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OSHA REGULATES UNINSPECTED DRY CARGO AND WORK-BARGE SAFETY

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NMA COMPLAINS OF UNSAFE WORKING CONDITIONS ON UNINSPECTED DRY CARGO BARGES

On Dec. 8, 2003, our Association filed formal complaints with the Coast Guard, OSHA, and the U.S. Army Corps of Engineers regarding unsafe working and conditions found aboard unmanned dry cargo barges in certain trades on the inland waters. This followed an accident in which a deckhand fell through an open manhole cover on the deck of a barge and was seriously injured.

This accident occurred in the same time period when the Brownwater Mariners Association reported that a barge worker was crushed between barges at 0511 on Dec. 6th in the Triangle Fleet, Reserve, LA.

The same mariner organization also reported on Dec. 9lh that a tugboat crewman was crushed between the barge and the pier at Pinto Island, Mobile, AL. Our Association requested copies of both accident reports and the reports of the Coast Guard investigation of the accident under the Freedom of Information Act.

The Coast Guard does not inspect most of the nation's dry cargo barges ó in other words, these barges exist and will continue to exist as "uninspected" commercial vessels.

Many of our mariners work on towing vessels that still remain largely unregulated while the Coast Guard and TSAC argue about the details of proposed new regulations for the past four years without bringing their proposals to the public in a Notice of Proposed Rulemaking. These mariners face <u>additional dangers</u> when they work on uninspected barges. Our Association documented the nature of the dangers with a number of photographs.

THE OSHA CONNECTION

As uninspected vessels, dry cargo barges are subject to inspection by the Occupational Safety and Health Administration (OSHA), a branch of the U.S. Department of Labor. The extent of this OSHA involvement appears in an OSHA Directive (i.e., based on a Memorandum of Understanding by two Federal agencies, OSHA and the Coast Guard) that we reproduced as our Report #R-347 available on our internet website.

The OSHA Regional Administrator in Atlanta responded to our complaint in the following letter. This letter outlines the complicated procedures mariners must follow to report unsafe conditions on uninspected dry cargo barges. These procedures ensure that OSHA will receive very few complaints from our mariners!

Although towing vessels are now designated as "inspected" vessels in 46 U.S. Code §3301 (15) according to Section 415 of the Coast Guard and Maritime Transportation Act of 2004 signed by the President on Aug. 9, 2004, this does not apply to the unmanned cargo barges that are towed by these vessels. These contrasts with most tank barges that come under the jurisdiction of the Coast Guard, are regularly inspected, and carry a Certificate of Inspection (COI). The Coast Guard is very attentive to the condition of these "inspected" vessels.

While many barges remain "uninspected," any "inspected" barge must carry its Certificate of Inspection (COI) on board at all times. If a barge doesn't have a COI, it is an "uninspected" vessel. Unless something very unexpected occurs in the next year or so, uninspected barges, especially thousands of dry cargo barges that do not carry "certain dangerous cargoes" (CDC) will remain under OSHA control. This distinction could be very important as well as very dangerous for mariners who are injured while working on or around these barges because our experience shows that the Coast Guard õcouldnøt care lessö about mariner injuries.

OSHA'S RESPONSE AND LIMITED INTEREST IN UNINSPECTED DRY CARGO BARGES

"The Atlanta Regional Office for the Occupational Safety and Health Administration (OSHA) is in receipt of your correspondence dated Dec. 8, 2003, where you advised our office of hazards involving unsafe vessels, including "uninspected" dry cargo barges. Your allegations address several jurisdictional areas, some that may involve OSHA coverage for confined space hazards and open (unattended) deck openings on the vessels where personnel may fall.

"Because you letter does not provide specific details as to employer identifications and when and where personnel were exposed to the hazards, we ask that .you have the trip pilot contact our office to provide needed information. The pilot should contact:

U.S. Department of Labor - OSHA
Atlanta Regional Office
Sam Nunn Atlanta Federal Center
61 Forsyth Street, SW; Room 6T50
Atlanta, Georgia 30303
(404) 562-2300 phone (404) 562-2295 fax
Attn: Team Leader - Enforcement Programs")

t[l) The Atlanta office covers AL, FL, GA, KY, MS, NC, SC & TN. For addresses and phone numbers of other OSHA offices, contact OSHA at (202) 693-1999 and ask for the office that covers your state.]

OSHA'S COMPLAINT PROCESS

OSHA's complaint process allows for anonymous and formal notices of hazards. OSHA evaluates each complaint to determine how it can be handled best ó an off site investigation or an on-site inspection. Workers who would like an on-site inspection must submit a written request. Workers who complain have the right to have their names withheld from their employers, and OSHA will not reveal this information. **At least one of the following eight criteria must be met for OSHA to conduct an on-site inspection:**

1. A written, signed complaint by a current employee or employee representative with enough detail to enable OSHA to determine that a violation or danger likely exists that threatens physical harm or that an imminent danger exists;
2. An allegation that physical harm has occurred as a result of the hazard and that it still exists.

3. A report of an imminent danger.
4. A complaint about a company in an industry covered by one of OSHA's local or national emphasis programs or a hazard targeted by one of these programs;
5. Inadequate response from an employer who has received information on the hazard through a phone/fax investigation;.
6. A complaint against an employer with a past history of egregious, willful or failure-to-abate OSHA citations within the past three years;
7. Referral from a whistleblower investigator; or
8. Complaint at a facility scheduled for or already undergoing an OSHA inspection.

"If you require additional information or assistance in this matter, please contact Benjamin Ross, Assistant Regional Administrator for Enforcement Programs at (404) 562-2300." Sincerely, Cindy Coe Laseter, Regional Administrator"

LOW TOWING INDUSTRY SAFETY STANDARDS

Our Report #R-276, Towing Vessel Regulatory Standards, was first published on May 15, 2001 and is well known to the Coast Guard and the Towing Safety Advisory Committee (TSAC). The ninth revision of this report currently appears on our internet website www.nationalmariners.org. Our Association originally supplemented this report with a 204-page book that contains extensive documentation as well as a comparison between existing regulations in 46 CFR Subchapters L and T and the Responsible Carrier Program (RCP) ó a proprietary Safety Management System of the American Waterways Operators.

One of our Report #R-276's most obvious conclusions is that the Responsible Carrier Program does meet ***existing*** Coast Guard regulatory standards. The problem is that the standards the Coast Guard sets for towing vessels are so much lower than the standards it sets for other commercial vessels in an industry where over 30,000 mariners work.

Conditions that are considered unsafe and violate existing regulations on a small passenger vessel or an offshore supply vessel turn out to be perfectly legal on a tug or towboat. The reason for this is either collusion between the Coast Guard and the towing industry that extends back many years or a laissez-faire attitude that allows retiring Coast Guard officers to accept lucrative positions in the industry they regulate. This collusion or attitude is manifested in an intense lobbying effort in Washington, where this arrangement is euphemistically called a "partnership." This "partnership" effectively stifles legitimate complaints from working mariners.

Further revisions

As a result of this and other complaints, our Association revised and updated Report #R-276 on June 1, 2005 as Revision #9 and included as Item #72, "Inspect Dry Cargo Barges for Workplace Safety." Our Association shortly thereafter transmitted the entire report as a direct appeal to Congress and entered it in its entirety in the Coast Guard's new Towing Vessel Inspection rulemaking docket. Since that time, we supplemented Report #R-276 with reports #R-276-A and #R-276-B.

OSHA CITES TOWING COMPANY FOR UNSAFE WORKING CONDITIONS.

In response to our formal complaint and another filed by an employee, OSHA inspected the worksite approximately eleven (11) months after a deckhand was seriously injured falling through an open manhole cover while attempting to pump the barge in the middle of the night. The deckhand was not provided with prompt medical care for his injury and, as a result, became seriously disabled.

[NMA Action: The employer, "Marine Carriers, Inc." was added to our Association's list of substandard employers as a warning to other mariners seeking employment.]

Consequently, Marine Carriers, Inc. in Mobile, AL, was notified by OSHA that "Employees are exposed to fall hazards due to open manholes (flush manholes) missing manhole covers on the barges they are working on. The manholes are in the walkways the employees use."

Citation #1, Item #1 reads as follows: "Type of Violation: SERIOUS. 29 CFR §1910.22(c): Cover(s) and/or guardrail(s) were not provided to protect personnel from the hazards of flush manhole openings....

"M/V TOMBIGBEE ó a deckhand was carrying a gasoline pump when he fell into a manhole on the log deck or passageway around the barge coaming where a manhole cover(s) were not installed. OR IN THE ALTERNATIVE... "Section 5(a)(1) of the Occupational Safety and Health Act of 1970: The employer did not furnish employment and a place of employment which were free from recognized hazards that were causing or likely to cause death or serious physical harm to employees in that employees were exposed to slip, trip and fall-in hazards."

The employer also received another citation as follows: "29 CFR §1904.29(a): A log of all Work-Related Injuries and Illnesses (OSHA Form 300) and/or the Summary of Work Related Injuries and Illnesses (OSHA FORM 300-A) and/or the Injury and Illness Incident Report (OSHA Form 301) or equivalent forms were not kept by the establishment."

The "proposed penalty" imposed by OSHA was $1,500. The citation and notification of penalty must be posted at the work site, corrective action must be taken and verified, and payment of the penalty is due in 15 days unless contested.

It is important to note that the injured deckhand had to hire an attorney and seek reimbursement for his medical expenses, pain and suffering because his employer did not compensate him for his injuries.

[NMA Comment: An appropriate legislative remedy needs to be provided to insure that our mariners receive immediate treatment for injuries received on the job and adequate compensation for resulting time off the job. Our Report #R-202, Rev. 4, Treatment of "Lower-Level" Mariners – Don't Count On Corporate Compassion or Coast Guard Concern: True Stories of Our Lost, Injured & Cheated Mariners) cites additional incidents of a similar nature.]

The OSHA Debt Collection Notice sent to Marine Carriers, Inc. also contains this wording: "Notice: The penalties assessed for this inspection already reflect reductions granted for size, good faith and history. The original penalty was $5,000. The reduced penalty is $1,500. . .If the hazards itemized on this citation are not abated/corrected and a follow-up inspection is conducted, your establishment may receive a Failure to Abate Citation for the uncorrected hazards with subsequent additional monetary penalties of up to **thirty (30) times the original penalty amount** of the uncorrected hazards."

UNINSPECTED CONSTRUCTION BARGEACCIDENT
NTSB REPORTS ON ATHENA 106 – M/V MISS MEGAN CONSTRUCTION BARGE ACCIDENT

*[**Sources:** File #M-660. Mnl50.8. GCMA Newsletter #43, Oct. 2006 provided press accounts on the fire that killed the crew of a towboat and most of the construction crew in an accident in Cote Blanche Bay, LA. On June 14, 2007 the NTSB released the following safety bulletin on that accident and subsequently approved its full report on the accident. On Aug. 27, 2007 we sent our Report #R-426, Rev. 1 to Congress discussing this and other barge related towing accidents.]*

Washington, DC ó The National Transportation Safety Board today determined that the failure of Athena Construction to require its crews to pin mooring spuds securely in place on its barges led to an unintentional release of one of the spuds. This resulted in a pipeline rupture that killed six.

On Oct. 12, 2006, the uninspected towing vessel MISS MEGAN was pushing two deck barges in the West Cote Blanche Bay oil field in Louisiana, en route to a pile-driving location. Barge Athena 106 was tied along the port side of barge IBR 234. The MISS MEGAN was secured astern of barge IBR 234 pushing both barges.

While the vessels were under way, the aft spud (a vertical steel shaft extending through a well in the bottom of the boat and used for mooring) on the Athena 106 released from its fully raised position. The spud dropped into the water and struck a submerged, high-pressure natural gas pipeline. The resulting gas release ignited and created a fireball that engulfed the towing vessel and both barges. The master of the towing vessel and four barge workers were killed. The MISS MEGAN deckhand and one barge worker survived. One barge worker is officially listed as missing.

"Having more rigorous requirements in place could have prevented this accident from occurring," said NTSB Chairman Mark Rosenker. Not only do these regulations need to be put in place but it is imperative that they are enforced and adhered to."

The Board stated in its final report that Athena Construction's manual contained no procedures mandating the use of the safety devices on the spud winch except during electrical work. It was found that if the Athena 106 crew had used

the steel pins to secure the retracted spuds during their transit, a pin would have prevented the aft spud from accidentally deploying. Furthermore, the spud would have remained locked in its lifted position regardless of whether the winch brake mechanism, the spud's supporting cable, or a piece of connecting hardware had failed.

Contributing to the accident was the failure of Central Boat Rentals to require, and M/V MISS MEGANøs Master to ensure, that the barge spuds were securely pinned before getting under way. The Board noted that investigators found no evidence that the MISS MEGANøs Master or deckhand checked whether the spuds had been properly secured before the tow began. While Central Boat Rentals had a health and safety manual and trained its crews, the written procedures did not specifically warn Masters about the need to secure spuds or other barge equipment before navigating. The company's crew should have been trained to identify potential safety hazards on vessels under their control.

As a result of these findings the Safety Board recommended that Athena Construction and Central Boat Rentals should develop procedures and train the employees of its barges to use the securing pins to hold spuds safely in place before transiting from one site to another.

Other recommendations the Board made as a result of this accident investigation include:

To the Occupational Safety and Health Administration:

- Direct the Maritime Advisory Committee for Occupational Safety and Health (MACOSH) to issue the following documents document to the maritime industry: (1) a fact sheet regarding the accident, and (2) a guidance document regarding the need to secure the gear on barges, including spud pins, before the barges are moved, and detailing any changes to your memorandum of understanding with the Coast Guard.

To the U. S. Coast Guard

- Finalize and implement the new towing vessel inspection regulations and require the establishment of safety management systems appropriate for the characteristics, methods of operation, and nature of service of towing vessels.
- Review and ***update your memorandum of understanding with the Occupational Safety and Health Administration to specifically address your respective oversight roles on vessels that are not subject to Coast Guard inspection***í .

We Emphasize That This Report Is Especially Important to All Towboatmen

The NTSB summary (above) fails to carry the impact of the full report that is available on the NTSB website titled õFire Aboard Construction Barge Athena 106, West Cote Blanche Bay, Louisiana, Oct. 16, 2006.ö The accident itself is straightforward and easy to understand ó a 5-ton spud released, dropped upon, and ruptured an 8-inch high-pressure gas pipeline and an explosion with six fatalities ensued. However, it insinuates itself into many other high profile events in Washington that are currently õhot itemsö. Consider this paragraph excerpted from page 29 of the full NTSB report:

õDeck barges such as Athena 106 ***will remain NOT subject to inspection***. According to the American Waterways Operators, the national trade association for the U.S. tugboat, towboat, and barge industry, ***more than 4,000 deck barges operate across the country, using different types of winches and other equipment in a variety of different operations***. Coast Guard data show that 305 people were fatally injured on barge/tow combinations between 1997 and 2006 and that 379 explosions or fires occurred on barges or towboats during the same period killing 14 people.ö

Of course, not all these barges are õspud bargesö and this was a unique accident. Yet, at any time, a towboat officer or crewman may be faced with handling a spud barge. From now on, it will be absolutely essential to remember to õpinö every raised spud in the õupö position so it cannot possibly drop ó even on a short move. Thatøs the simple, easy, and free lesson in safety that six men paid for with their lives. Yet, it is far from the most important lesson.

There will be other important lessons that come from this accident that will apply to other loosely-regulated õwork bargesö that the Coast Guard and OSHA have inefficiently and ineffectively regulated or flat-out refused to regulate over the years. We reiterated this in our Report #R-426, Rev. 1, Report to Congress: Challenges To The Coast Guardøs Marine Safety Program ó Effectively Regulating the Towing Industry.

Our Association filed numerous complaints with our local Marine Safety Unit in vain about how a local company placed its maritime workers at risk by taking advantage of the õuninspectedö nature of their manned work barges.

The full NTSB report shows clearly how the Coast Guard and OSHA between them consistently failed to effectively protect maritime workers on these work barges. This became clear in the 2000 Supreme Court decision

Chao, Secretary of Labor vs. Mallard Bay Drilling, Inc. (Our Report #R-300) and the fact that Congress ordered the Coast Guard to end the õuninspectedö status of towing vessels in 2004. We now ask Congress to examine the status of thousands of uninspected barges.

This NTSB report makes it clear that a similar inspection requirements may well be required for every õwork bargesö at some time in the future. Work barges are ***industrial workplaces*** that have been ignored for far too long. The Coast Guard ignored and failed to apply OSHA regulations to maritime enterprises for far too long.

Not only has this occurred in inland waters, but the ***delay*** in finalizing changes to 33 CFR Subchapter N for over 10 years shows the power of the offshore oil industry over legitimate government regulatory agencies like the Coast Guard (which are supposed to enforce OSHA workplace safety regulations on the Outer Continental Shelf (OCS).

This report should be an important step in drawing attention to a situation that has received far too little attention. In addition, the desperate and primitive working conditions on many substandard uninspected dry cargo barges also needs attention as our Report #R-426 also illustrates. We hope that this NTSB report will help us to draw a connection between the two.

The repercussions of this accident may be long-lasting indeed. We believe this is one advantage of reconstituting the National Transportation Safety Board so that it conducts ALL maritime safety accident investigations using full-time professional staff members. This would replace the Coast Guard and its badly-flawed investigative system that we described in detail in our Report #R-429, GCMA Report to Congress: How Coast Guard Investigations Adversely Affect Lower Level Mariners and in our Report #R-429-M, United States Coast Guardøs Management of the Marine Casualty Investigations Program., an annotated reprint of Department of Homeland Security Report #OIG-08-51.

TOWBOATMAN REPORTS CARBON MONOXIDE POISONING

We have brought this õ***Marine Inspection***ö issue to the attention of Coast Guard.

The first report came to us several years ago from a mariner working aboard a workboat laying either a cable or pipeline across Long Island Sound. The vessel had loaded a self-contained building aboard the after deck of an OSV-type vessel to accommodate extra construction crew members on the vessel. These accommodation spaces were served by a õwindow-typeö air conditioner unit. A crewmember called to tell us that the air conditioners sucked in exhaust fumes from the vesseløs main engines and generators while he slept and that he nearly died from carbon monoxide poisoning as a result. We would have moved forward on the case at that time except that the mariner was unwilling to press the issue.

More recently, we learned of a crewmember of a towing vessel who reported that he was sickened by fumes and immediately reported the incident to his employer. He was immediately fired by his employer but immediately sought medical treatment. He was examined, tested, and told he suffered a heart attack as a result of carbon monoxide poisoning.

Realizing that the Coast Guard couldnøt care less about the fact that he had been fired for reporting unsafe conditions aboard the towing vessel he served on, the mariner reported the incident to a representative of the **Occupational Safety and Health Administration (OSHA).**

According to the Memorandum of Understanding between the Coast Guard and OSHA, OSHA will investigate workplace accidents aboard õuninspectedö vessels. Since there are no õinspectionö regulations currently in place for towing vessels, OSHA stepped in to this case on behalf of the mariner.

The mariner asserted to us that õí there is carbon monoxide getting into the living quarters. There is also black smutty, dusty stuff coming out of the A/C ductwork if it has not been cleaned yet! I have a small dirt-devil vacuum that I was using to keep my room (as) dust free as I could. The filter has some of this black stuff in it. I tried to have it tested at (the university) but no one at the school can tell me who or where I need to bring it to. My bunkroom is where the A/C intake is located for the second deck. The intake would pull through the louvered door into my bunkroom! I have more faith in OHSA than the coasties ö In addition, the towing vessel is equipped with a window-type air conditioner that sucks up fumes from the vesseløs exhaust stacks and feeds it into the pilothouse. This poisonous air also can circulate below into the crewøs quarters.

While OSHA did step in, ***the apparent thrust of their investigation was to mediate between the employer and employee for lost wages after his report of an unsafe workplace condition***. The result, if accepted by both parties, would pay the marinerøs back wages. It would also bar him from discussing the incident. Our Association urged the mariner to õí take the money and runö because there is nothing õnon-unionö mariners can do about unfair termination. We will not reveal the marinerøs name or the name of the offending company under the OSHA-

sponsored agreement. We will mention, however, that the company is a member of the American Waterways Operators, the tug and barge industryøs trade association and sponsor of the Responsible Carrier Program. This is a problem they ***also*** need to be alert to. However, we will bring the importance of guarding against Carbon Monoxide poisoning to the attention of both Congress and the Coast Guard.

Our Association also caution our mariners who are not members of a union and work under a contract with their employers, are treated as õemployees-at-willö and can be terminated for any reason whatsoever ó such as õcomplainingö about unsafe working conditions. We explain the background thoroughly in NMA Report #R-370-D titled Whistleblower Protection, Work Hour Abuse and õDeadheadö Transportation.

Carbon Monoxide Poisoning Symptoms

Because carbon monoxide is odorless and colorless it is not always evident when it has become a problem. Often people who have a mild to moderate problem will find they feel sick while they spend time indoors. They might feel a little better outside in the fresh air but will have re-occurring symptoms shortly after returning inside. If other members of the crew have re-occurring bouts with flu-like symptoms while engines or any fuel-burning appliances in use it may be time to have the vessel checked by a professional.

Low levels of carbon monoxide poisoning can be confused with flu symptoms, food poisoning or other illnesses and can have a long term health risk if left unattended. Some of the symptoms are as follows:

- Shortness of breath
- Mild nausea
- Mild headaches

Moderate levels of CO exposure can cause death if the following symptoms persist for a long measure of time.

- Headaches
- Dizziness
- Nausea
- Light-headedness

High levels of Carbon Monoxide can be fatal causing death within minutes.

On workboats like tugs, towboats and offshore supply boats carbon monoxide may be recognized as an annoyance. Many of these vessels may have been altered so that exhaust stacks are directed outboard rather than in the more traditional õstraight upö smoke stack configuration. However, we have heard of company officials in major towing companies who refuse to do this because they believe it gives their vessels an odd appearance. Modern OSVs have gradually evolved with tall õNorth Seaö stacks, which are much more effective in removing carbon monoxide and other pollutants from gassing their deck crews. However, carbon monoxide poisoning is much more than the annoyance of the stench of diesel exhaust. It can be fatal. Our mariner had been in õgood healthö until he was diagnosed with an apparent mild heart attack as reported above.

We believe it is incumbent upon the Coast Guard and OSHA as regulatory agencies to properly inspect the location of air intakes for all enclosed areas on the vessel and to see that proper carbon monoxide warning signs and detectors are installed and maintained.

Treatment Options

There are immediate measures you can take to help those suffering from carbon monoxide poisoning.

- Get the victim into fresh air ***immediately***.
- If you cannot get the people out of doors, then open all windows, doors, and hatches. Turn off any appliances, such as heaters, that have an open flame.
- Take those who were subjected to carbon monoxide to a hospital emergency room as quickly as possible. A simple blood test will be able to determine if carbon monoxide poisoning has occurred.

LETTER TO PRESIDENT OBAMA ON WORKPLACE SAFETY ON THE OUTER CONTINENTAL SHELF

*[**Background:** Many of our mariners transport supplies and materials in support of the oil and gas industry on the Outer Continental Shelf (OCS) and to deepwater locations. In the past, we brought a number of standing issues to the attention of the Coast Guard and Congressional oversight committees. This letter reiterates several of these issues and carries our concerns to the highest level of the Executive Branch.]*

May 17, 2010

President Barack H. Obama
The White House
1600 Pennsylvania Ave., NW
Washington, DC 20500

Subject: Gulf of Mexico Oil Spill and Stalled Safety Initiatives on the OCS
Reference: Our File GCM-278

Dear President Obama,

This letter is in response to your well-directed comments of May 14, 2010 in which you condemned the õridiculous spectacleö of oil executives shifting blame in the Congressional hearings and denounced the õ***cozy relationship" between companies and the federal government***. In this letter, we dwell on our experiences with the U.S. Coast Guard regarding safety initiatives on the Outer Continental Shelf that remain stalled after 10 years.

Our Association speaks on behalf of the safety, health and welfare of approximately 126,000 õlimited tonnageö mariners who work on oilfield vessels, tugs, towboats, and small passenger vessels not only on the Outer Continental Shelf but throughout the nation. Many of our mariners along with hundreds of fishermen, are engaged in attempting to clean up the filthy mess left by British Petroleum in the Gulf of Mexico.

Please forgive us if we appear to be hugely skeptical of both the oil companies and the Coast Guard. With our years of experience with the Coast Guard, we are considerably less gullible than the general public.

We do not intend to speculate on the cause of the well blow out that continues to disgorge millions of gallons of crude oil into the Gulf of Mexico. The CBS Report aired on õ60 Minutesö on Sunday May 16th. is probably as close to the truth as we will ever get.

However, our Association has good reason to be extremely skeptical of the joint õ***investigation***ö that will take place, and we believe that you, as President and head of the Executive Branch, should be equally skeptical of the Coast Guardøs ability to investigate ***anything*** after reading (or recalling) the Department of Homeland Security Inspector Generaløs report in 2008[1] closely followed by the revelations of the inept response and investigation of the COSCO BUSAN oil spill that further emphasized the shortcomings the DHS report disclosed. These shortcomings in Coast Guard investigations were first reported as early as 1994[2] and confirmed in 1996[3] by two government reports. As we approach the second anniversary of the large oil spill that closed the Mississippi River, the Coast Guard still has not completed its review of that extremely well documented event. *[[1]DHS Report #OIG-08-51, reprinted as our Report #R-429-M **[Enclosure #1]**. [2]Reprinted as our Report #R-429-A **[Enclosure #2]**. [3]Reprinted as our Report #R-429-B **[Enclosure #3]**.*

The Outer Continental Shelf (OCS)

According to 43 U.S. Code §1347(c), regulations applying to ***unregulated hazardous working conditions***, **"…**the Secretary of the Department in which the Coast Guard is operating (i.e., DHS) shall promulgate regulations or standards applying to ***unregulated hazardous working conditions*** related to activities on the Outer Continental Shelf when he determines such regulations or standards are necessary. The Secretary í may from time to time modify any regulations, interim or final, dealing with hazardous working conditions on the Outer Continental Shelf.ö

With eleven fatalities in this latest õincident,ö we question why high-ranking Coast Guard officials allowed one important rulemaking package to languish for an entire decade. The ***existing*** Outer Continental Shelf (OCS) regulations are almost 30 years old[1] and serve as one excellent ***example*** of the õ***cozy relationship***ö that exists between the Coast Guard and industry. *[[1]33 CFR Subchapter N, Parts 140-147, March 4, 1982.]*

In 1999, the Coast Guard proposed a regulatory package to update OCS regulations.[1] Our Association was interested in this õpackageö because the rulemaking defined õ***OCS Units***ö to include ***vessels*** working on the OCS. There are about a thousand such vessels manned by our mariners. This regulation would have provided our mariners as well as oilfield workers significant protections comparable to OSHA occupational safety and health regulations that protect workers ashore. Since many of our mariners serve on ***oilfield vessels***, our interest in this rulemaking began with letters to the Docket beginning in February 2000 ó ten years ago. We believe this rulemaking stalled for an entire decade because industry found it unpopular and had sufficient political clout to prevent it from moving forward. In allowing this to happen, the protection of thousands of offshore workers including our mariners were placed at risk. *[[1]Docket #USCG-1998-3868; 64 FR 68415-68505, Dec. 7, 1999.]*

The proposed rule would have brought ***OSHA-type safety and health regulations*** not only to oil and gas drilling and production units but also to ***vessels*** operating on the OCS. But, it never happened because industry in collusion with very senior Coast Guard officers did not want it to happen! ***Neither our mariners nor the workers on offshore oil facilities are protected by labor unions*** and, consequently, were deprived of a voice. We pointed out to Congressional oversight committees in the past that our mariners are inadequately represented on several Coast Guard advisory committees.

Benefits Evaluation of the Proposed Rule
(Please note quotations)

õAccording to the MMS FY95 report to Congress, ***a noticeable increase of accidents and injuries have occurred to personnel engaged in OCS activities*** due to the rapid increase of oil exploration and production over the last 20 years. The proposed rule would provide benefits through implementing workplace safety and health, lifesaving and fire-fighting equipment, and structural fire protection requirements. Also, the proposed rule would require the owner or operator of a foreign vessel or foreign floating facility engaged in OCS activities to comply with requirements similar to those imposed on U.S. OCS units. ÷

õ***Most accidents on the OCS occur during drilling or production***. ***Trends show that the two main causes of incidents are equipment failure and human error***. The proposed rule would provide benefits by reducing the number of accidents or decreasing the severity of injury to personnel. We did not include the valuation of property damage from blowouts, fires, and explosions as a potential benefit due to insufficient data to support accurate assumptions. Some of the proposed measures that will reduce the likelihood of deaths and injuries include ***improved workplace safety and health requirements***, structural fire protection, and additional lifesaving, fire-fighting, and fire-protection equipmentí .ö

The explosion of the DISCOVERER DEEPWATER HORIZON claimed eleven (11) lives and, according to current reports, was caused by ***equipment failure*** of a blowout preventer (BOP) as well as ***human error***.

õTo determine potential benefits, we examined both the Coast Guard[(2)] and Mineral Management databases for accidents involving personnel on OCS units and identified the trends. This data is summarized in Table 3 in this preamble.ö[(1)] *[[(1)]Quoted from 64 FR 68440, Dec. 7, 1999. [(2)]Our Association has reported serious problems with the way personal injuries are reported to the Coast Guard. We brought this information to the attention of Congressional oversight committees in our Report #R-350, Rev. 5, Issue "Y"* ***[Enclosure #4].***

The Purpose of the Rulemaking

õThe Coast Guard is [supposed to be][(1)] the lead Federal agency for workplace safety and health, other than for matters generally related to drilling and production that are regulated by the MMS, on facilities ***and vessels*** engaged in the exploration for, or development or production of, minerals on the OCS. The ***last major revision of our current OCS regulations occurred in 1982***. In 1982, the offshore industry was not as high tech as today's operations. Offshore activities were in relatively shallow water near land, where help was readily available during emergency situations. The equipment regulations required only basic equipment, primarily for lifesaving appliances and hand-held portable fire extinguishers. Since 1982, the requirements in 33 CFR chapter I, ***Subchapter N, have not kept pace with the changing offshore technology or the safety problems*** it creates as OCS activities extend to deeper water (7,500 feet) and move farther offshore (127 miles). This proposed rule is intended to revisit all of our current OCS regulations in Subchapter N to take advantage of past experiences and new improvements to make the OCS a safer workplace.ö *[Quoted from 64 FR 68417, Dec. 7, 1999. [(1)]We* ***inserted*** *this wording that represents our opinion.]*

Casualty Reporting

õFour comments suggested that the Coast Guard, MMS, and Occupational Safety and Health Administration (OSHA) develop a single casualty reporting form to be submitted to all of these agencies. The comments stated that the three agencies' current casualty reporting requirements are redundant and that the duplication of reporting should be eliminated.

õ**We agree**.[(1)] We have developed and propose a new consolidated form. Information about the proposed form is located at the end of the discussion of proposed changes. *[Quoted from 64 FR 68418, Dec. 7, 1999. [(1)]We = the Coast Guard!]*

Existing Regulations Are Inadequate

õOne comment stated that the current regulations in 33 CFR parts 140-147 were inadequate in the following areas: design and equipment; operations; ***workplace safety and health, including confined-space entry; and accident reporting***. **We agree**[1] and ***propose many new workplace safety and health regulations*** that are similar to recently developed OSHA regulations.ö *[Quoted from 64 FR 68418, Dec. 7, 1999. [1]We = the Coast Guard!]*

õTwo comments suggest that the Coast Guard consult with OSHA to update the 1979 MOU to clearly confirm that redundant jurisdiction and regulatory enforcement on the OCS does not exist. One comment contends that ***if the Coast Guard is unwilling to comprehensively address OCS issues, then it would be appropriate for it to formally withdraw from exercising regulatory jurisdiction over occupational safety and health issues on the OCS, leaving such activities to OSHA***ö *[Quoted from 64 FR 68418, Dec. 7, 1999.]*

Instead of addressing workplace safety and health issues, it appears that the Coast Guard at the highest levels within the Marine Safety Directorate simply ***sandbagged*** the issue and allowed its entire 1999 Notice of Proposed Rulemaking to wither on the vine for the next ten years. Regardless of the considerable time and professional talent invested in preparing the entire regulatory package, this rulemaking has yet to see the light of day. Every question about the progress of this rulemaking that we presented to each National Offshore Safety Advisory Committee (NOSAC) meeting we attended went unanswered for 10 years.

We believe that this rulemaking package was prepared professionally, conscientiously, and to exacting standards. ***Nevertheless, the rulemaking was unpopular with the offshore oil industry that was given free reign for years and allowed to do pretty much whatever it decided to do free of Coast Guard restraint***. Since our mariners as well as oilfield workers were discouraged from joining labor unions by a virtually unlimited outpouring of money from industry, we were effectively deprived of a voice in Washington. We were left to deal with the Coast Guard that proved to us that it had no intention of enforcing many basic workplace protections promised by Congress in the Occupational Safety and Health Act of 1970.

This Rule Was Supposed to Apply to Our Mariners

õThe workplace safety and health regulations in part 142 ***apply to personnel engaged in operation on the OCS, whether onboard a foreign OCS unit or a U.S. OCS unit***[1] The proposed revisions to part 142 will ***add many new workplace safety and health items*** which should increase the level of safety for U.S. citizens employed on foreign units engaged in OCS activities.ö *[[1]An "OCS Unit" by definition at proposed 33 CFR §140.35* ***would have*** *included "****vessels engaged in OSC Activities****" which explains our Association's primary interest in this rulemaking. [2] Quoted from 64 FR 68418, Dec. 7, 1999.]*

Lifesaving Issues

õOne comment stated that the Coast Guard should adopt an underlying principal that ***lifesaving equipment should be capable of keeping 100 percent of the personnel on a facility out of the water in case of abandonment or evacuation***. **We agree**[1] Current regulations for fixed facilities require ***life floats***[1] for 100 percent of facility personnel. This is not adequate to protect personnel in the event of a blowout nor is it the best available and safest technology for this purpose. See proposed Section 143.826 for the survival craft requirements for fixed facilities. This would align fixed facility requirements with similar regulations for MODU's and floating facilities. *[[1]The NTSB as well as our Association oppose the continued approval and use of "life floats." Our reasons are fully stated in our Report #R-354, Rev. 4* ***[Enclosure #5]****. The Coast Guard Headquarters continues to bow to industry pressures.]*

Delaying this Rulemaking Withheld Safety & Health Protections Mandated by Congress for 10 Years

õOne comment encouraged the Coast Guard to include in this regulatory effort any new requirements developed by OSHA for onshore locations that may apply offshore. We continually review new OSHA regulations[2] to determine applicability to the OCS. Many workplace safety and health regulations included in this proposed rule are similar to recent regulations developed by OSHA for onshore locations.ö *[[1]Quoted from 64 FR 68419, Dec. 7, 1999. [2]"We" means the Coast Guard]*

An Unfulfilled Promise by Congress to Mariners
The Occupational Safety and Health Act of 1970

(a) The Congress finds that personal injuries and illnesses arising out of work situations impose a substantial burden

upon, and are a hindrance to, interstate commerce in terms of lost production, wage loss, medical expenses, and disability compensation payments.

(b) The Congress declares it to be its purpose and policy, through the exercise of its powers to regulate commerce among the several States and with foreign nations and to provide for the general welfare, ***to assure so far as possible every working man and woman in the Nation safe and healthful working conditions and to preserve our human resources*** ó

- **(1)** by encouraging employers and employees in their efforts to reduce the number of occupational safety and health hazards at their places of employment, and to stimulate employers and employees to institute new and to perfect existing programs for providing safe and healthful working conditions;
- **(2)** by providing that ***employers and employees have separate but dependent responsibilities and rights*** with respect to achieving safe and healthful working conditions;
- **(3)** by authorizing the Secretary of Labor to set ***mandatory occupational safety and health standards applicable to businesses affecting interstate commerce***, and by creating an Occupational Safety and Health Review Commission for carrying out adjudicatory functions under this chapter;
- **(4)** by building upon advances already made through employer and employee initiative for providing safe and healthful working conditions;
- **(5)** by providing for research in the field of occupational safety and health, including the psychological factors involved, and by developing innovative methods, techniques, and approaches for dealing with occupational safety and health problems;
- **(6)** by exploring ways to discover latent diseases, establishing causal connections between diseases and work in environmental conditions, and conducting other research relating to health problems, in recognition of the fact that occupational health standards present problems often different from those involved in occupational safety;
- **(7)** by providing medical criteria which will ***assure insofar as practicable that no employee will suffer diminished health, functional capacity, or life expectancy as a result of his work experience***;
- **(8)** by providing for training programs to increase the number and competence of personnel engaged in the field of occupational safety and health;
- **(9)** by providing for the development and promulgation of occupational safety and health standards;
- **(10)** by providing an effective enforcement program which shall include a prohibition against giving advance notice of any inspection and sanctions for any individual violating this prohibition;
- **(11)** by encouraging the States to assume the fullest responsibility for the administration and enforcement of their occupational safety and health laws by providing grants to the States to assist in identifying their needs and responsibilities in the area of occupational safety and health, to develop plans in accordance with the provisions of this chapter, to improve the administration and enforcement of State occupational safety and health laws, and to conduct experimental and demonstration projects in connection therewith;
- **(12)** by providing for ***appropriate reporting procedures with respect to occupational safety and health*** which procedures will help achieve the objectives of this chapter and accurately describe the nature of the occupational safety and health problem;
- **(13)** by encouraging joint labor-management efforts to reduce injuries and disease arising out of employment.

The Big Lie

If the Coast Guard õcontinually reviews new OSHA regulations to determine applicability to the OCSö ***it is remarkable that the Coast Guard currently enforces so few of OSHA regulations***. In probing this issue as we have done for the past 10 years, we recently received a letter from the Acting Chief of the Office of Design and Engineering Standards on Feb. 26, 2010 ***[Enclosure #12]*** that stated in part: õHowever, ***we do not prepare our inspectors to enforce OSHA regulations, or any other agency's regulations***, on uninspected vessels. Neither the Towing Vessel Center of Expertise nor the Offshore Operations Center of Expertise has been ***contacted by industry*** with concerns regarding asbestos;[1] however, our office has forwarded your letters and Gulf Coast Mariner's Report #R-205[2] to ensure they are aware of the potential concerns. *[[1]Our letter cited three major continuing areas of regulatory neglect: 1)Hearing protection 2)Provision of adequate potable water, and 3)Asbestos protection. [2]Refer to our Report #R-205* ***[Enclosure #6]****.*

As Chief Executive, we believe you should be concerned that two Executive Branch agencies, the Coast Guard and OSHA, are unable to work together to adequately protect offshore workersø safety and health! Although our Association submitted a number of reports[1] to Congress, and especially to the House Transportation and Infrastructure Committee

and testified before them on three occasions, their role is oversight. They are not staffed or equipped to manage the Coast Guard. We believe, Mr. President, that it is time to rein in the Coast Guard and make it enforce the laws and regulations for the benefit of the people of the United States and not for õspecial interestsö that it has become much too close to over the years. *[(1)Currently, 25 reports, some updated several times.]*

The Coast Guard recently established a number of õcenters of expertiseö where, hopefully, the parade of officers moving up through the ranks will learn at least the basics about the different sectors of the maritime industry that they are expected to regulate. However, working mariners who encounter real problems every day are being ignored. We previously testified to Congress[1] on the disaster the Coast Guard õexpertsö made of the mariner credentialing process and arbitrarily ruined the careers of so many of our mariners. But safety and health issues ruin more than careers. *[(1) Refer to our Reports #R-428-D* ***[Enclosure #7] and*** *R-428-D, Rev.1* ***[Enclosure #8].***

The Coast Guardøs failure to protect our mariners from the same type of safety and health hazards that face onshore workers has gone on since 1970, a ***period of forty years***. The Coast Guard clearly receives their marching orders from the industry and appear to have little interest protecting the maritime industryøs workers or Congressional oversight. Even though Congress õdid the right thingö in 2004 and got to the bottom of our Associationøs potable water complaints, the Coast Guard has not yet raised a finger to implement Congressø instructions. We often cite the lack of effective leadership at the highest levels of the Coast Guard.

Taxpayers Pay for All That Wasted Effort

Our Association carefully studied the 1999 proposed rulemaking on Outer Continental Shelf Activities and made several comments on it. As a result of our attendance at NOSAC and other Coast Guard Advisory Committee meetings for the past decade, we came to know and respect the Project Officer for this rulemaking, Mr. James Magill. We believe that Mr. Magill, with his engineering background and years of experience in the in the maritime industry as well as his conscientious approach, was without question, ***the person best suited at Coast Guard Headquarters to prepare this rulemaking package***. This was his project, and he worked on it diligently for years. Yet its progress of this rulemaking was crippled by senior Coast Guard officials who failed to provide this important rulemaking the necessary priority. In our view, the changes Mr. Magill proposed in the rule were changes that needed to be made. However, ten years have passed and at this point Mr. Magill is planning to retire. Headquarters decided to re-consider and re-work the rulemaking proposals. We believe that by õreactivatingö this project last Fall and assigning someone with limited background, knowledge, and skill to handle this complex project is just part of the Coast Guardøs partnership with industry officials to defeat and downgrade this rulemaking to the detriment of the workers it was meant to protect. We respectfully request that you consider the impact of the proposed improvements to workplace safety the Coast Guard could have provided in respect for the eleven lives of the workers lost in the Gulf rig explosion.

Our Association provided the following background material and later attended a õmeetingö to discuss some technical aspects of this stalled rulemaking that was convened last November by **ABSG Consulting, Inc. –** ***a government contractor.*** We wrote them as follows:

Our Association's Complaints
Protection of Mariners in the Workplace

õAlmost 40 years ago, Congress declared the purpose of the Occupational Safety and Health Act of 1970 (29 U.S. Code 651) õí to provide for the general welfare, to assure so far as possible every working man and woman in the nation safe and healthful working conditions and to preserve our human resources.ö While the Act placed most of the burden on the Secretary of Labor, the ***Coast Guard was supposed to look after the health, safety, and welfare of our mariners***.

õWe believe the ***Coast Guard failed to provide a safe workplace for most of our "limited tonnage" mariners including those working in Outer Continental Shelf (OCS) activities***. In 2008, the Department of Homeland Security Inspector Generaløs Office reported on the dismal state of Coast Guard casualty investigations in Report #OIG-08-51 confirming a trend that had been confirmed fourteen years earlier.ö

Additional Concerns Since Our Letters

õWhile the Department of Labor provided ***regulations*** for many land based operations, in at least two areas the Coast Guard provided only õguidanceö in the form of NVICs that do not have the force of law. I refer specifically to NVIC 12-82 (***Hearing***) and NVIC 6-87 (***Asbestos***). I understand that the Coast Guard recently decided to review its NVICs ó hopefully for the shortcomings mentioned below.

õOur Association believes that the scope of coverage of maritime workplace issues needs to be upgraded from õguidanceö to a more formal and enforceable ***regulatory protection*** in order to better protect our working mariners as spelled out in our õReportsö listed below. We believe that in several cases, this can best be accomplished by considering the possibility of using õIncorporation by Referenceö of existing OSHA regulations applicable to conditions aboard ships including vessels on which our õlimited tonnageö mariners live and work.

"In 2004**,** Congress passed Section 416 of the Coast Guard and Maritime Transportation Act of 2004 relative to providing clean and safe potable water aboard vessels. However, the Coast Guard hasnøt done anything substantial to move forward and create new regulations to carry out Congressional directions. We find this inertia to be totally unacceptable. As late as a year ago, the Coast Guard and Maritime Transportation Subcommittee indicated that it was considering convening a hearing on this matter. We notified our mariners who were part of our original complaint to be prepared to testify.

õWe know of a very recent case where a shipyard painted the potable water tank of a towing vessel with a two-part epoxy solution but forgot to mix the two parts. Consequently, the tank coating never cured or dried leaving the ***drinking, cooking, and bathing water on the vessel contaminated with a chemical substance*** that smelled like acetone. The mariners who work for the company reportedly never bothered to have the sample they provided tested by an approved laboratory. There may be serious health considerations involved.

õWe want our mariners shipboard potable water supplies to be at least as well protected as those provided to the Coast Guardøs military and civilian employees. Nevertheless**,** we expect a reasonable, workable solution not one that invokes excessively technical regulations our mariners and vessel owners may not be able to read and understand.

õOur Association will be pushing these three additional issues because they are all extremely important to the health, welfare, and safety of our mariners. ***We believe the Coast Guard has not been sufficiently concerned with these issues and with the safety, health, and welfare of our "limited tonnage" mariners in the past***. We expect to see some concrete action taken on these issues.

õWe brought these issues to the attention of Mrs. Mayte Medina, Chief, Maritime Personnel Qualification Division (CG-5221) in early October 2009. These issues are summarized in our Report #R-350, Rev. 5, as **Issue "Q"** Protecting Mariner Hearing., **Issue "U"** Protecting Our Mariners from Asbestos, .and **Issue "R"** Provide Safe and Adequate Potable Water.ö ***[Enclosure #4]*** I will attach a copy of this report as well as our Report #R-349, #R-445 and #R-395, Rev. 2 ***[Enclosures #9, 10 & 11 respectively]*** that discuss these issues in greater detail and ask that these issues be considered in regard to any future changes in Subchapter N.ö

Towing Vessels

"In our previous letters, we expressed considerable concern about the safety of our mariners working on board towing vessels in OCS activities. In September 2004, Congress added towing vessels to the list of õinspectedö vessels. The Coast Guard is engaged in the process of preparing a Notice of Proposed Rulemaking (NPRM) on these vessels. However, since the NPRM has yet to be published after six years, ***we have no idea whether these proposed regulations will reflect our concerns on the OSHA issues stated above***. ***We believe the Coast Guard has failed to provide a comparable degree of safety in the offshore workplace as OSHA has done on shore***. We believe the issue needs to be confronted now even though it is admittedly 40 years late.ö

In closing, our Association believes that the Coast Guardøs failure to apply and enforce workplace safety regulations for the past 40 years has adversely affected our mariners throughout the United States including those who serve on vessels working in the waters of the Outer Continental Shelf.

Very truly yours,
s/Richard A. Block, B.A., M.S.
Master #1186377, Issue #9
Secretary, National Mariners Association

Enclosures:
★***Enclosure #1 = Our Report #R-429-M***
★***Enclosure #2 = Our Report #R-429-A***
★***Enclosure #3 = Our Report #R-429-B***
★***Enclosure #4 = Our Report #R-350, Revision 5***
★***Enclosure #5 = Our Report #R-354, Revision 4***
★***Enclosure #6 = Our Report #R-205***
★***Enclosure #7 = Our Report #R-428-D***

★*Enclosure #8 = Our Report #R-428-D, Revision 1*
★*Enclosure #9 = Our Report #R-349*
★*Enclosure #10 = Our Report #R-445*
★*Enclosure #11 = Our Report #R-395, Revision 2*
Enclosure #12 = Coast Guard (CG-521) letter of Feb. 26, 2010
★ *= To save paper, Enclosures 1 thru 11 are on disk. However, each of these reports also is available on our website www.nationalmariners.org under "Research Reports. We enclose a copy of "Index R" that is a list of all 229 of our reports.*

MARINERS BEWARE: REPORTS OF OSHA TREATMENT OF WORKER INJURIES IS DISTURBING

*[**Source:** OSHA: Discounted Lives, By Mike Casey, Kansas City Star, Dec. 11, 2005. To reach Mike Casey, call (816) 234-4305 or send e-mail to mcasey@kcstar.com. Copyright 2005, Knight Ridder.]*

Workplace deaths can devastate families, but government fines are often modest – if employer's pay at all.

Only hours after starting his first day on the job, Les James was dead.

The 25-year-old father of three was working on a window-cleaning crew in July 2000. Suddenly, the window-washing rig fell off the roof of Research Medical Center, catapulting James to his death 84 feet below. Two other window washers were seriously injured.

That morning, the Occupational Safety and Health Administration launched an investigation. OSHA cited the Holden, Mo., window-cleaning company ó which had a fatal accident only four years earlier ó for serious safety violations in James' accident, records show.

The company's fine: $2,700.

When James' mother learned of the amount, she wept. "That's nothing for taking my son's life," said Donna Frailey of Warsaw, Mo.

Low fines for workplace deaths or injuries are common even when OSHA cites employers for a serious violation, The Kansas City Star found in an examination of the agency's inspection database for the metropolitan area.

The Star found that in 80 such fatal and injury accidents, half of the fines Kansas City area employers paid were $3,000 or less. Regulators and OSHA lawyers reduced employers' initial fines by nearly 60 percent. Adjusted for inflation, fines last year averaged less than they were in 1972.

And in three accidents that killed five area workers, OSHA changed its most serious citations from willful violations to "unclassified" ó removing the word "willful" in describing the violations ó and then significantly reduced the fines.

Nationwide, fines were even lower in the last decade. Half of the fines employers paid were $2,500 or less in fatal and injury accidents involving at least one serious violation.

Many experts said low fines were a symptom of the agency's weakness, even when taking enforcement action in the worst accidents.

However, OSHA's regional administrator in Kansas City, Chuck Adkins, said that the agency was more interested in improving safety than in collecting money.

"As far as we're concerned, the amount of the penalty is incidental to the accomplishment that we get as the result of that inspection," Adkins said.

But even former OSHA administrators decried the low fines.

"Fines are not a deterrent," said Charles Jeffress, who led the agency in the Clinton administration. "The level of fines that Congress has authorized is an insult to the American worker,"

Jerry Scannell, an OSHA administrator in the administration of President George H.W. Bush, said: "It's almost like chump change with some companies." OSHA's own policies state that penalties should be "sufficient to serve as an effective deterrent to violations."

But the agency is limited by law to maximum civil fines of $7,000 for each serious violation and $70,000 for each willful violation. Those maximums have not been raised since 1991. And OSHA's policies allow it to reduce fines for companies with fewer than 251 employees and for other factors.

Adkins, whose jurisdiction includes Kansas and Missouri, acknowledged that OSHA fines cannot make up for a family's loss.

"The penalty we propose is not intended to pay for that life," he said, adding that it's more important to remove workplace hazards and provide safety training to prevent accidents.

Adkins said OSHA sometimes reduces fines in exchange for companies making safety improvements. He noted that some fines also are reduced by OSHA's lawyers in the Labor Department, who operate independently of the agency.

Low fines 'appalling'

Certainly, OSHA has levied multi-million dollar penalties in high-profile accidents.

BP Products North America Inc. agreed to pay $21 million for a March 23 explosion that killed 15 workers and injured more than 170 others at its Texas City, Texas, facility. That fine, for numerous violations, was nearly double the next largest penalty, officials said.

OSHA officials said that since the agency's inception in 1971, on-the-job deaths have declined more than 60 percent. Nearly 1,000 fewer workers died last year than in 1994. Fatalities last year totaled 5,703, or 2 percent more than the previous year, but total workplace injuries and illnesses were down slightly over the same period.

Agency officials attribute encouraging trends to its enforcement efforts, training programs and cooperative ventures with business. For example, OSHA has a program with Kansas City Power & Light Co. to make tree trimmers aware of electrical hazards.

Yet OSHA's role is just one factor in the overall drop in fatalities in recent years, experts said. They maintain that deaths and injuries could be reduced even more with tougher enforcement.

Susan Baker, a professor of public health at Johns Hopkins University who has expertise in occupational safety, attributed some of the decline in deaths to fewer workers employed in dangerous industries, such as steel making and coal mining, and better emergency room treatment.

Baker is convinced, however, that higher OSHA fines would prompt many companies to correct serious safety hazards faster. Baker called The Star's findings on low fines "appalling."

"Until the fine for ignoring a hazard is bigger than the cost of fixing the hazard, a lot of employers won't do anything," she said.

Safety advocates also said OSHA needs to issue stiff fines because its inspectors check only a small percentage of businesses. Agency inspectors investigate workplace deaths and complaints, and focus on some high-hazard industries. But it would take inspectors many years to visit every workplace under their jurisdiction.

Given the agency's relatively low profile, the threat of higher fines is not going to make businesses safer, a director with the U.S. Chamber of Commerce said.

"A lot of employers ... are never going to see an OSHA inspector, and that fear is never going to motivate them," said Marc Freedman. "I'm not convinced employers look at the OSHA citation situation in deciding whether they're going to do the right thing in protecting their employees."

Indeed, some businesses said the fear of workers' compensation costs is a bigger factor in eliminating safety hazards than OSHA fines. In its database analysis, The Star reviewed more than 27,000 inspection records for thousands of area companies. From 1994 through early 2005, the newspaper found that OSHA issued at least one serious violation citation in 80 accidents that had killed or injured workers.

To be sure, the vast majority of businesses didn't have a fatality, including some large employers such as the General Motors Fairfax assembly plant in Kansas City, KS., or Hallmark Cards' local production and distribution facilities. Still, The Star found that more than 130 area workers have died on the job since 1994 and about half perished at construction sites. Roofing and utility construction were the deadliest industries.

Seventy-five workers were killed in accidents that resulted in serious OSHA violation citations for inadequate training, lack of equipment and deficient safety policies.

Among the victims was Guy Beller Jr., 44, an ex-Marine and father of two.

In August 1996, Beller, an employee of Allied Hydro-Blasters of KC Inc., was on a beam about 10 feet above the floor as he cleaned part of the GST Steel plant. Beller fell, became entangled in a rope and died of asphyxia.

Allied was cited for failing to provide fall protection such as a safety harness system, which the company said was more of a hazard, records show. Those often cost less than $300, safety experts said.

OSHA proposed a $1,500 fine. When it didn't receive payment, OSHA turned the debt over to the Treasury Department, but it couldn't locate Allied and the government gave up trying to collect in 1999, records show.

The Star, however, found Allied's president in Florida after only one phone call.

Charles Boyd said the company was out of business. Boyd would not discuss the accident and said he was unaware of the fine.

When told Allied never paid the fine, Beller's daughter was upset.

"They should be made to pay," Misty St. Lawrence said.

Three fatalities

In the accident that killed Les James, OSHA cited Quality Window Cleaning Inc. for three serious violations, which carried maximum fines of $21,000.

But because of OSHA rules ó particularly those regarding small companies ó the agency proposed a fine of only $4,500. Then the company received a 40 percent reduction after settling the case for $2,700 with OSHA's lawyers.

OSHA cited Quality Window for failing to provide James with a safety line or a guardrail and for not securing the window-washing rig to the roof. The company also was cited for failing to attach the window washers' lifelines to a secure point on the hospital's roof, separately from the rig.

At the time of the accident, Quality Window owner Brian Mannschreck told an OSHA inspector that he had not trained James, saying that was the responsibility of the other window washers, records show. The inspector found inadequacies in the company's safety training.

Records also show that the accident wasn't the first time that OSHA had found the company's training deficient.

In 1996, a Quality Window worker died from a fall in Kansas City, and OSHA noted weaknesses then in the company's safety and health training.

The agency issued four serious violation citations, but agency lawyers dropped two and reduced two others after Quality Window contested them and paid no fine. Mannschreck blamed employee error in the accident.

Two years after James' death, another Quality Window worker died from a fall in Lenexa.

Mannschreck again blamed employee error. OSHA found no violations in that accident.

But the company's three deaths over a six-year period troubled OSHA's regional director.

"Three," Adkins said. "That's terrible."

Meanwhile, a union official said that new window washers such as James should never have been on a roof. "You don't send a guy up there without experience," said John Zarris of Local 1 of the Service Employees International Union in Chicago.

James' widow has sued Mannschreck in Jackson County Circuit Court, alleging he put her husband to work without training. Mannschreck's lawyers have denied the allegation. In its settlement agreement with OSHA, the company did not admit to any wrongdoing. Such provisions are common in OSHA settlements.

"It's been our position all along that Mr. Mannschreck did nothing wrong," said his attorney, Jeff Stigall.

In court records, Stigall had argued that Missouri's workers' compensation law shields him from the lawsuit and that James and one of the injured window washers were negligent.

‘Unclassified’ deaths

About 15 years ago, OSHA began changing some of its willful safety violations ó its most serious charge ó to "unclassified." The reclassification does not change OSHA's findings, but it removes the words "willful," "repeat" or "serious" in describing the nature of the violations, OSHA's Adkins said.

OSHA records show that the agency uses the unclassified citations as a "***settlement tool***" to correct safety hazards quickly and avoid lengthy litigation. The change also allows employers to avoid the stigma of being labeled a willful violator, records noted.

But the newspaper found that changing willful violations to unclassified in at least three local fatal workplace accidents also was accompanied by dramatically lower fines.

Adkins said the agency has a policy of collecting at least 80% of a proposed penalty in settlements that involve unclassified violations, but he acknowledged, "That doesn't always occur."

It certainly didn't occur in a case involving Stephen Barber III, 26. Barber worked at Kansas City Southern Railway's facility in Kansas City. One evening in February 1999, Barber was walking along the track when a large industrial truck crushed him.

OSHA's investigation led to a willful violation citation and a maximum fine of $70,000. The citation stated that union officials had repeatedly warned Kansas City Southern of the dangers.

Two years before the fatal accident, Kent Nelson, a United Transportation Union official, wrote Kansas City Southern: "I am very concerned that a tragic occurrence is (going to happen) without a doubt in the future." Nelson suggested vehicles stop while yard crews were working.

Kansas City Southern, however, challenged the citation. In a settlement agreement, OSHA's lawyers changed the willful violation citation to unclassified and lowered the fine by 40 percent to $42,000.

The action infuriated union leadership.

"This is truly a case of big business has its way," Thomas Stoltz, a Brotherhood of Locomotive Engineers official, wrote in a protest letter to OSHA's lawyer. Stoltz, a Vietnam War veteran, added: "in war, you expect to suffer casualties, but not in your workplace."

Kansas City Southern told The Star it was "deeply saddened" by Barber's death. Since the accident, the company prohibits vehicles from operating while train crews are working in certain areas of the rail facility. The company also requires crews to wear vests with reflectors and takes other precautions.

Barber's mother, Mary Ann Barber, likened the negotiations between OSHA's lawyers and the company to "plea bargaining." His father, Steve Barber, said the pain of his son's death has not faded. "It'll be seven years in February, and it doesn't get any easier," he said as he dabbed tears from his eyes.

OSHA also changed citations from willful to unclassified in an electrical explosion eight years ago that claimed the lives of three workers at Western Resources' Lawrence Energy Center.

The company, now Westar Energy, contested the numerous violation citations. OSHA changed willful violations to unclassified and reduced the initial fine by 56 percent to $200,000. The utility promised to make safety improvements.

Westar officials said the utility had taken corrective actions and made further safety advancements.

OSHA's lawyers also changed willful citations to unclassified after a flash fire killed a worker at Hodgdon Powder Co. in Shawnee, KS, in 1994. OSHA proposed a $108,850 fine, but its lawyers settled the case for $30,650 ó a 7'2 percent reduction. Records show Hodgdon Powder corrected the hazards. A company official declined to be interviewed. Worker safety advocates criticized OSHA for its use of unclassified citations.

"I think it's really outrageous," said Peg Seminario, direct& of safety and health for the AFL-CIO. "There should be no unclassified citations, particularly in the case of fatalities." Even after many years, workplace deaths still haunt families who lost loved ones. On a recent fall day, the leaves at Mound Grove Cemetery in Independence were fading to yellow as Donna and Harold Frailey stood over the grave of their son, Les James. There were warm memories about a young man who loved his three daughters, fishing and motorcycles. But there also was a deep sense of loss. And lingering anger over OSHA's fine. "Just peanuts," Harold Frailey said, bitterly.

Samuel Mera died when a trench collapsed. The OSHA fine was $5,525

Guy Beller Jr. died after falling, entangling in a rope. The OSHA fine was $1,500, but it was never paid.

Les James died in a window-washing accident. The OSHA fine was $2,700

AMERICAN BUSINESSES KILL 14 WORKERS EVERY DAY…

*[**Source:** By Tom O'Connor, Executive Director of the National Council for Occupational Safety and Health, the umbrella organization of 20 state and local COSH groups. Article forwarded to us by Capt. J. David Miller]*

Now ó in the wake of a slew of highly publicized and preventable disasters ó is the time to demand action, before more workers die.

Itøs been a very bad couple of months for worker safety: Seven dead in Anacortes, Washington, following the explosion of the Tesoro refinery. Six dead in Middletown, Connecticut, in the Kleen Energy power plant explosion. Twenty-nine dead in West Virginiaøs Upper Big Branch mine disaster. And ***11 dead in the Gulf of Mexico oil rig collapse (a fact almost completely overlooked in media coverage of the spill's environmental consequences).***

But behind the headlines on the latest disaster is a far quieter but equally disturbing story of daily carnage. In the same week as the human-created disaster in the Massey mine in West Virginia, local media outlets around the country carried dozens of stories with headlines like õMan Killed in Trench Collapseö or õFall from Roof Fatal.ö

The toll of these routine incidents ó 14 deaths a day from injuries alone ó is obscured because most occur one death at a time.

Month after month, year after year, workers die in trench collapses and falls from roofs. OSHA cites the employer, slaps it with a ***modest fine (a median penalty of only $3,675 per death in 2007)***, and points out that simple methods exist to prevent such tragic loss of life. Yet some employers continue to ignore the hazards and workers continue to lose their lives due to this criminal neglect.

Like the high-profile workplace disasters, the vast majority of deaths on the job are entirely preventable. The problem is not a technical one of chemical concentrations, safe machinery, and ventilation, but a political one ó simply put, ***our national system for enforcing health and safety regulations in the workplace is broken.***

We know how to prevent trenches from collapsing ó by using trench boxes to shore them up. We know how to prevent falls from roofs from becoming fatal ó by properly using safety harnesses. We know how to prevent coal

mine explosions by minimizing the build-up of coal dust and monitoring methane concentrations. ***But employers routinely refuse to use these established precautions, and OSHA does not force them to.***

Why No Enforcement?

First, itøs a problem of resources: ***OSHA's budget for enforcement is pitifully inadequate, a situation that has worsened since deregulation began in the Reagan era***. In the late 1970s, OSHA had one inspector per 30,000 covered workers; today itøs one per 60,000.

Second, obstacles to any new workplace safety rules, put in place by deregulation ideologues in Congress, have effectively brought the OSHA regulatory process to a complete standstill. As the Center for Progressive Reform puts it, õ***In the nearly 40 years since its enactment, the OSHA Act has been exposed as a virtually useless tool for establishing occupational health and safety standards***.ö In the last 13 years, OSHA has issued exactly one new health standard establishing the maximum safe exposure to a chemical, and that under the duress of a court order.

Third, ***OSHA's promise that all workers have the right to speak up about unsafe or unhealthy conditions without retaliation has proven to be a cruel joke to those who have risked their jobs by calling OSHA***. ***The agency's whistleblower protection program is so ineffective that worker advocates cannot in good conscience advise a non-union worker to file an OSHA complaint if he or she wants to keep the job.***

The Massey mine explosion demonstrated clearly that the combination of de-unionization, lack of enforcement of safety regulations, minimal penalties for violations, and lack of whistleblower protections is lethal. As several current and former Massey workers noted, the mine was a time bomb waiting to explode, but ***in a non-union mine, it was keep your mouth shut or lose your job***.

How To Fix It

The solutions to this sorry state of affairs are not complex:

1) Congress should amend the OSH Act and the Mine Safety and Health (MSH) Act to ***protect whistleblowers and to require serious monetary and criminal penalties for egregious violators*** whose willful neglect of safety results in workersø deaths. Under current law, even the most egregious case of employer neglect can result in no more than a misdemeanor, punishable by a maximum six months in jail. Civil penalties also lag far behind those for violations of other federal law. New OSHA chief David Michaels noted in a recent Congressional hearing that when a Delaware refinery worker was killed in a sulfuric acid explosion, OSHA assessed a fine of $175,000, while the same incident resulted in EPA fines of $10 million for violations of the Clean Water Act.
2) Congress should dramatically ***increase the budget for OSHA enforcement***.
3) OSHA should fundamentally rework its system for regulating hazards. It should issue a broad õHealth and Safety Program Standardö and cite employers under the õGeneral Duty Clauseö for unsafe conditions. These measures would require employers to develop worksite-specific health and safety programs and allow OSHA to enforce the employerøs duty to provide a safe workplace ó without having to navigate the endless bureaucratic obstacles to issuing safety or health standards on a one-by-one basis.
4) Congress should ***close the loophole in the MSH Act that allows companies like Massey to avoid paying fines by contesting most MSHA citations, effectively shutting down the penalty system***. Massey contested 3,601 citations in 2009, creating a logjam that prevents MSHA from collecting on assessed penalties.
5) Congress should enact labor law reform so that workers who want to join a union and speak up about unsafe conditions are able to do so.

Fist-Pounding

But these changes wonøt come about because Congress simply decides to do so. Despite much fist-pounding by senators at recent hearings on the mine disaster, they will likely soon forget about worker safety and move on to the next crisis.

A bill introduced in 2009 would go a long way toward strengthening OSHAøs ability to protect workers. The Protecting Americaøs Workers Act would increase maximum civil and criminal penalties, expand protections for whistleblowers, and extend OSHA protections to public employees, many of whom are now excluded.

Unfortunately, a timid Democratic-controlled Senate Labor Committee appears unwilling to move the bill without Republican support. (Can someone explain to me why itøs not a good idea to force Republicans to cast a vote against worker safety after the recent disasters?)

So perhaps we can expect little from Congress ó unless the labor movement and its allies turn up the heat on our representatives. Now ó in the wake of a slew of highly publicized and preventable disasters ó is the time to demand action, before more workers die.