermen aboard the ENERGY 5501 determined multiple starboard cargo tanks were holed and reported the starboard aft corner of the barge was submerged to the deck.

All 6 starboard tanks of the single-skin tank barge were holed. The barge was loaded with 52,000 barrels of No. 2 heating oil. There was no damage to the tug. Fortunately, and after a great deal of hard work by the crew, the Coast Guard and spill contractors, the barge discharged only about 68 barrels (2,500 gallons) of oil into the waters of Long Island Sound, although none of the oil was recovered from the marine environment or impacted the shorelines of Connecticut or Long Island, NY. The accident occurred in the middle of winter with temperatures in the upper teens and immediately before the onset of northeast gales and snow.

Electronic Chart Navigation Issues

[Source: Our file #M-413, Mislé Activity #1755770, Mislé case #106884, FOIA #03-0864, release date July 25, 2008]

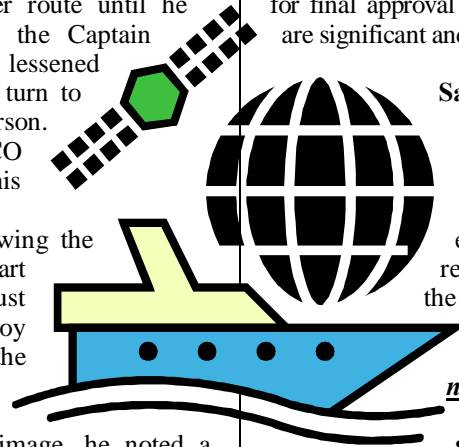
Coast Guard recommendations are initiated by the Coast Guard investigators and are sent through the chain of command for final approval by Headquarters. These recommendations are significant and may eventually impact our mariners.

Safety Recommendation #5765: Regulation Changes

The Coast Guard is currently reviewing regulations in Title 33 Code of Federal Regulations §164.72 to modify the equipment carriage requirements. It is recommended that the Coast Guard modify the training requirements and require additional training courses and instruction in the use of electronic chart navigation tools. The skill sets necessary to navigate with the use of paper charts is significantly different from those needed to properly use and apply electronic chart systems for the purpose of vessel navigation.

Concur. This case highlights the fact that mariners are using electronic chart systems (ECS) without adequate knowledge of how to best use these systems. Nor do they necessarily understand the functional differences that exist between paper and electronic charts (both ECS and ECDIS). This is evident in the manner in which the master plotted by zooming out the heavy weather chart by zooming out to maximize the area displayed on the screen rather than ensuring that the chart was displayed at the proper scale. It is important that during this period of transition from paper charts to electronic charts, that mariners learn how to make proper use of ECS. Part of this process must include addressing the training provided to mariners as well as the questions asked on licensing exams.

It should be noted that vessels may make more use of electronic charts than paper charts insofar as most ECS displays found on towing and other smaller commercial vessels are located where they can be viewed by the officer on watch while they are conning the vessel whereas most chart tables are located at the back of the pilot house.



Concur with the recommendation of the Investigating Officer and the endorsement of the command. The requirements for equipment carriage aboard towing vessels do not take into account the necessity for the user to attain and demonstrate proficiency with that equipment.

[NMA Comment: How long will it take for the Coast Guard to turn this information into a regulatory requirement? This oil spill could have dumped 2, 184,000 gallons of oil into Long Island Sound – potentially 2½ times as much as the Scandia-North Cape accident that blackened most of the Rhode Island Coastline in January 1996.]

The steadily increasing influx of electronic navigation equipment and plotting practices begs for the inclusion of training and proficiency exams as part of the towboat operator's licensing and license endorsement processes.

Weasel Words

We (i.e., the Commandant) partially concur with this recommendation.

There are existing regulations in place requiring all licensed individuals to be familiar with the relevant characteristics of the vessel on which engaged, specifically including "proper operation of the installed navigation equipment." See 46 CFR §15.405. There is also a requirement in 33 CFR §164.78 mandating that the operators of towing vessels must be able to "fix the position of the vessel using installed navigation equipment." Thus, to be in compliance with existing regulations, the operator of the towing vessel in this case should have been sufficiently trained in the proper use of the electronic chart plotter equipment that was installed on the vessel.

However, if Electronic Chart System/Electronic Chart Display and Information System (ECS/ECDIS) equipment becomes required on towing vessels through the implementation of the provisions of Sec.4A of Public Law

108-293 into regulations, which is the subject of a current rulemaking project, we will consider amending the current training requirements for towing vessel operators to include ECS/ECDIS training and examination questions. If it is ultimately determined that ECS/ECDIS will not be required on towing vessels, we cannot require ECS/ECDIS training and/or examination for towing vessel officer licenses.

The Mate on watch was using the tug's electronic chart plotter and radar to navigate the vessel through the waters of Long Island Sound. His course at the time of the impact was left 2 degrees, or approximately 300 yards, from the intended track line on the chart plotter. This difference placed the tug and barge on a course taking them directly over the 18-foot rock. Had the Mate maintained the intended track line, the tug and barge would have missed the 18-foot rock.

It is possible the Master and Mate of the tug NORTH SERVICE were using the electronic chart plotter beyond the scale it was designed for. That could explain why the 18-foot mark was not shaded in blue when zoomed out.

The foul-weather route was created by the Master of the NORTH SERVICE to avoid a rough ride in certain weather conditions. This route kept the tug and barge away from noted charted obstructions, including the 18-foot rock. However, the Master never noted 18-foot rock while plotting his foul-weather route.

The Company is the "Responsible Party"

Hornbeck Offshore was a member of AWO at the time of this casualty. In March 2003, Hornbeck Offshore discontinued their membership with the AWO. While a member of the AWO, the company passed an AWO RCP audit (some time between 2000 and 2001), but the fleet of vessels was not certified. They did have a program in place under the RCP, and had a 3-volume Operating Policy and Procedures Manual they expected all employees to follow. However, this manual was originally written by Spentonbush/Red Star, previous owner of the tug, and had not been updated when Hornbeck purchased 18 vessels in 2001.

NMA QUESTIONS ACCIDENT INVESTIGATIONS THAT SEEM TO LAST FOREVER

In our Report # R-429-M, United States Coast Guard's Management of the Marine Casualty Investigations Program, a reprint of the DHS Inspector General's Report #OIG-08-51, it is clear that the Coast Guard has not been keeping up with their accident investigations.

In the following letter, we questioned why it took the Coast Guard over seven (7) years to investigate a collision on the Ohio River in which six persons perished.

Our Association submitted a Freedom of Information Act request several days after the accident and are yet to receive further information although Coast Guard press releases stated that a "Formal Investigation" was underway. Did they "forget" about it or did they simply "dump" the case as they did with thousands of others as revealed on pages 12-16 in the Inspector General's report.

Our Letter

To: CG-611

Reference: GCMA/NMA Reference #M-243

Dear Sir or Madam,

Seven years ago, we⁽¹⁾ requested an accident report and complete information on the collision between the towing vessel ELAINE G and a pleasure craft near Ohio River mile marker 568 on or about July 15, 2001 in which there were multiple fatalities. ⁽¹⁾ Our original request was made in the name of the Gulf Coast Mariners Association. On Jan. 1, 2008 we changed our corporate name to National Mariners Association.

We note from the Coast Guard Eighth District News Release dated July 19, 2001 [**Enclosure #1**] that the Coast Guard is conducting a FORMAL INVESTIGATION of this accident. A "Formal Investigation" represents a very comprehensive type of investigation similar to the current investigation on the 419,000 gallon oil spill conducted by the Eighth Coast Guard District in New Orleans.

Significance: One of the most serious problems our licensed mariners who serve on towing vessels encounter is the interface between commercial towing vessels and pleasure boats. It is clear from the nature of this particular accident that there are many lessons that could be (or could have been) learned if the accident investigation was completed and reported in a timely manner. However, since we have received no further word on this accident and the Coast

Guard's investigation thereof, NO lessons were learned while other accidents of this nature have been reported.

Nature of the Accident: In this accident, a towing vessel pushing 14 empty barges collided with a pleasure boat at night and in restricted visibility. Seven years have passed since the date of the accident and yet we have been furnished no releasable information concerning this accident in which there were MULTIPLE (6) FATALITIES.

During this time, the Towing Safety Advisory Committee (TSAC) initiated a "Recreational/Commercial Boating Interface Working Group" under the able leadership of Mrs. Cathy Hammond. We believe this accident was significant enough that the progress of the Coast Guard's investigative efforts should be brought to the attention of the Towing Safety Advisory Committee at their next meeting which we plan to attend. However, if this investigation has not been performed properly, or in a timely manner, this information needs to be brought to the attention of Congress.

In a recent Congressional hearing, Mrs. Higgins of the National Transportation Safety Board spoke and sought authority

from Congress to allow the NTSB the option to choose to become the lead investigative agency in high profile maritime investigations. We believe that this accident would be such an example where the NTSB might have performed in a more timely manner than the Coast Guard if it had been the lead agency in the investigation. I cannot recall where the NTSB ever took this long to complete an investigation of this nature.

The DHS OIG Report. Earlier this Spring, the Department of Homeland Security, Office of the Inspector General released report #OIG-08-51 that described a number of shocking revelations about shortcomings involving Coast Guard Accident Investigations. We reprinted the report in its entirety and placed it on our website as our Report #R-429-M.

Our request: We respectfully request that all releasable information on this accident, that is now seven years old, be provided to us in response to our original FOIA #01-1916. We also ask that the same information be furnished for distribution to TSAC at its next scheduled meeting on September 17-18 (ATTN: Mr. Gerald Miente, in Room 1210 at Coast Guard Headquarters).

MARINERS REPORT INSUFFICIENT BARGE LIGHTING

On April 27, 2008, after receiving reports from several very concerned mariners, we addressed the following letter to the Eighth District Commander.

The Complaint

SUBJECT: Barge Lighting; 33 CFR §88.13

Dear Admiral Whitehead,

On Thursday April 24, 2008 one of our most experienced mariners called us from the vicinity of Lake Charles, LA and informed us that a large number of barges at the two Devall fleets near the Ellender Bridge, GIWW miles 242-244 WHL, were unlighted at night and that a dangerous condition existed there for Intracoastal waterway traffic transiting the area that needed to be remedied.

This conversation triggered me to recall an earlier letter on exactly the same subject on behalf of a different towboat pilot four years ago. On May 4, 2004 our Association at the request of [redacted] wrote regarding the same problem in the same area to the Commanding Officer of the Marine Safety Office in **Port Arthur, TX** with a copy to **MSD Lake Charles** as well as to Commander Stewart at the **Eighth District Headquarters**. [Enclosure #1]. I searched both my electronic and paper files and can state with confidence that I did not receive a written response to this complaint.

I live on the Intracoastal Waterway and watch the constant parade of tows,

many of which are red-flag tows carrying dangerous chemicals, petroleum, and other cargoes that must be moved safely so as to not pollute our waterways. Apparently, barge owners get away with leaving barges anywhere they choose to do so at night without providing adequate lighting.

Our Association submits that it really is time for the Coast Guard to specify that barge owners no longer be allowed to use a light bulb wired to a dry cell battery or other cheap, temporary plastic lights and be required to provide adequate rechargeable lighting for barges that are left in inadequately lighted areas (i.e., in places other than those specifically listed in 33 CFR §88.13(e) that extend out into the waterway. The Devall fleet apparently is a repeat violator. They are an AWO member and follow the Responsible Carrier Program. Yet, they apparently show little consideration for the vessel traffic that passes by their own fleeting areas.

I was informed by the same mariner that he counted fourteen (14) Coast Guard go-fast boats in the Lake Charles-Port Arthur area on this trip alone. This example, provided by a trustworthy, mature, and experienced mariner could well serve as an example of the Coast Guard's preoccupation with missions other than Marine Safety that was the subject of the Congressional hearing I attended last August 2nd.

Upon further discussion, this mariner also recorded his disappointment in the failure of many fleets in the industrial corridor between New Orleans and Baton Rouge to maintain adequate barge

lighting as well. This led me to recall a second letter on May 6, 2004 where Captain [redacted] reported he almost had a collision on the Morgan City-Port Allen Waterway with an unlighted barge at night [Enclosure #2]. We have no idea whether any action was taken in this case because we never received an answer.

I observe that it has become part of the Coast Guard's normal course of business not to respond in writing to many of our letters. We correspond in writing because we seek to maintain a paper trail on important issues. When our mariners discuss matters like this with us, they become important issues which are important enough to draft a letter. When issues are important to our mariners and your Agency ignores them, we assemble the paper and submit them directly to DHS or, if necessary, to Congress. We neither intend to waste your time nor be ignored.

After four years, we request a response on the steps you intend to follow to enforce 33 CFR §88.13 throughout the district and, specifically with your industry "partners" to illuminate the Devall fleet.

The Coast Guard Response

Dear Mr. Block:

This is a follow up to my letter of May 16, 2008 concerning the issue of unlit barges observed in the Lake Charles, Louisiana area and other areas by members of your association. The navigation safety issue has been addressed by the Coast Guard Marine Safety Unit in Lake Charles. Marine Safety Unit Lake Charles personnel have

visited the area on several occasions. They have exercised their authority and coordinated with the owner. Any deficiencies that may have existed have been corrected.

I also wish to inform you that if you or anyone of your constituents observes any further barge lighting or any issues pertaining to navigation safety in the Lake Charles area, please feel free to contact Lieutenant Felix Rivera, Chief of Prevention for Marine Safety Unit Lake

Charles at: Phone (337) 491-7804 / Fax (337) 491-7839. I wish to thank you and your organization for your time and efforts in keeping our waterways safe for all mariners.

Sincerely,

T. D. Hooper, Captain, U.S. Coast Guard Chief, Prevention Division, By direction of the Commander, Eighth Coast Guard District.

[NMA Comment: The COSCO BUSAN accident in San Francisco and the 419,000 gallon oil spill in New Orleans are both examples of "torn metal" where pollutants hit the water. Ramming an unlighted barge with an oil or chemical tow is a scenario with a high potential of death and environmental destruction – all because "someone" was too cheap (management) or too lazy (boat crew) to provide adequate barge lighting.]

MISSISSIPPI RIVER COMMISSION MEETING

On Friday Aug. 22, 2008, our Association participated in a meeting of the Mississippi River Commission held in the auditorium on the Corps of Engineers towboat M/V MISSISSIPPI. Brigadier General Michael Walsh, President-designee of the Commission presided over the meeting with Commission Members Smith, Angel, and Jones in attendance. The meeting was held in Houma, Louisiana and was dominated by important regional officials who are responsible for working with Corps officials on hurricane protection, flood abatement, and dredging issues.

Captain John R. Sutton, Member of our Association and former President of the American Inland Mariners Association, relieved the Master of the M/V MISSISSIPPI at the time of the meeting

Speakers at the meeting included General Walsh, New Orleans District Engineer Colonel A. Lee, Louisiana state Senator Reggie Dupre, State Representative Damon Baldone, State Representative Gordon Dove, Terrebonne Parish President Michel Claudet, and several officials and consultants from Plaquemines Parish, Lafourche Parish, and the Ports of Terrebonne and Morgan City. It was one of the most informative USACE meetings our Association has attended and demonstrated the importance of providing immediate hurricane and flood protection to southeast Louisiana.

Unlike previous meetings, very little was mentioned about purely navigational issues. However, much was mentioned about the beneficial use of dredged material to build up the thousands of acres of wetlands in south Louisiana that are lost to the sea each year.

Our Association briefly brought up the only truly navigation issue in a 53-page prepared statement introduced by the Association and delivered to the commission. The introduction follows:

President, Mississippi River Commission
820 Crawford Street
Vicksburg, MS 39180

Subject: Safety and Infrastructure Considerations on the Morgan City – Port Allen Waterway
Reference: Our file #GCM 145

Dear Sir,

We want to bring to your attention our mariners' concerns about the Morgan City & Port Allen alternate route, an important part of the Gulf Intracoastal Waterway.

In 2006, a major barge line sought to open that portion of the GIWW to large towboats pushing eight barges, (two

strings, four barges long) known as "eight-packs" with lengths exceeding 950 feet. The tows were to travel between Baton Rouge, LA and Houston, TX. Our Association submitted position papers to the Coast Guard in opposition to these oversize tows. Eventually, the Coast Guard did not approve the idea. It was shelved, not because of our arguments, but rather because of opposition by the Coast Guard on the Houston end of the proposed route.

We expressed our concern because of possible damage to the waterway itself and levees, roads, locks, and private property by these oversize tows. Meeting, overtaking, and waiting to lock these oversize tows in this narrow waterway does pose problems for our mariners. The project width of the GIWW is only 125 feet. Four barges abreast of each other take up a minimum of 140 feet with alignment for safe passage taking considerably more. The banks of the waterway consist of alluvial soil that is easily displaced by heavy tows and propeller wash especially when vessels stray out of the channel.

The problem as we see it is as much a waterways maintenance issue as it is a vessel traffic problem. Admiral Whitehead, Commander of the Eighth Coast Guard District noted in part: I cannot provide comment on bank erosion as it relates to tow horsepower. This issue falls outside of our expertise therefore, I have forwarded your letter to the U.S. Army Corps of Engineers New Orleans District for review.

In the past, the Coast Guard always held itself up to mariners as experts in everything in the maritime realm including towing vessel horsepower issues. We appreciate the Admiral's candor and note that the Corps, as the agency responsible for the maintenance of our waterways, locks, and related infrastructure understands our mariners' concern.

In this report and its attached enclosures, our Association also wants to express its concern for the people who live within the protection of the Atchafalaya Basin levee system and their need to fully utilize taxpayer-provided infrastructure like roads and bridges in their everyday lives. Our concern extends to preventing collisions and oil and chemical spills, fires and explosions resulting from close-quarters situations between large tows on the Port Allen Route.

We want to recognize Captain David C. Whitehurst, a life-long resident of the Atchafalaya Basin, and member of our Board of Directors for his work and insight on this project. Very truly yours, Richard A. Block, Secretary, National Mariners Association.

[NMA Comment: Report #R-340, Rev. 9, NMA Report to Congress: Safety Problems With Oversize and Overloaded Tows was enclosed with our report. Our Association reiterated to the commission the importance of protecting our waterways from operators who are willing to exploit and damage them to increase their "bottom line" rather than quietly cleaning up the damage afterwards with taxpayer funds.]

**MARITIME ADMINISTRATION DISCOVERS
THERE REALLY IS A SHORTAGE OF MARINERS**

Sean T. Connaughton, Maritime Administrator
U.S. Department of Transportation
1200 New Jersey Avenue, SE
Washington, DC 20590

Subject: Maritime Operator Survey Concerning Mariner Availability

Dear Mr. Connaughton,

I quote the following from the Executive Summary of your Agency's recent report:

“A Maritime Operator Survey Concerning Mariner Availability was launched to determine whether the U.S. Maritime Industry has a recruitment and retention problem that the Maritime Administration should address with greater attention or resources. The results of this survey indicate that industry does have a problem with mariner availability. A larger research effort is recommended to delve into greater detail on the issues affecting each segment of the industry and how these issues are affected by Federal programs, policies, and regulations.”

[NMA Comment: One might think that MARAD would have made this discovery years ago. After all, a conference was held several years ago on this subject at the U.S. Merchant Marine Academy that is controlled and funded by MARAD.]

Our Association speaks for approximately 126,000 of the “lower-level” licensed and certificated mariners who work on vessels of less than 1,600 gross register tons and for many others who require neither licenses nor merchant mariner documents and are conveniently overlooked by the Coast Guard.

We recognized this problem affected our mariners a number of years ago. If your Agency plans “a larger research effort” into this issue, we suggest that you might start by researching the fifty-three (53) reports on the attached list to help you to understand WHY these problems currently exist.

[NMA Comment: MARAD might even discover what 126,000 lower-level mariners do for a living!]

If the U.S. Coast Guard, which used to be part of the Department of Transportation, had paid as much attention to our mariners as they paid to vessel “operators,” there is a good chance that these problems would be much more manageable today. We note as well that your recent “survey” relied on 845 “operators” and zero mariners.

Our reports have been available free of charge on the internet for years. You may recall that our Association handed out several of these reports at the Towing Safety Advisory Committee while you were a member of the committee before your appointment as Maritime Administrator. However, if you need printed copies, please apply the prices cited for each report.

Very truly yours,

Richard A. Block

Master #1186377, Issue #9

Secretary, National Mariners Association

**PROPOSED RULE
PASSENGER WEIGHT & INSPECTED VESSEL
STABILITY REQUIREMENTS**

[References: File #M-626; Newsletter #40, mnl40.5F; GCM-129; NTSB MAR-06-01.]

A Notice of Proposed Rulemaking was published in the Federal Register at 73 FR 49224-49275 on August 20, 2008. The Docket number is USCG-2007-0030 which can be used to find the rulemaking proposal at <http://www.regulations.gov>. The comment period on the NPRM will close on Nov. 18, 2008. The rulemaking affects passenger vessels inspected under 46 CFR Subchapters H, K, and T.

This rulemaking is a direct consequence of the LADY D accident in Baltimore Harbor on March 6, 2004 in which five (5) passengers were killed and four (4) more were seriously injured. The causes of the accident are covered in detail in NTSB Report MAR-06-01 and in our Report #R-432.

The NTSB determined the probable cause of the capsizing of this pontoon-style small passenger vessel was its lack of intact stability, which was insufficient to withstand the strong winds and waves the boat encountered. The lack of intact stability was caused by overloading which resulted from a combination of the following:

The LADY D was erroneously granted sister status by the U.S. Coast Guard to a pontoon vessel with different design characteristics.

The Coast Guard certificated the LADY D to carry too many people as a result of an inappropriate stability test on the vessel to which it was granted sister status; and

The Coast Guard's regulatory stability test standards on which the LADY D's passenger allowance was based use an inaccurate average passenger weight.

Recent Coast Guard documents conveniently try to shift the blame from their own administrative ineptitude to actions by the Master of the vessel. The accident is still being litigated.

Based on Coast Guard data, this proposed rule would affect 6,073 inspected passenger vessels. These vessels would all be required to have updated stability letters. Of these vessels, 1,140 would require both a new stability test and a reduction in passenger load to obtain an updated stability letter. Additionally, 3,542 vessels would require either a new stability test or a stability recertification, but would not need to reduce maximum passenger load. Finally, 1,391 vessels would require no additional stability test or recertification and no reduction in passenger load in order to receive an updated stability letter. ⁽¹⁾ [73 FR 49258]

There will be other changes as well. Since the LADY D accident occurred in a squall, a new paragraph would explicitly call attention to the OCMI's prerogative to include operational limits on a passenger vessel's Certificate of Inspection.

Because it has been demonstrated that vessels traditionally “gain weight” over the years, stability will have to be verified every 10 years. In addition, the owner/operator will have to certify that he has reviewed the stability information at the time of each vessel inspection. Further, “So that the Master can effectively verify that the loaded vessel complies with the stability letter's maximum draft restriction, draft or loading marks must be provided that allow the Master to compare the actual vessel's draft with the maximum draft restriction. If the maximum draft restriction in the stability letter does not correspond to the information obtained from draft mark readings, a new stability letter with a revised restriction and/or draft marks would be needed.” ⁽¹⁾ This would respond to complaints we received from Masters of small passenger vessels who are often forced to leave the dock with vessels that are clearly overloaded. ⁽¹⁾ [73 FR 49253]

HOUSE OF REPRESENTATIVES PLANS TO UPGRADE MARINE SAFETY

On Aug. 2, 2007, the Coast Guard and Maritime Transportation Subcommittee held a hearing on the Coast Guard's "Marine Safety" mission. NMA testified at that hearing.⁽¹⁾ The Coast Guard was taken to task at that meeting with several quite tangible results. [⁽¹⁾Refer to our Report #R-350, Rev. 3]

First, Commandant Thad Allen asked retired Vice Admiral James C. Card to look into the Coast Guard's Marine Safety mission, make an independent assessment of the situation, and report back to him. We reprinted Admiral Card's report in its entirety along with our comments in our Report #R-401-E titled Marine Safety: Where the Coast Guard Went Wrong. During the same time frame, the Coast Guard staff prepared and submitted its own suggestions of how it could improve its marine safety mission and submitted them to Congress. All this happened by early February 2008.

On April 22, 2008 in House Report #110-604, the House Transportation and Infrastructure Committee presented their proposed reforms that overwhelmingly passed the House by a vote of 395 to 7 in H.R.-2830.

The House of Representatives clearly has a different view of the importance of the Coast Guard's Marine Safety mission and how they would like to see it managed and that view does not necessarily please the Coast Guard. However, we believe the Congressional Report clearly has merit. We edited the following from House Report #110-604 and added emphasis:

TITLE XI—MARINE SAFETY

SEC. 1101. MARINE SAFETY.

(a) ESTABLISH MARINE SAFETY AS A COAST GUARD FUNCTION. § Chapter 5 of title 14, United States Code, is further amended by adding at the end the following new section:

“§ 100. Marine safety

“(a) To protect life, property, and the environment on, under, and over waters subject to the jurisdiction of the United States and on vessels subject to the jurisdiction of the United States, the Commandant shall promote maritime safety as follows:

“(1) By taking actions necessary and in the public interest to protect such life, property, and the environment.

“(2) Based on the following priorities:

“(A) Preventing marine casualties and threats to the environment.

“(B) Minimizing the impacts of marine casualties and environmental threats.

“(C) Maximizing lives and property saved and environment protected in the event of a marine casualty.”

SEC. 1102. MARINE SAFETY STAFF.

(a) IN GENERAL. § Chapter 3 of title 14, United States Code, is further amended by adding at the end the following new section:

“§ 57. Marine safety staff

“(a) ASSISTANT COMMANDANT FOR MARINE SAFETY § (1) There shall be in the Coast Guard an Assistant Commandant for Marine Safety who shall be a Rear Admiral or civilian from the Senior Executive Service (career reserved) selected by the Secretary.

“(2) The Assistant Commandant for Marine Safety shall serve as the principal advisor to the Commandant regarding marine safety, and carry out the duties and powers delegated and imposed by the Secretary under section 631(b).

“(b) CHIEF OF MARINE SAFETY. § (1) There shall be in each Coast Guard sector a Chief of Marine Safety who –

“(A) shall be at least a Commander or civilian at level GS-14; and

“(B) shall be colocated with the Coast Guard officer in command of that sector.

“(2) The chief of marine safety for a sector

“(A) is responsible for all individuals who, on behalf of the Coast Guard, inspect or examine vessels, conduct marine casualty investigations, or perform other marine safety responsibilities defined in section 631(b) in the sector; and

“(B) if not the Coast Guard officer in command of that sector, is the principle advisor to that officers regarding marine safety matters in that sector.

“(c) QUALIFICATIONS. § (1) The Assistant Commandant for Marine Safety and the Chiefs of Marine Safety of sectors, and all marine safety inspectors, investigators, examiners, and other professional staff assigned to the marine safety program of the Coast Guard, shall be appointed on the basis of their –

“(A) knowledge, skill, and practical experience in—

“(i) the construction and operation of commercial vessels; and

“(ii) judging the character, strength, stability, and safety qualities of such vessels and their equipment; and

“(B) knowledge about the qualifications and training of vessel personnel.

“(2) Marine inspectors shall have the training, experience, and qualifications equivalent to that required for a surveyor of a similar position of a classification society recognized by the Secretary under section 3316 of title 46 for the type of vessel, system, or equipment that is inspected.

“(3) Marine casualty investigators shall have the training, experience, and qualifications in investigation, accident reconstruction, human factors, and documentation equivalent to that required for a marine casualty investigator of the National Transportation Safety Board.

“(4) The Chief of Marine Safety of a sector shall be a qualified marine casualty investigator and marine inspector qualified to inspect vessels, vessel systems, and equipment commonly found in the sector..

“(5) Each individual signing a letter of qualification for marine safety personnel must hold a letter of qualification for the type they are signing.

“(6) The Assistant Commandant for Marine Safety shall be a qualified marine casualty investigator and a marine inspector qualified for types of vessels, vessel systems, and equipment.

“§ 58. Limited duty officers

“(a) ESTABLISHMENT. § The Commandant shall establish in the Coast Guard a limited duty officer program for marine safety.

“(b) OFFICER ELIGIBILITY § (1) Only commissioned officers in the Coast Guard with grade not above commander and chief warrant officers who have more than four years of marine safety experience may serve as limited duty officers under such program.

“(2) The Commandant may establish other limitations on eligibility that the Commandant believes are necessary for the good of the marine safety program.

“(3) Notwithstanding section 41a and chapter 11 of this title,

the Commandant shall, by regulation, establish procedures pertaining to 6

⚭(A) the promotion of commissioned officers and chief warrant officers who serve as limited duty officers, including the *maintenance of a separate promotion list for commissioned officers who serve as limited duty officers;*

⚭(B) the discharge, retirement, and revocation of commissions of such officers; and

⚭(C) the separation for cause of such officers.

⚭(4) The Commandant shall ensure that the procedures promulgated under paragraph (3)(A) *encourage a specialization in marine safety and do not, in any way, inhibit or prejudice the orderly promotion or advancement of commissioned officers and chief warrant officers who serve as limited duty officers.*

⚭(5) The Commandant shall, by regulation, prescribe a step increase in the pay system for limited duty officers in the marine safety program.

⚭(c) RECRUITMENT. 6 (1) The Commandant shall, by regulation, *establish procedures pertaining to the recruitment of graduates from the United States Merchant Marine Academy and the State maritime colleges and individuals holding licenses* issued under chapter 71 of title 46 to serve as limited duty officers.

⚭(2) Not later than the date of the submission of the President's budget request under section 1105 of title 31 for each fiscal year, the Commandant shall submit to the Committee on Transportation and Infrastructure of the House of Representatives and the Committee on Commerce, Science, and Transportation of the Senate a *report on the Coast Guard's efforts to recruit graduates from the United States Merchant Marine Academy and the State maritime colleges and individuals holding licenses issued* under chapter 71 of title 46 to serve as limited duty officers. The report shall include information on the number of graduates recruited, the lengths of service, the retention rates, and other activities undertaken by the Coast Guard to sustain or increase the numbers of recruits and officers.

“§ 59. Center for Expertise for Marine Safety

⚭(a) ESTABLISHMENT.6 The Commandant of the Coast Guard may establish and operate a one or more Centers for Expertise for Marine Safety (in this section referred to as a Center).

⚭(b) MISSIONS. 6 The Centers shall 6

⚭(1) be used to *provide and facilitate education, training, and research in marine safety including vessel inspection and casualty investigation;*

⚭(2) develop a repository of information on marine safety; and

⚭(3) perform any other missions as the Commandant may specify.

⚭(c) JOINT OPERATION WITH EDUCATIONAL INSTITUTION AUTHORIZED. 6 The Commandant may enter into an agreement with an appropriate official of an institution of higher education to 6

⚭(1) provide for joint operation of a Center; and

⚭(2) provide necessary administrative services for a Center, including administration and allocation of funds.

⚭(d) ACCEPTANCE OF DONATIONS.6 (1) Except as provided in paragraph (2), the Commandant may accept, on behalf of a Center, donations to be used to defray the costs of the Center or to enhance the operation of the Center. Those donations may be accepted from any State or local government,

any foreign government, any foundation or other charitable organization (including any that is organized or operates under the laws of a foreign country), or any individual.

⚭(2) *The Commandant may not accept a donation under paragraph (1) if the acceptance of the donation would compromise or appear to compromise –*

“(A) the ability of the Coast Guard or the department in which the Coast Guard is operating, any employee of the Coast Guard or the department, or any member of the armed forces to carry out any responsibility or duty in a fair and objective manner; or

⚭(B) the integrity of any program of the Coast Guard, the department in which the Coast Guard is operating, or of any person involved in such a program.

⚭(3) The Commandant shall prescribe written guidance setting forth the criteria to be used in determining whether or not the acceptance of a donation from a foreign source would have a result described in paragraph (2).

“§ 60. Marine industry training program.

⚭(a) IN GENERAL. 6 The Commandant shall, by policy, *establish a program under which an officer, member, or employee of the Coast Guard may be assigned to a private entity to further the institutional interests of the Coast Guard with regard to marine safety, including for the purpose of providing training to an officer, member, or employee.*

Policies to carry out the program 6

⚭(1) with regard to an employee of the Coast Guard, shall include provisions, consistent with sections 3702 through 3704 of title 5, as to matters concerning 6

⚭(A) the duration and termination of assignments;

⚭(B) reimbursements; and

⚭(C) status, entitlements, benefits, and obligations of program participants; and

⚭(2) shall require the Commandant, *before approving the assignment of an officer, member, or employee of the Coast Guard to a private entity, to determine that the assignment is an effective use of the Coast Guard's funds, taking into account the best interests of the Coast Guard* and the costs and benefits of alternative methods of achieving the same results and objectives.

⚭(b) ANNUAL REPORT. 6 Not later than the date of the submission each year of the President's budget request under section 1105 of title 31, the Commandant shall submit to the Committee on Transportation and Infrastructure of the House of Representatives and the Committee on Commerce, Science, and Transportation of the Senate a report that describes 6

⚭(1) the number of officers, members, and employees of the Coast Guard assigned to private entities under this section;

⚭(2) the specific benefit that accrues to the Coast Guard for each assignment.66

(b) CERTIFICATES OF INSPECTION.6 Section 3309 of title 46, United States Code, is amended by adding at the end the following:

⚭(d) *A certificate of inspection issued under this section shall be signed by the individuals that inspected the vessel.*66

SEC. 1103. MARINE SAFETY MISSION PRIORITIES AND LONG TERM GOALS.

(a) IN GENERAL 6 Chapter 21 of title 46, United States Code, is further amended by adding after section 2116, as added by section 313 of this Act, the following new section:

“§ 2117. Marine Safety Strategy, goals, and performance

assessments

∴(a) LONG-TERM STRATEGY AND GOALS∴ In conjunction with existing federally required strategic planning efforts, *the Secretary shall develop a long-term strategy for improving vessel safety and the safety of individuals on vessels.* The strategy shall include the issuance each year of an annual plan and schedule for achieving the following goals:

- ∴(1) Reducing the number and rates of marine casualties.
- ∴(2) Improving the consistency and effectiveness of vessel and operator enforcement and compliance programs.
- ∴(3) *Identifying and targeting enforcement efforts at high risk vessels and operators.*
- ∴(4) Improving research efforts to enhance and promote vessel and operator safety and performance.

∴(b) CONTENTS OF STRATEGY AND ANNUAL PLANS∴

∴(1) MEASURABLE GOALS∴ The strategy and annual plans shall include specific numeric or measurable goals designed to achieve the goals set forth in subsection (a). The purposes of the numeric or measurable goals are the following:

“(A) To increase the number of safety examinations on all high-risk vessels.

“(B) To eliminate the backlog of marine safety-related rulemakings.

“(C) To improve the quality and effectiveness of marine safety information databases by ensuring that all Coast Guard personnel accurately and effectively report all safety, casualty, and injury information.

∴(D) To provide for a sufficient number of Coast Guard marine safety personnel, and provide adequate facilities and equipment to carry out the powers and duties delegated and imposed by the Secretary under section 631(b).

∴(2) RESOURCE NEEDS.∴ The strategy and annual plans shall include estimates of∴

- ∴(A) the funds and staff resources needed to accomplish each activity included in the strategy and plans; and
- ∴(B) the staff skills and training needed for timely and effective accomplishment of each goal.

∴(c) SUBMISSION WITH THE PRESIDENT’S BUDGET.∴ Beginning with fiscal year 2010 and each fiscal year thereafter, the Secretary shall submit to Congress the strategy and annual plan at the same time as the President’s budget submission under section 1105 of title 31.

∴(d) ACHIEVEMENT OF GOALS. ∴

∴(1) PROGRESS ASSESSMENT. ∴ No less frequently than semiannually, the Coast Guard Commandant and the Assistant Commandant for Marine Safety shall jointly assess the progress of the Coast Guard toward achieving the goals set forth in subsection (b). The Commandant and the Assistant Commandant shall jointly convey their assessment to the employees of the Assistant Commandant and shall identify any deficiencies that should be remedied before the next progress assessment.

∴(2) REPORT TO CONGRESS ∴ The Secretary shall report annually to the Committee on Transportation and Infrastructure of the House of Representatives and the Committee on Commerce, Science, and Transportation of the Senate ∴

∴(A) on the performance of the marine safety program in achieving the goals of the marine safety strategy and annual plan under subsection (a) for the year covered by the report;

∴(B) on the program’s mission performance in achieving numerical measurable goals established under subsection (b); and

∴(C) recommendations on how to improve performance of the program.∴∴

SEC. 1104. POWERS AND DUTIES.

Section 631 of title 14, United States Code, is amended ∴

- (1) by inserting ∴(a)∴ before the first sentence; and
- (2) by adding at the end the following new subsection:

∴(b) *The Assistant Commandant for Marine Safety shall serve as the principle advisor to the Commandant regarding –*

∴(1) the operation, regulation, inspection, identification, manning, and measurement of vessels, including plan approval and the application of load lines;

∴(2) approval of materials, equipment, appliances, and associated equipment;

∴(3) the reporting and investigation of marine casualties and accidents;

∴(4) *the licensing, certification, documentation, protection and relief of merchant seamen;*

∴(5) suspension and revocation of licenses and certificates;

∴(6) enforcement of manning requirements, citizenship requirements, *control of log books;*

∴(7) documentation and numbering of vessels;

∴(8) State boating safety programs;

∴(9) commercial instruments and maritime liens;

∴(10) the administration of bridge safety;

∴(11) administration of the navigation rules;

∴(12) the prevention of pollution from vessels;

∴(13) ports and waterways safety;

∴(14) waterways management; including regulation for regattas and marine parades;

∴(15) aids to navigation; and

∴(16) other duties and powers of the Secretary related to marine safety and stewardship.

∴(c) OTHER AUTHORITY NOT AFFECTED ∴ Nothing in subsection (b) affects ∴

∴(1) the authority of Coast Guard officers and members to enforce marine safety regulations using authority under section 89 of this title; or

∴(2) the exercise of authority under section 91 of this title and the provisions of law codified at sections 191 through 195 of title 50 on the date of enactment of this paragraph.∴∴

SEC. 1105. APPEALS AND WAIVERS.

(a) IN GENERAL∴ Chapter 5 of title 14, United States Code, is further amended by inserting at the end the following new section:

“§ 102. Appeals and waivers

∴Except for the Commandant of the Coast Guard, any individual adjudicating an appeal of a decision or granting a waiver regarding marine safety, including inspection or manning and threats to the environment, shall be a qualified specialist with the training, experience and qualifications in marine safety to judge the facts and circumstances involved in the appeal or waiver and make a judgment regarding the merits of the appeal or waiver. In the case of an appeal or waiver involving an inspected vessel, vessel systems or equipment, the individual shall hold a letter of qualification to inspect the type of vessel, vessel systems or equipment involved in the appeal or waiver.∴∴

SEC. 1106. COAST GUARD ACADEMY.

(a) IN GENERAL.∴ Chapter 9 of title 14, United States Code, is amended by adding at the end the following new section:

“§ 199. Marine safety curriculum

∓The Commandant of the Coast Guard shall ensure that professional courses of study in marine safety are provided at the Coast Guard Academy, and during other officer accession programs, to give Coast Guard cadets and other officer candidates a background and understanding of the marine safety program. These courses may include such topics as program history, vessel design and construction, vessel inspection, casualty investigation, and administrative law and regulations.∅

SEC. 1107. GEOGRAPHIC STABILITY.

(a) IN GENERAL.∅ Chapter 11 of title 14, United States Code, is further amended by inserting after section 336 the following new section:

“§ 337. Geographic stability

∓The Commandant shall establish procedures that provide geographic stability to interested Coast Guard officers, employees, and members assigned to the marine safety program carried out under section 100 who have a minimum of 10 years of service in the marine safety program.∅

SEC. 1108. APPRENTICE PROGRAM.

(a) IN GENERAL.∅ Chapter 11 of title 14, United States Code, is further amended by inserting after section 337, as added by section 1107 of this Act, the following new section:

“§ 338. Apprentice program

∓Any officer, member, or employee of the Coast Guard in training to become a marine inspector shall serve a minimum of one-year apprenticeship, unless otherwise directed by the Commandant of the Coast Guard, under the guidance of a qualified inspector before conducting unsupervised inspections of vessels under part B of subtitle II of title 46. The Commandant may authorize shorter apprentice periods for certain qualifications, as appropriate.∅

SEC. 1109. REPORT REGARDING CIVILIAN MARINE INSPECTORS.

Not later than one year after the date of enactment of this Act, the Commandant of the Coast Guard shall submit to the Committee on Transportation and Infrastructure of the House of Representatives and the Committee on Commerce, Science, and Transportation of the Senate a report on Coast Guard∅ efforts to recruit and retain civilian marine inspectors and investigators and the impact of such recruitment and retention efforts on Coast Guard organizational performance.

NEW AND REVISED NMA REPORTS

NMA Report #R-429-N, Rev. 1. July 28, 2008. Report to the 110th Congress: Maritime Towing Accidents Involving Apprentice Mates/Steersmen. 24p.

Two events in the past month triggered the release of this report that was in the works for the past four years: 1) Release of the report of the sinking of the towboat ELIZABETH M at Montgomery Lock and Dam on the upper Ohio River on Jan. 10, 2005 and the deaths of four (4) crewmembers, and 2) the collision between the tow of the towboat MEL OLIVER and the tank ship TINTOMARA and its spill of up to 419,000 gallons of heavy oil on the Mississippi River at New Orleans on July 23, 2008. Apprentice Mates/Steersmen played roles in both these and at least several other accidents. In the case of the accident in New Orleans, it appears to be a leading role.

Our Association was part of the Towing Safety Advisory Committee (TSAC) Working Group that worked on the new∅ towing officer licensing regulations in the Fall and Winter of 2000-2001. Although the Working Group worked hard and did its best under the circumstances, problems began to arise with the new licensing regulations from the outset.

Working mariners were one of the major driving forces of the new regulations as shown in several well attended public meetings in the late 1990s and an unprecedented 800+ comments submitted to the Coast Guard∅ Notice of Proposed Rulemaking. **Adequate training for watch standers** was high on the agenda. Unfortunately, training is expensive.

On July 25, 2004, our Association presented a paper to the TSAC licensing working group meeting at Buffalo Marine in Houston detailing 44 problems or suggestions to improve the program. These were ignored.

We attempted to bring many of these matters up in a full TSAC meeting in St. Louis in September 2006 ∅ another costly exercise in futility.

While the story of all of these meetings and missed opportunities makes dull reading, the missed opportunities by Coast Guard Headquarters staff and towing industry bigwigs to get the message out to mariners must be recorded as a part of the History.

When senior Coast Guard officers speak to the American Waterways Operators or to the Towing Safety Advisory Committee, they **mistakenly** believe the message will be delivered to working mariners. We repeatedly told Coast Guard officials they were missing the mark over the past decade.⁽¹⁾ [⁽¹⁾ Refer to our Report #R-382, **Why Our Mariners Don't Get the Message.**]

We furnished copies of this report to about 100 Members of Congress to inform them of things they may otherwise never hear about.

NMA Report #R-417-A, Rev. 1. Aug. 27, 2008. Comments on Revising NVIC 4-01, “Licensing and Manning for Officers of Towing Vessels” to the Towing Safety Advisory Committee.

∅New∅ towing vessel officer licensing regulations went into effect on May 21, 2001. On the same day the Coast Guard issued NVIC 4-01. The purpose of this 99-page ∅guidance document∅ was to help explain the new regulations to about 1,000 towing companies and 30,000 mariners.

[NMA Comment: The next time the Coast Guard introduces a complex program involving our mariners and towing vessel employers they should script an instructional video to accompany the new regulations.]

Our Association was a part of the TSAC working group that worked on the new regulations in the Fall and Winter of 2000-2001. In July 2005 the working group re-assembled to examine a number of problems that had arisen. Our Association submitted a document to the Working Group listing some of these problems ∅ but it was largely ignored at the time.

Since ∅revising NVIC 4-01∅ and refining the Towing Officer Assessment Records appears to be on the TSAC agenda for its September Meeting in Maryland, we brought out the 2005 paper and updated it in hope that it may receive the attention we believe it deserves from TSAC this time around. We also furnished a copy to Congress in case TSAC ignores it again.

SETTING POOR EXAMPLES

Senior Coast Guard Officer Accused of Using Cocaine Will Be Investigated on Cocaine and Obstruction of Justice Charges

[By Angela Woodall, Oakland Tribune. Alameda, CA. Aug., 20, 2008. Contact #510-208-6413.]

A senior officer with the U.S. Coast Guard's Pacific Area staff has been temporarily reassigned to a no-supervisory position after being charged with using cocaine, the Coast Guard announced Wednesday.

Capt. ■, who had been serving at the Coast Guard Island in Alameda as the area Chief of Response, was charged Tuesday with wrongful use of cocaine and one charge of obstruction of justice, according to the Coast Guard.

The Captain, a commissioned officer with the Coast Guard since 1982, has no prior charges, said spokesman Michael Anderson.

■ will be investigated in accordance with the Uniform Code of Military Justice and will have a preliminary hearing before charges are dismissed or referred for trial to a general court-martial.

The hearing is the military equivalent of a civilian arraignment, Anderson said. "The charges against Capt. ■ are just accusations right now," he said.

If found guilty of both charges, ■ faces up to 10 years of incarceration, dismissal from the Coast Guard and forfeiture of all pay and allowances.

As part of its zero-tolerance policy for illegal narcotics, the Coast Guard randomly tests its members periodically, Anderson said.

Of the roughly 42,000 members who were subject to testing in 2007, there were 100 positive results for illegal narcotics, a number that includes false positives, he said. The number of those convicted was not available.

[NMA Comment: By comparison (e.g., "apples to oranges") a merchant marine officer would face Suspension and Revocation (S&R) charges, a "settlement agreement" or a trial before an Administrative Law Judge, completion of rehabilitation, followed by a request for Administrative Clemency, with the possibly of recovering his /her license and livelihood back within a time frame of 1½ to 6 years.]

Former Coast Guard Chief Warrant Officer Sentenced

[Source: <http://www.marinelog.com/>]

David G. Williams, a former Chief Warrant Officer in the U.S. Coast Guard and main propulsion assistant for the Coast Guard Cutter RUSH, was sentenced in U.S. District Court in Hawaii for making a false statement to federal criminal agents investigating allegations of potential discharges of oil-contaminated waste from the cutter into the Honolulu Harbor, announced Ronald J. Tenpas, Assistant Attorney General for the Justice Department's Environment and Natural Resources Division.

Williams was sentenced to pay a \$5,000 fine, serve 200 hours of community service and serve two years of probation.

Williams was indicted by a federal grand jury on Aug. 8, 2007, for lying to federal criminal investigators about his knowledge of the direct overboard discharge of bilge wastes through the ship's deep sink into the Honolulu Harbor. As the main propulsion assistant, he oversaw the maintenance of the

main diesel engines and other machinery in the engine room for the RUSH, a 378 ft high-endurance cutter stationed in Honolulu. On May 1, 2008, Williams pleaded guilty to making a false statement to federal law enforcement agents.

According to the plea agreement, on or about March 8, 2006, Williams had knowledge of the direct discharge of bilge wastes into Honolulu Harbor. The Engineering Department personnel aboard the Rush engaged in an unusual and abnormal operation and configuration of engine room equipment to pump bilge wastes from the aft bilge to the deep sink and overboard into Honolulu Harbor, thereby bypassing the "oily water separator" (OWS) system. The OWS system is a pollution prevention control device used by high endurance Coast Guard cutters like the Rush to manage accumulations of bilge wastes while underway at sea. The OWS system collects, stores and processes wastes to separate the water from the oil and other wastes.

[NMA Comment: Refer to our Report # R-444., Bilge Water Processing Equipment: Comments to the Docket.]

On or about March 13, 2006, the State of Hawaii Department of Health received an anonymous complaint stating that RUSH crewmembers were ordered to pump approximately 2,000 gallons of bilge waste into Honolulu Harbor. On May 1, 2006, investigators from the U.S. Coast Guard Investigative Service (CGIS) received confirmation from Main Propulsion Division personnel who personally participated that bilge wastes had indeed been discharged through the deep sink and into Honolulu Harbor. CGIS investigators obtained various corroborative documents from the RUSH, including engineering and ship's logs, tank level sounding sheets, as well as the pneumatic pump used to facilitate the discharges.

When interviewed by investigators from the CGIS, Williams denied knowledge of personnel discharging bilge waste to the deep sink and stated that he was not aware of the pumping of bilge wastes to bypass the ship's OWS system.

The government's investigation was initiated by the CGIS. The case is being prosecuted by Assistant Section Chief Joseph A. Poux of the Justice Department's Environmental Crimes Section; Ronald G. Johnson, chief of the Major Crimes Section and Assistant U.S. Attorney William L. Shipley, both of the District of Hawaii; and Commander Timothy P. Connors of the Coast Guard.

CURRENT NMA "BROWN-LIST"

This list remains unchanged since Newsletter #51. Some of the industry's least desirable employers continue to receive unfavorable mention in their plunge to the bottom of the tank.



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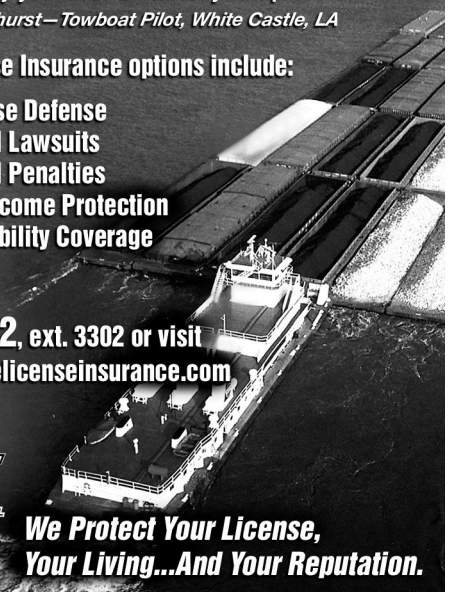
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