Mv. Fritz Cenac Sinks In Mississippi Sound

The mv. Fritz Cenac partially sank in Mississippi Sound off Alabama November 26 as a blustery cold front swept through the eastern Gulf states. Wind and choppy seas separated the boat from the 297- by 54-foot double-hulled tank barge it was towing; the barge drifted ashore on Chief Petty Officer Jeff Murphy of the Dauphin Island. Four crew members aboard the tow scrambled to safety.

The Cenac Towing Company tow was tied off to a mooring buoy at about Mile 120 EHL on the Gulf Intracoastal Waterway awaiting passage of the cold front when the high-riding empty barge broke free at about 5 a.m., said Chief Petty Officer Jeff Murphy of the Dauphin Island. Four crew members aboard the tow scrambled to safety.

The Cenac was tied off to a buoy in the Mississippi Sound when high winds separated it from the buoy and the barge it was towing. The towboat sank to its second deck, while the barge drifted about two miles to Dauphin Island.

Cenac

(Continued from Page 3)

The towboat’s crew was unable to recover the barge when it was blown into shallow water, Murphy said. One Fritz Cenac crewman who had been working lines aboard the barge CTGOS10 as it broke loose rode the barge until it grounded on the north shore of Dauphin Island at about Mile 118 EHL.

Meanwhile, three crewmembers remaining aboard the towboat maneuvered the crippled vessel alongside barges of another Cenac towboat, the Philip Cenac, which was moored nearby, also awaiting weather. The crewmembers stepped onto the Philip Cenac’s barges as the Fritz Cenac settled to the bottom in about 14 feet of water. The vessel submerged to its second deck level, sitting upright.

Cenac Towing summoned United States Environmental Service, Mobile, Ala., to contain and recover diesel fuel leaking from the Fritz Cenac. McKinney Salvage & Heavy Lift, Baton Rouge, La., raised the 60- by 22-foot, 1,160 hp. towboat December 2 before turning attention to the stricken barge.

No injuries were reported in the accident.

—See CENAC PAGE 6
AMENDMENT #1

After talking with other vessels in the area and listening to marine weather broadcasts, the Fritz Cenac with one empty tank barge in tow, CTCO 310, departed Mobile, Alabama at 0001 hours, on 11/27/03, enroute to Houma, La.

While traveling west bound near mile 120 EHL - GIWW, the wheelman received reports via radio about an eastbound vessel that had broken up its tow while crossing the sounds.

The wheelman decided to secure the tow to the mooring buoys located just north of the GIWW near mile 119 EHL. The tow was secured at 0530 hours.

At 0400 hours the next day, 11/28/03, the mooring line parted setting the tow adrift. As the tow drifted south, the main engines were immediately started and the captain of the tow, attempted to regain control of the tow. It was reported that the boat had a port list at this time.

The boat was striking ground in 3-4' seas, and the port jockey wire and port face wires parted. At the direction of the captain, the wheelman jumped on the barge and released the starboard wires from the barge. The barge immediately drifted away from the boat in the high winds and headed south towards the west end of Dauphin Island where it grounded on the beach.

The boat began listing more to port and was down by the bow. The captain called for assistance and headed back towards the mooring buoys where another Cenac vessel, the Fritz Cenac, was moored. Keeping constant radio contact with the Philip Cenac, the Fritz Cenac made its way back to the moorings and came alongside of the Philip Cenac's barges. It was reported that the main deck was completely under water and the bow was down by the bow and listing heavily to port and getting worse quickly.

All crew members got off the Fritz Cenac and onto the Philip Cenac. Moments later the Fritz Cenac sank upright in approximately 12-15 feet of water. The top half of the vessel, from the second deck going upwards, was clearly visible above the water line.

The boat was lifted by a hired salvage company and reflotated on the evening of 12/2/03. The boat is presently in the custody of a Cenac vessel and on its way to the facilities of Cenac Towing Co. in Houma, La. for inspection, cleaning, and possible repair.

ENCLOSURE #2
**REPORT OF MARINE ACCIDENT, INJURY OR DEATH**

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**ENCLOSURE #2**

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**Sweepstakes Information**

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<td>Official License</td>
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**30**
**Sea Attachment 11**

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**SECTION IV. DESCRIPTION OF CASUALTY**

See Attachment #1

---

**SECTION V. PERSON MAKING THIS REPORT**

- **Name:** (Redacted)
- **Address:** (Redacted)
- **Date:** 12/07/03

**FOR COAST GUARD USE ONLY**

**REPORTING OFFICE:**

**APPARENT CAUSE:**

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<td>APPROVED BY (Name)</td>
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31

ENCLOSURE #2
### SECTION II—INCIDENT INFORMATION

11. Type of Surface Marine Incident (Check Appropriate Box(es), See Instructions on Reverse)

- [ ] a. Death (Append to Form CG-3682)
- [ ] b. Injury requiring medical treatment (Append to Form CG-3682)
- [ ] c. Property damage in excess of $100,000 (Append to Form CG-3682)
- [ ] d. Loss of inspected vessel (Append to Form CG-3682)
- [ ] e. Loss of uninspected, self-propelled vessel of over 100 gross tons (Append to Form CG-3682)
- [ ] f. Discharge of oil of 10,000 gallons or more into U.S. waters
- [ ] g. Discharge of a reportable quantity of hazardous substance into U.S. waters
- [ ] h. Release of a reportable quantity of hazardous substance into U.S. environment

12. Date of Incident: 11/28/03
13. Time (Exact Time of Incident): 04:15
14. Location of Incident (Latitude and Longitude or Other and When)

Near mile 119 EHL - Gulf Intracoastal Waterway

### SECTION III—PERSONNEL/TESTING INFORMATION

15. Personnel Directly Involved in Surface Marine Incident

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16. Drug and Alcohol Testing (See Instructions on Reverse)

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<tr>
<td>YES</td>
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<td>YES</td>
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17. Laboratory Conducting Chemical Drug Tests

Name: Kroll LSI
Address: 1111 Newton Street
Gretna, LA 70053
Telephone Number: (504) 457-0493

18. Laboratory Conducting Blood Alcohol Test(s) or Individual Conducting Breath Test(s)

Name: XMSI Services
Address: 409 N. Hollywood Road
Houma, LA 70364
Telephone Number: (985) 351-5080

19. Persons Making This Report (Please Print)

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20. Report to

Title: Human Resources Manager

21. Date: 12/04/03

ENCLOSURE #2
NMA REPORT #R-202-C, Rev. 2
DATE: July 7, 2010

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. 9th 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—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 additional dangers 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 "couldn't care less" 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")

(Enclosure #4)

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 – 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.

42 ENCLOSEMENT#4
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) – 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 – 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 BARGE ACCIDENT 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 – 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 MEGAN’s 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 MEGAN’s 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.

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 “Fire Aboard Construction Barge Athena 106, West Cote Blanche Bay, Louisiana, Oct. 16, 2006.” The accident itself is straightforward and easy to understand - 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 “hot items”. Consider this paragraph excerpted from page 29 of the full NTSB report:

"Deck 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."

Of course, not all these barges are “spud barges” 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 “pin” every raised spud in the “up” position so it cannot possibly drop - even on a short move. That’s 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 “work barges” 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 Guard’s Marine Safety Program — 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 “uninspected” 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 "uninspected" status of towing vessels in 2004. We now ask Congress to examine the status of thousands of uninspected barges.

This NTMB report makes it clear that a similar inspection requirements may well be required for every "work barges" 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 Guard's 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 "Marine Inspection" 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 "window-type" air conditioner unit. A crewmember called to tell us that the air conditioners sucked in exhaust fumes from the vessel's 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 couldn't 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 "uninspected" vessels. Since there are no "inspection" regulations currently in place for towing vessels, OSHA stepped in to this case on behalf of the mariner.

The mariner asserted to us that "...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 " In addition, the towing vessel is equipped with a window-type air conditioner that sucks up fumes from the vessel's exhaust stacks and feeds it into the pilothouse. This poisonous air also can circulate below into the crew's 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 mariner's back wages. It would also bar him from discussing the incident. Our Association urged the mariner to "...take the money and run" because there is nothing "non-union" mariners can do about unfair termination. We will not reveal the mariner's name or the name of the offending company under the OSHA-

ENCLOSURE#4
sponsored agreement. We will mention, however, that the company is a member of the American Waterways Operators, the tug and barge industry’s 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 “employees-at-will” and can be terminated for any reason whatsoever – such as “complaining” about unsafe working conditions. We explain the background thoroughly in NMA Report #R-370-D titled Whistleblower Protection, Work Hour Abuse and “Deadhead” 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 “straight up” 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 “North Sea” 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 “good health” 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 "ridiculous spectacle" of oil executives shifting blame in the Congressional hearings and denounced the "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 "limited tonnage" 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 "60 Minutes" on Sunday May 16, 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 "investigation" that will take place, and we believe that you, as President and head of the Executive Branch, should be equally skeptical of the Coast Guard's ability to investigate anything after reading (or recalling) the Department of Homeland Security Inspector General's report in 2008 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 and confirmed in 1996 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.

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 ... may from time to time modify any regulations, interim or final, dealing with hazardous working conditions on the Outer Continental Shelf."

With eleven fatalities in this latest "incident," 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 and serve as one excellent example of the "cozy relationship" that exists between the Coast Guard and industry.

In 1999, the Coast Guard proposed a regulatory package to update OCS regulations. Our Association was interested in this "package" because the rulemaking defined "OCS Units" to include vessels 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 – 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.
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)

"According 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.

"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, firefighting, and fire-protection equipment.

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.

"To determine potential benefits, we examined both the Coast Guard 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."[Quoted from 64 FR 68440, Dec. 7, 1999.]

The Purpose of the Rulemaking

"The Coast Guard is supposed to be 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." [Quoted from 64 FR 68417, Dec. 7, 1999.]

Casualty Reporting

"Four 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.

"We agree. 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.]

ENCLOSURE #4
Existing Regulations Are Inadequate

“One 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[10] and propose many new workplace safety and health regulations that are similar to recently developed OSHA regulations.” [Quoted from 64 FR 68418, Dec. 7, 1999. [10]“We = the Coast Guard!”]

“Two 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.” [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

“The 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[11]. 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.” [11]“An “OCS Unit” by definition at proposed 33 CFR §140.35 would have included “vessels engaged in OCS Activities” which explains our Association’s primary interest in this rulemaking. [12] Quoted from 64 FR 68418, Dec. 7, 1999.]

Lifesaving Issues

“One 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[13] Current regulations for fixed facilities require life floats[14] 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. [13]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

“One 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[15] 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.” [15]Quoted from 64 FR 68419, Dec. 7, 1999. [21]“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

50 ENCLOSEMENT#4
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 –

(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 "continually reviews new OSHA regulations to determine applicability to the OCS" 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: "However, 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," however, our office has forwarded your letters and Gulf Coast Mariner's Report #R-205 to ensure they are aware of the potential concerns. Our letter cited three major continuing areas of regulatory neglect: 1) Hearing protection 2) Provision of adequate potable water, and 3) Asbestos protection.

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 workers' safety and health! Although our Association submitted a number of reports 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 "special interests" that it has become much too close to over the years.  

The Coast Guard recently established a number of "centers of expertise" 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\(^{11}\) on the disaster the Coast Guard "experts" 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. \(^{11}\) Refer to our Reports #R-428-D [Enclosure #7] and R-428-D, Rev. 1 [Enclosure #8].

The Coast Guard's 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 industry's workers or Congressional oversight. Even though Congress "did the right thing" in 2004 and got to the bottom of our Association's potable water complaints, the Coast Guard has not yet raised a finger to implement Congress' 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 "reactivating" this project last Fall and assigning someone with limited background, knowledge, and skill to handle this complex project is just part of the Coast Guard's 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 "meeting" 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**

"Almost 40 years ago, Congress declared the purpose of the Occupational Safety and Health Act of 1970 (29 U.S. Code 651) "...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." 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.

"We 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 General's 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."

**Additional Concerns Since Our Letters**

"While the Department of Labor provided regulations for many land based operations, in at least two areas the Coast Guard provided only "guidance" 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 – hopefully for the shortcomings mentioned below."
“Our Association believes that the scope of coverage of maritime workplace issues needs to be upgraded from "guidance" to a more formal and enforceable regulatory protection in order to better protect our working mariners as spelled out in our "Reports" listed below. We believe that in several cases, this can best be accomplished by considering the possibility of using "Incorporation by Reference" of existing OSHA regulations applicable to conditions aboard ships including vessels on which our "limited tonnage" 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 hasn’t 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.

“We 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.

“We want our mariners shipboard potable water supplies to be at least as well protected as those provided to the Coast Guard’s 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.

“Our 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.

“We 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.” [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."

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 "inspected" 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.”

In closing, our Association believes that the Coast Guard’s 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
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 – which had a fatal accident only four years earlier – 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" – removing the word "willful" in describing the violations – 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 - particularly those regarding small companies - 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.


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 I 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 - its most serious charge - 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 -- a 72 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, director 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 CSH groups. Article forwarded to us by Capt. J. David Miller)

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

It's 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 Virginia's 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 "Man Killed in Trench Collapse" or "Fall from Roof Fatal."

The toll of these routine incidents -- 14 deaths a day from injuries alone -- 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 -- simply put, our national system for enforcing health and safety regulations in the workplace is broken.

We know how to prevent trenches from collapsing -- by using trench boxes to shore them up. We know how to prevent falls from roofs from becoming fatal -- 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, it's 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 it's 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, "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." 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 workers' 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 "Health and Safety Program Standard" and cite employers under the "General Duty Clause" for unsafe conditions. These measures would require employers to develop worksite-specific health and safety programs and allow OSHA to enforce the employer's duty to provide a safe workplace — 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 won't 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 OSHA's ability to protect workers. The Protecting America's 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 it's 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 — unless the labor movement and its allies turn up the heat on our representatives. Now — in the wake of a slew of highly publicized and preventable disasters — is the time to demand action, before more workers die.
MARINE ACCIDENT REPORT

Therefore, the need for a swimmer to enter the water should always be anticipated under such conditions. Since it is extremely difficult to remove anti-exposure coveralls and don a dry or wet suit on a rolling and pitching small boat in rough seas, a pre-designated swimmer should don appropriate thermal protective garments before the boat leaves the station in cold-water areas. The Safety Board concludes that had the swimmer been properly attired, he probably would not have become hypothermic. The Safety Board, therefore, believes that the Coast Guard should establish and implement procedures to require a pre-designated swimmer to don suitable thermal protective clothing before launching a small boat on a SAR mission in cold water.

**Decision to Return to Barge**

The Safety Board analyzed the group commander’s decision to send a Coast Guard crew, along with two Scundia crewmen, to the North Cape to drop its anchor. This decision required an analysis of the potential risks of injury or death to the Coast Guard and civilian personnel, an assessment of the risk of loss of or damage to Coast Guard resources, and a judgment about the probability of success.

The group commander learned that assistance from commercial tugs would not be available in time; consequently, he knew that using a tug to re-establish control over the drilling barge was no longer an option. Then, after the air station declined to provide a helicopter to deliver the two tug crewmen to the barge, the group commander decided to send the M.I.B to the barge.

He said that he believed because of several factors that the mission was likely to succeed: the EMC had assured him that the crew was capable of dropping the anchor, the coxswain had agreed to deliver the crewmen to the barge, and the tug crewmen themselves were confident they could drop the anchor within 5 minutes of boarding the barge. Although the group commander believed he had made a reasonable decision, in the Safety Board’s view, the decision was based on incomplete facts and was not fully justified.

Even though the EMC told the group commander that the tug crew could drop the anchor, the EMC did not fully understand either the condition of the surf in which the attempt would be made or the condition of the anchoring gear on the barge. The EMC had no knowledge of the limitations of the Coast Guard vessel or of the stress on the crew. While the EMC’s advice may have been well intended, it was based upon incomplete knowledge of the conditions and should not have been a basis upon which the group commander made his decision.

Although the coxswain agreed to the group commander’s decision, the coxswain had no way of knowing that the sea and weather had become much more dangerous or that the barge would be in the surf when he arrived on scene. According to the group commander, the return trip to the barge would not have been attempted without the coxswain’s consent. However, it is possible that the coxswain was so tired from having
just completed a strenuous rescue operation in rough seas that he may have been incapable of accurately judging his own fitness for continued duty.

The chief engineer and mate of the Scandia both volunteered to return to the barge and believed that they could be successfully drop the anchor within 5 minutes of boarding the barge. However, neither man knew what condition the anchoring equipment would be in when they boarded the barge or had any information about how treacherous the on-scene conditions had become. Their belief that they could accomplish the task quickly was more a matter of wishful thinking than a matter of fact.

Thus, the three criteria on which the group commander based his decision were little more than opinions with no basis in fact. Of particular concern to the Board was his decision to place civilian lives at risk to conduct this dangerous mission. The Safety Board, therefore, concludes that although the coxswain, the Coast Guard boat crew, and the tug crew volunteers made a heroic attempt to prevent an oil spill, the decision to allow them to do so was ill-conceived and not justified.

The Coast Guard Air Station Cape Cod had informed the group commander that the air station would not provide a helicopter to deliver anyone to the barge because aviation risk assessment criteria specify that SAR personnel should only be placed at risk if human lives are in danger. When the group commander proceeded with the salvage mission, he did not tell the air station. Had he told the air station, its personnel may have reviewed the criteria for launching and may have made a decision not to place civilian and Coast Guard personnel at unnecessary risk.

While the group commander thought he had assessed the risks fully before he ordered the attempt to drop the barge anchor, in the Safety Board's view he had not. He did not fully recognize the severity of the sea and weather conditions or anticipate that another life-threatening rescue would be necessitated as a result of the dangers encountered by the salvage crew. Such an assessment has been identified in previous Safety Board investigations.

As a result of its investigation of the 1991 capsizing and sinking of the U.S. commercial fishing vessel Sea King, the Safety Board issued Safety Recommendation M-92-54 to the Coast Guard:

Incorporate into the training of SAR personnel procedures to ensure the gathering and dissemination of pertinent information by all appropriate SAR personnel to facilitate a thorough assessment of the potential risks to persons involved in a SAR mission.

As the result of the investigation of three 1993 accidents involving Coast Guard SAR responses that proved unsuccessful because of the inadequacy of the risk

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33 For more information, read Marine Accident Report—Capsizing and Sinking of the U.S. Fishing Vessel Sea King Near Astoria, Oregon, January 11, 1991 (NTSB MAR-92/03).

34 For more information, read Marine Accident Brief Reports—Grounding of the U.S. Sailing Pleasure
assessments, the Safety Board issued Safety Recommendation M-94-7 to the Coast Guard:

Provide risk assessment training to all Coast Guard personnel directly involved in SAR missions.

On November 21, 1994, the Coast Guard Commandant stated:

I concur with these recommendations. The Coast Guard has taken action to add risk assessment training for SAR personnel at appropriate levels in the operational chain of command, and full implementation is expected by May of 1995.

The Commandant's response further indicated that, as a result of the Board's recommendations, risk assessment training had been included in training courses for small-boat coxswains, for pilots and aircrews, for small-boat station commanders, for cutter commanders and executive officers, for operations-center watchstanders, and for group and station commanding officers and executive officers. As a result of the Commandant's response, Safety Recommendations M-92-54 and M-94-7 were classified "Closed--Acceptable Action."

While the Safety Board is gratified that the Coast Guard has incorporated risk assessment training in the training for all levels of SAR activity, from small-boat coxswain to group commander, training in and of itself does not ensure that proper risk assessments will be made in all cases. To be truly effective, training must be reinforced by pertinent operational guidelines. According to the pilot of the second rescue helicopter, the operations officer at the air station declined to provide helicopter assistance for the salvage mission after consulting personnel from the Group. The request was denied because the formal risk assessment guidelines, which are in the Coast Guard Commandant's Instruction 3710, Air Operations Manual, prohibit the placing of a Coast Guard helicopter and air crew at grave risk for any operation, such as a salvage mission, that is not a life-threatening emergency. (The risk of losing the aircraft or the air crew is considered a grave risk.)

The group commander did not have any comparable published formal risk assessment guidelines to follow in making his assessment of the risks presented by the salvage operation. In the Board's opinion, it is just as necessary to provide guidelines for placing Coast Guard surface craft and surface personnel at "grave risk" as it is to provide such guidelines for aircraft and aviation personnel. The guidelines should clearly explain the procedures for conducting risk assessments and analyses that are necessary before conducting SAR and salvage missions, for identifying grave risk to surface craft and personnel, and for obtaining concurrence and approval from the respective district commands. In particular, the guidelines should emphasize the need to protect civilian
lives from unnecessary "grave risk." The Safety Board concludes that developing and implementing risk assessment guidelines for the deployment of surface SAR units that are similar to those for the deployment of aircraft would enhance the quality of risk assessments by Coast Guard operational commanders. The Safety Board, therefore, believes that the Coast Guard should develop and implement risk assessment guidelines for the deployment of surface SAR units that are similar to those published in Coast Guard Commandant's Instruction 3710.

**Coxswain’s Decision to Leave Mate on Barge**

After returning to the scene, the chief engineer and the mate successfully boarded the barge. After their attempt to drop the anchor had failed, the coxswain was able to retrieve only the chief engineer. The coxswain spent about half an hour attempting to maneuver the MLB near the barge so that he could retrieve the mate, but he was unable to do so because the sea had worsened considerably. He was faced with an extremely difficult decision in weighing the dangers faced by his crew and vessel against the safety of the stranded crewman. The coxswain realized that the MLB was at risk of capsizing in the rough surf and that some of the MLB's electronic equipment was functioning erratically because of the rough seas. He asked for a Coast Guard helicopter to rescue the stranded crewman. He then left because there was nothing more that he could do other than endanger his vessel and crew. The Safety Board concludes that the coxswain's decision to leave after asking for a rescue helicopter for the stranded crewman was reasonable, considering the need to protect his own crew and vessel and his inability to retrieve the crewman.

**Pollution Response**

Because the weather was rough enough to move the oil deflection booms from their intended locations and to hamper cleanup activities, some oil seeped into environmentally sensitive areas, resulting in a significant short-term impact on the fishing grounds and local fisheries. Because the spilled oil was light grade, much of it weathered and evaporated into the atmosphere under the action of sunlight and the turbulent waves, as demonstrated by the tests conducted by the EPA 5 days later, which showed that the level of petroleum hydrocarbon was well below the level considered harmful to marine life. Most of the remaining oil was corralled by the floating booms and mechanically skimmed from the surface by vacuum hoses.

However, NOAA is still assessing the degree of long-term environmental damage, including the impact on fish and bird populations, which are expected to need several years to return to the numbers they had reached before the accident.

As required by the area contingency plan, the responsible governmental agencies, parties, and environmental cleanup resources were notified soon after the crew abandoned the tug that a major oil spill was anticipated. Consequently, pollution cleanup resources were being transported to the scene well before the North Cape's tanks were breached.
The Safety Board concludes that the notifications and the pollution cleanup response were adequate, considering the adverse weather following the accident.
Encourage your member towing vessel companies to develop and implement voyage planning standards and checklists to ensure that adequate risk reduction measures are taken before starting a voyage, including an assessment of weather risks, the adequacy of the vessel's equipment, and of the operational precautions. (M-99-121)

In cooperation with the Coast Guard, develop a means of releasing anchors on unmanned towed barges by remote control from the towing vessel. (M-98-122)

BY THE NATIONAL TRANSPORTATION SAFETY BOARD

JAMES E. HALL
Chairman

ROBERT T. FRANCIS II
Vice Chairman

JOHN A. HAMMERSCHMIDT
Member

JOHN J. GOGLIA
Member

GEORGE W. BLACK, JR.
Member

July 14, 1998

Vice Chairman Robert T. Francis submitted the following statement:

I have concurred in the probable cause of this accident because I believe it adequately addresses the chain of events that ultimately led to the fire aboard the tug Scandia and the subsequent grounding of the Scandia and the tank barge North Cape. However, I can not concur in our criticism of the U.S. Coast Guard coxswain of Station Point Judith for his choice of the 41-foot utility boat for the initial response for the rescue of the crewmembers of the Scandia.

The report acknowledges valid reasons for the coxswain’s initial choice—the utility boat was significantly faster, more maneuverable, and offered greater protection from the weather for the crew and, presumably, for the six rescued passengers from the Scandia tug. According to our investigation, the multi-mission, 41-foot utility boat is used most often to perform most missions, although the 44-foot motor life boat is available for more difficult sea conditions. The coxswain’s decision to take the faster and more agile boat to rescue civilians in serious, life-threatening and immediate danger comport not only with the experience of the coxswain and station command, but also with the Coast Guard’s procedures for deploying the appropriate boat—procedures that the Safety Board finds to be “adequate.”
Of necessity, our accident investigation process reviews actions taken in such incidents with 20-20 hindsight, which enables the Safety Board to make considered decisions and thoughtful recommendations. However, I cannot concur in the use of this distant and cool review to criticize the coxswain's decisions made under immediate, urgent, and critical circumstances on which the lives of the crew of the Scandia depended. The coxswain could have been better informed about the current weather and sea conditions before he left Station Point Judith. Yet, his decisions, the assembly of the duty boat crew, and the launch for the rescue operation all occurred within approximately 5 minutes. I am reluctant to criticize that sort of timeliness where lives are at stake. And, while outcome-determinative analysis is not desirable for Safety Board investigations, this mission was successful—the crew of the Scandia was rescued and the crew of the Station Point Judith 44-foot motor life boat all returned to the station despite the 20-minute delay to return to the station for the 44-foot motor life boat.

The Coast Guard performs the difficult and dangerous job of search and rescue admirably. For the Coast Guard, the answer to the question of initiating a search and rescue operation on our Nation's waters is not "whether" but "when." I want to ensure that our investigation and report here do not discourage prudent, courageous action or dampen the enthusiasm and commitment of those who choose to serve in the U.S. Coast Guard.
1 result for "MARAD-2010-0035-0004"

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Oct. 15, 2012

RADM Roy A. Nash  
Commander, Eighth Coast Guard District  
Hale Boggs Federal Building  
500 Poydras Street New Orleans, LA 70130

Subject: Proposed Offshore Operation of Unmanned Cargo Barges in the Gulf of Mexico.  
USCG Reference: Docket #USCG-2011-0925  
NMA References: GCM-318 & R-202-D

Dear Admiral Nash,

Our Association recently responded to comments on a Petition for Rulemaking by the Parker Towing Company, a major inland towing company in this District. I enclose a copy of the Federal Register notice and the petitioner’s letter.

In our response, we mentioned a number of problems our Association has had in dealing with the general lack of oversight of important workplace issues on "river barges" by the Eighth Coast Guard District between the Coast Guard and OSHA as covered in our Enclosure #4 (NMA Report #R-202-C, Rev. 2) as included as part of our response to the Docket. As far as our mariners are concerned and as expressed to Congress, workplace issues on dry cargo barges appear to be a largely unregulated area that leaves our mariners unprotected.

We also pointed out a concern we previously reported that some local towing companies dispatch “push boats” to work with deck and work barges in construction and oilfield-related activities in exposed waters including open waters of the Gulf and that we never received a response resolving this as a policy issue.

We have additional concerns regarding the assignment of “routes” for “push boats” (towboats) on exposed waters that we believe should be covered in the Towing Vessel Inspection rulemaking project currently being considered.

We also point out in regard to our comments to the Docket that your District might want to respond to this docket regarding the Search and Rescue capabilities available on your portion of the Alabama and west Florida coastline between Mobile and the Eighth District boundary at the Econfina River and in concert with the Seventh District south of the Econfina River to Tampa, FL. Enclosure #5 paints a scenario that might occur in the exposed shallow waters of this coastline.

We also understand that coal is delivered by barge from Myrtle Grove, LA to Crystal River, FL across the Gulf of Mexico. We would like to ascertain how the Eighth District handles load line exemptions, if any, on this existing route.

We would appreciate your views on these issues.

Very truly yours.

Richard A. Block  
Secretary, National Mariners Association
October 15, 2012

Mr. Patrick Mannion (CG-5222)
U.S. Coast Guard headquarters
2100 Second St. SW
Washington, DC 20593

Dear Patrick,

Our Association recently responded to a Petition for Rulemaking for the Offshore Operation of Unmanned Cargo Barges in the Gulf of Mexico – copy enclosed. In this, our Association believes that the towing vessel inspection rulemaking should and will address the assignment of routes for inspected towing vessels including “push boats” on protected and/or exposed waters. We believe in general that inspected “push boats” should be carefully regulated if allowed to operate pushing tows on exposed waters.

Our Association submitted comments in 2005 (NMA Report #R-276, Rev. 9) regarding the provision of anchors and ground tackle on towing vessels. We mention this in our response to the petition (attached).

Realizing that you cannot discuss the Towing Vessel NPRM or accept additional comments at this time, we are furnishing our reply to this request for rulemaking on Docket #USCG-2011-0925 for your information as it may also have a future impact on the Towing Vessel Inspection rulemaking project you are working on. This will become part of NMA Report #R-202-D.

Very truly yours,

Richard A. Block
Secretary, National Mariners Association
October 16, 2012

Supervisor:
Towing Vessel National Center of Expertise
504 Broadway, Suite 101
Paducah, KY 42001

Subject #1: Offshore Operation of Unmanned Cargo Barges in the Gulf of Mexico

Dear Sir,

We recently learned of a petition for rulemaking requesting a load line exemption to move non-load line river barges across exposed waters in the northeast part of the Gulf of Mexico between Mobile, AL and Tampa, FL.

In our response to the Federal Register notice (77FR 59881-59882, Oct. 1, 2012) and the petitioner’s request (copies enclosed) we express concern for the safety of the mariners assigned to the towing vessels that must handle these “unmanned” cargo barges on exposed waters. We also express concerns about possible towing vessel route assignments that allow “push boats” into open waters. As this will most likely depend upon the Towing Vessel Inspection rulemaking currently in progress, we provide a copy of our correspondence for your information and consideration only.

Very truly yours,

Richard A. Block
Secretary, National Mariners Association
Memorandum

Subject: WAIVER OF 10-MONTH RULE IN CGBCMR CASE DOCKET NO. 97-115 (JONES)

From: Chief Counsel, U.S. Coast Guard

To: Chairman, Board for Correction of Military Records (C-60)

Ref: (a) Applicant's DD Forms 149 filed 01 May 1997
(b) CGBCMR Chairman Memo dated 19 August 1997
(c) CGBCMR Chairman Memo dated 02 November 1998

Date: 17 May 1999
5420/3

Reply to Attn. Of: G-LMJ
CDR Ganser
7-0272

1. The Coast Guard requests that the Chairman of the CGBCMR waive the application of the 10-Month time limit in CGBCMR Case # 1997-115 (JONES) and amend the record to reflect this waiver.

2. Consistent with the provisions of 33 C.F.R. § 52.61(c), the Chairman shall accept additional evidence relevant to the application if, and only if, the applicant agrees that the 10-month time limit per §52.68 shall not apply to the case. The additional evidence in this case was the request and the material the Applicant submitted in two letters to the BCMR per references (b) and (c). The Coast Guard requests that the record reflect the fact that the Applicant has waived the 10-month rule for this case.

3. While the Coast Guard intends to submit an advisory opinion on this case in the near future, the above waiver will permit a more extensive review of this case based on the best information available and will allow for a review by the Deputy General Counsel of this case per 33 C.F.R. § 52.64(b) should it be necessary. Thank you...

By direction

M.J. DEVINE

1 In reference (c), Applicant changed his application by amending his requested relief.
Subj: ADVISORY OPINION IN CGBCMR DOCKET 1997-115 (JONES)

d. On 25 February 1981, a Coast Guard Law Specialist consulted with the Applicant and counseled him regarding acceptance or rejection of the CPEB’s findings and recommended disposition. On 06 March 1981, the Applicant rejected the CPEB’s findings and disposition and demanded a hearing before a Formal Physical Evaluation Board (FPEB).

e. On 13 May 1981, a Coast Guard Law Specialist consulted with the Applicant and counseled him regarding his upcoming FPEB along with his alternatives including accepting the CPEB’s findings and recommended disposition. The Applicant chose to accept the CPEB’s findings and recommended disposition and waived his right to a hearing before the FPEB. The acceptance was conditional on the Applicant being discharged on or after 27 May 1981 so that he would qualify for severance pay based on 2 years of service rather than just one year of service.

f. On 06 June 1981, Commandant approved final action of the CPEB’s findings and recommendation. On 15 June 1981, the Applicant was discharged from the service and was paid $2,234.40 in disability severance pay.

g. On 6 January 1982, Applicant filed a claim with Veterans Administration (VA) for disability compensation. On 5 December 1984, the VA rated the Applicant for a service connected disability for Paranoid Schizophrenia, Competent, 50% disabling from 15 June 1981. He was not treated or rated for any such condition while serving on active duty.

h. In a further appeal to the VA in 1993, the VA, in part, affirmed their previous determination made in December 1984 regarding the service-connected disabilities claimed by the Applicant.

4. Summary of Analysis: The Board should deny relief in this case because the Applicant has failed to provide sufficient evidence to merit the waiver of the Statute of Limitations. There is no evidence that the Coast Guard committed error by failing to properly diagnose and rate him for service connected disabilities in 1981 or that the Coast Guard failed to pay him the severance pay authorized under statute.

5. Analysis of the Case:

   a. The Applicant failed to submit a timely application and has not provided any basis or reason why it is in the interest of justice to excuse the delay.

   (1) There record shows that the Applicant was or should have been aware of the allegations he made in his application within three years of his 15 June 1981 discharge date. Applicant indicates that August 1996 was the date of discovery of the alleged error or injustice, over fifteen years after the date of the alleged error. This statement by Applicant contradicts the unrefuted evidence in the record. Applicant acknowledged in CG-4809 dated 13 May 1981, “CPEB Findings and Recommended Disposition”, that he was informed of the Board’s recommended disposition and that he accepted the finding (as long as he received 4 months severance pay). Additionally, Applicant fails to assert or explain why
disabling injuries. Physical Disability Evaluation System Manual, COMDTINST M1850.2C ("PDES Manual") Art. 1-A. The sole standard for a physical disability separation is unfitness to perform duties... (emphasis added). Id., Art. 2-C-2a, Art. 2-A-47. 10 U.S.C. §1203 provides that a disability separation must be based on a finding that the member is "unfit to perform the duties of his office, grade, rank, or rating because of physical disability incurred while entitled to basic pay ..." Before issuing a disability rating, the Coast Guard must first establish that the member is unfit for duty because of a physical disability.

(3) In contrast, the DVA is the principal agency responsible for compensating former service members whose earning capacity is reduced, at any time, as a result of injuries suffered incident to, or aggravated by, military service. See Lord v. United States, 2 Ct. Cl. 749, 754 (1983); CGBCMR Dkt. No. 33-96. The DVA determines to what extent a veteran’s earning capacity has been reduced as a result of physical disabilities, and provides disability compensation as well as other benefits. The procedures and presumptions applicable to the DVA evaluation process are fundamentally different from, and more favorable to the veteran than those applied under the Coast Guard’s Physical Disability Evaluation System. The DVA is also not limited to the time of the Applicant’s discharge. If a service-connected condition later becomes disabling, the DVA may award compensation on that basis. The DVA’s subsequent finding that the Applicant was disabled is not binding on the Coast Guard nor indicative of differing or conflicting medical opinions between Coast Guard and DVA medical officials. Therefore, there was no error or injustice as to his disability rating.

(4) Finally, as to Applicant’s allegations regarding the disability severance pay he received as authorized under Chapter 61, Title 10, the Applicant received disability severance pay in the amount of $2,234.40 on 15 June 1981. See, Applicant S/R, DD 113.1C and Fifth CG District ltr 7220 dated 18 June 1981. The amount of $2,234.40 was equal to four months of the Applicant’s base pay, the statutorily authorized amount. Therefore, there was no error or injustice as to his disability rating or his severance pay.

6. Recommendation. The Coast Guard recommends that the Board deny the relief requested. If the Board determines that other matters merit comment by the Coast Guard, we would welcome the opportunity to address such matters in accordance with 33 C.F.R. §52.64(b), 52.81, and 52.82.
REPORT TO CONGRESS: CHALLENGES TO THE COAST GUARD’S MARINE SAFETY PROGRAM – EFFECTIVELY REGULATING THE TOWING INDUSTRY
Edited by Capt. Richard A. Block, Secretary, GCMA

Table of Contents

The Players ............................................................................................................................................... 1

OSHA Was Supposed to Regulate Dry Cargo Barge Safety But Failed ............................................. 2
Unsafe Working Conditions on Dry Cargo Barges ................................................................................. 2
NTSB Pinpoints the Problem ................................................................................................................... 3
The OSHA Connection ............................................................................................................................. 3
OSHA’s Drops the Ball on Dry Cargo Barges .......................................................................................... 4
OSHA’s Bureaucratic Complaint Review Process Fits Their Needs, Not Mariners’ .............................. 4
Low Towing Industry Standards ..............................................................................................................
OSHA Finally Cites Employer for Unsafe Conditions ............................................................................ 5

NTSB Report on Athena 106 Uninspected Construction Barge Accident (June 2007) ................. 6
The Significance of the problem .............................................................................................................. 6
The accident ............................................................................................................................................. 6
GCMA Criticizes the Coast Guard for not Requiring Equipment Training ........................................ 7
Pertinent NTSB Recommendations ......................................................................................................... 7
Reports Importance to All Towing Vessel Personnel .......................................................................... 8
Athena’s Short Term Significance ............................................................................................................. 9
When the Coast Guard Refuses to Penalize Violators ...................................................................... 9
Safety Management System Recommendations ..................................................................................... 9
Unfulfilled Promises of the OSH Act ..................................................................................................... 10

These OSHA Land-Based Workplace Procedures Are Not Welcome In The Maritime Industry ......... 11
Workplace Deaths Devastate Families, but OSHA Fines are Only Modest – if Employers Pay At All ...... 11
Low Fines Are Appalling ........................................................................................................................... 12
Three Fatalities ....................................................................................................................................... 12
Unclassified Deaths ................................................................................................................................. 13

THE PLAYERS

The American Waterways Operators (AWO) is an effective industry lobby based in Arlington, VA that
represents the nation’s tug and barge industry. In a letter of Aug. 25, 2005, the Coast Guard informed us: “You
also assert that AWO claims to represent 80% of the “tug and barge industry,” and you ask us to verify this
claim. The Coast Guard is under no obligation to verify the claims of AWO, and we neither collect nor maintain
the data necessary to fulfill your request in this regard. Nonetheless, Mr. Miante (G-MSO) spoke with AWO
about the 80% figure. AWO advised us of the following: 1.) using Army Corps of Engineers’ data, AWO
estimates that there are approximately 1,287 towing vessel companies, including those that engage both in
towing and in other endeavors (but excluding government agencies, oil field production, shipyard and other “tug
OSHA WAS carrying pulpwood cargo on the inland waters, specifically the Tennessee-Tombigbee Waterway. This followed an Engineers about unsafe working conditions and unsatisfactory barge maintenance on unmanned dry cargo barges accident in which a deckhand injured. A worker was crushed between barges at organization also reported on Dec. 9, the reports of the Coast Guard investigation of the accident under the Freedom of Information Act.

Island, Mobile, AL. Accidents of this type and fatalities from falls overboard from towing vessels and barges are frequent and well documented occurrences. GCMA, as is customary, requested copies of all three accident reports and •

The Occupational Safety & Health Administration (OSHA), created within the U.S. Department of Labor pursuant to the OSH Act of 1970 that is supposed to firmly and fairly enforce safety and health rules. Congress declared "...its purpose and policy...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." Two Memoranda of Understanding with the Coast Guard in 1983 and 1986 delineated OSHA's responsibility for enforcing their rules on uninspected vessels. This includes all barges that do not carry a Coast Guard Certificate of Inspection including, inter alia, deck barges, dry cargo barges, and many manned and unmanned "work barges." [40 OSH Act, §651]

The Gulf Coast Mariners Association (GCMA) is a voluntary membership association of licensed and unlicensed mariners who serve on commercial vessels like tugs, towboats, oilfield vessels, and small passenger vessels of up to 1,600 gross register tons.

The House Committee on Transportation and Infrastructure took the first step to change the status of towing vessels to "inspected vessels" in 2004. In a hearing held on Aug. 2, 2007, the Subcommittee on Coast Guard and Maritime Transportation considered "Challenges Facing the Coast Guard's Marine Safety Program." GCMA offers this report to the Committee in addition to our written testimony to identify a major "Challenge" to the safety program that none of the other parties previously presented. Since both the Coast Guard and OSHA ignored the matter for the past 37 years, we assert that that neither Executive Branch agency as presently constituted should be entrusted to address this challenge.

OSHA WAS SUPPOSED TO REGULATE UNINSPECTED DRY CARGO BARGE SAFETY BUT FAILED

[Source: GCMA Newsletter #26, Nov. 2004.]

Unsafe Working Conditions on Dry Cargo Barges
On Dec. 8, 2003, GCMA filed formal complaints with the Coast Guard, OSHA, and the U.S. Army Corps of Engineers about unsafe working conditions and unsatisfactory barge maintenance on unmanned dry cargo barges carrying pulpwood cargo on the inland waters, specifically the Tennessee-Tombigbee Waterway. This followed an accident in which a deckhand fell through an open manhole cover on the deck of a barge at night 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. 6, 2003 in the Triangle Fleet, at Reserve, LA. The same mariner organization also reported on Dec. 9, 2003 that a tugboat crewman was crushed between a barge and the pier at Pinto Island, Mobile, AL. Accidents of this type and fatalities from falls overboard from towing vessels and barges are frequent and well documented occurrences. GCMA, as is customary, requested copies of all three 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 estimated to number in excess of 17,000. These barges exist and will continue to exist as "uninspected" commercial vessels.
The NTSB Pinpoints the Problem

In the ATHENA 106 report discussed below, the NTSB stated (pg.39) that: "No regulatory agency inspects operations — general working conditions, safety gear, equipment, and operating practices — on barges that are not subject to inspection. Coast Guard oversight is limited to examining the lifesaving and firefighting equipment on certain uninspected vessels such as MISS MEGAN. OSHA investigates only after an accident, in the case of an employee complaint, or as part of a "special emphasis" program focusing on particular workplace safety hazards...This accident illustrates that before an accident occurs, no agency currently inspects operations involving barges not subject to inspection, and that even if a material defect or unsafe work practice exists, in the absence of no complaint no preventive regulatory action will take place."

In its analysis of a recent accident(14) (p.40) the Safety Board stated: "When the new regulations supporting the Coast Guard and Maritime Transportation Act of 2004 are promulgated, they should restate the master's responsibility for his vessel and for the safety of the vessels in tow. The new regulations will add a layer of oversight for vessels under tow that are not subject to inspection. Although towboats will be inspected under the new rules, monitoring of workplace safety aboard barges such as ATHENA 106 needs to be improved. The memorandum of understanding that the Coast Guard and OSHA signed in 1983 was "intended to eliminate confusion among members of the public with regard to the relative authorities of the two agencies." The memorandum does not address uninspected vessels. Although OSHA has exercised its jurisdiction over workplace safety on barges after accidents, responsibility has been divided between the two agencies. With the advent of regulations for towing vessels, the gap will shrink between vessels subject to inspection and uninspected barges such as the ATHENA 106. The Safety Board concludes that workplace safety on uninspected vessels should be more closely observed before accidents occur, and that the agreement between the Coast Guard and OSHA should reflect the new regulatory scheme, address all specifics of workplace and navigational safety, and encourage communication between the two agencies and industry. ["The Athena 106 accident, p.40, is described later in this report. 14 A subsequent MOU in 1996, reprinted in GCMA Report #R-347, discusses uninspected vessels in greater detail.]

Our mariners who work on uninspected towing vessels face additional dangers when they work on many uninspected barges. GCMA documented the nature of the dangers with a number of photographs in our reports of the mariner who fell through the manhole at night.

The OSHA Connection

As uninspected vessels, dry cargo barges are subject to inspection by the Occupational Safety and Health Administration (OSHA). However, the full extent of this OSHA involvement is spelled out in the 1996 OSHA Directive noted above.

In the case of the mariner who fell through the manhole cover, the OSHA Regional Administrator in Atlanta responded to our complaint in a letter that outlined the procedures mariners must do to report unsafe conditions on uninspected cargo barges. These procedures involve filing written reports of safety violations — something our mariners hesitate to do. Such reports easily compromise the employment of barge workers and towboat crewmembers who serve as "employees at will" throughout the industry regardless of scrupulous protection of "confidentiality." Furthermore, "penalties" do not provide for medical care for any injuries that occur on these barges — an extremely important item. Many employers ignore "maintenance and cure" and medical bills as a result of these accidents in order to ignore and starve out potential litigants. Consequently, injured parties must hire attorneys to represent them.

Although towing vessels are now designated as "inspected" vessels, this 2004 statute does not apply to unmanned cargo barges towed by these vessels. This is in contrast to most tank barges that come under the jurisdiction of the Coast Guard, are regularly inspected, and carry Certificates of Inspection (COI). If a barge does not have a COI, it is an "uninspected" vessel. The Coast Guard marine safety program carefully attends to the condition of "inspected" tank barges but washes its hands of concern for dry cargo barges, deck barges and others without a Certificate of Inspection.

[GCMA Comment: One of the "Challenges" facing Congress is to provide for the safety of mariners and barge workers on all types of "uninspected" barges. We want to point out that neither the Coast Guard nor OSHA brought this matter to the attention of Congress. Consequently, in light of this failure to either recognize or address the issue, we question whether the Coast Guard should continue to oversee the nation's commercial vessel inspection program.]
[GCMA Comment: We see this as part of a pattern by AWO to avoid the regulation of a large part of its assets in spite of the industry's poor safety record. Refer to GCMA Report #R-351, Rev. 1, How Safe Is The Towing Industry?]

Unless Congress takes action, thousands of dry cargo barges that do not carry “certain dangerous cargoes” will remain under OSHA control and will continue to be very dangerous and unregulated workplaces for our mariners and other barge workers. Chances are excellent that any injuries they receive will not be properly investigated by either agency. GCMA submitted our comments in a 302-page report titled Investigations – Shortcomings in Personal Injury Reporting and Recordkeeping as Part of Accident Reporting to the Department of Homeland Security, Office of the Inspector General on Mar. 10, 2007.

OSHA Drops the Ball on 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 your 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 6T30, Atlanta, Georgia 30303. (404) 562-2300 phone (404) 562-2295 fax. Attn: Team Leader - Enforcement Programs[1] [2][3][4][5][6][7][8][9][10].

"The vessel's Master, Captain David C. Whitehurst, a GCMA Director, immediately contacted OSHA and provided all information required. He kept in touch with his injured crewmember, the Coast Guard, OSHA and USACE. The Atlanta office covers AL, FL, GA, KY, MS, NC, SC & TN.]

OSHA’s Bureaucratic Complaint Review Process Fits Their Needs, Not Mariners’

“OSHA’s complaint process allows for anonymous and formal notices of hazards. OSHA evaluates each complaint to determine how it can be handled best—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 whistle blower 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 Standards

Our Association urged that towing vessels be inspected as early as May 15, 2001 when we published GCMA Report #R-276[11] and presented it to the Towing Safety Advisory Committee (TSAC), a Federal advisory committee. We included in that report is Item #72, “Inspect Dry Cargo Barges for Workplace Safety.” The ninth
One of GCMA Report #R-276’s conclusions is that the Responsible Carrier Program does meet existing Coast Guard regulatory standards as far as they go. However, the standards the Coast Guard set for towing industry vessels are unacceptably lower than the standards it sets for other comparable commercial vessels. Over 30,000 mariners work in the towing industry and are at risk unless properly regulated. Three years after Congress ordered towing vessels to be inspected, the Coast Guard still has not issued a Notice of Proposed Rulemaking. Furthermore, TSAC—which is dominated by industry lobbyists from AWO—has commandeered the rulemaking process as we pointed out in GCMA Report #R-417, Rev. 1, Report to the 110th Congress: Request for Congressional Oversight on the Towing Safety Advisory Committee.

Conditions that are unsafe and violate existing regulations on a small passenger vessel or an offshore supply vessel often turn out to be perfectly legal on uninspected vessels. We cite as an example, that the Coast Guard claimed to be powerless to prevent a towing vessel from operating without any engineroom doors since they had no regulations specifically outlawing the practice. Although they acknowledge the hazardous nature of this shortcoming in “downstreaming” operations where a towboat can sink if the current forces the vessel side to the current and water pours through the opening and floods into the engineroom, they left the vessel’s crew at risk. Many towing vessels sank when caught in downstreaming maneuvers as documented in a widely circulated videotape sponsored jointly by the Coast Guard and AWO. However, the fact that Coast Guard never sought authority from Congress to deal with this and other common sense situations clearly dangerous to life and limb eroded the credibility of their “marine safety” programs with our mariners.

The reason for turning a blind eye to safety is longstanding collusion between the Coast Guard and towing industry management or a laissez-faire attitude that allows retiring Coast Guard officers to accept lucrative positions in the industry they regulate. This collusion or attitude was manifested in an intense lobbying effort in Washington a number of years ago whose result is euphemistically called a “partnership.” Only company management is invited to partner with the Coast Guard—not labor unions or our mariners. This “partnership” as evidenced in the operation of the Towing Safety Advisory Committee effectively stifled many legitimate complaints from working mariners.

OSHA Finally Cites the Employer for Unsafe Conditions

In response to our formal complaint and another filed by the injured employee, OSHA inspected the worksite (the pulpwood barge) approximately eleven (11) months after the deckhand was seriously injured falling through an open manhole cover while attempting to pump the barge in the middle of the night. The employer failed to provide the deckhand with prompt medical care for his injury at the time and, as a result, he was seriously disabled and lost months of work.

Consequently, OSHA notified the employer, Marine Carriers, Inc. in Mobile, AL. 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.” (Duh!)

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—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 significant to note that the injured deckhand had to hire an attorney after the accident and seek reimbursement for his medical expenses, pain and suffering. He later reported he was not satisfied with the way the attorney handled the case. He no longer works in the industry.

[GCMA Comment: An appropriate legislative remedy needs to be provided to insure that our mariners receive immediate medical treatment for injuries received on uninspected barges and receive adequate compensation for resulting time off the job. GCMA Report #R-333, Don't Count On Corporate Compassion or Coast Guard Concern – True Stories of Our Lost, Injured, and Cheated Mariners, cites additional incidents of a similar nature.]

The OSHA Debt Collection Notice subsequently sent to Marine Carriers, Inc. contained 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."

We have no idea if OSHA ever collected the "reduced penalty." The entire procedure as respects protection of our mariners is entirely unsatisfactory.

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<th>NTSB REPORT ON ATHENA 106 CONSTRUCTION BARGE ACCIDENT</th>
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| [Source: GCMA File #M-660. GCMA Newsletter #43, Oct. 2006 provided press accounts on the fire that killed the crew of a towboat and most of the construction crew of Construction Barge Athena 106 in an accident in Cote Blanche Bay, LA. On June 14, 2007 the NTSB released its full report on the accident as NTSB/MAR-07/01 described below.]

The National Transportation Safety Board 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.

The accident itself is straightforward and easy to understand: The aft 5-ton mooring spud used to anchor the deck barge, accidentally released, dropped upon, and ruptured an 8-inch high-pressure gas pipeline while penetrating 17-feet into the bay bottom causing a gas cloud to surface, explode, and claim six mariner lives. The NTSB investigators were unable to determine the mechanical reason why one drum of the winch released the spud although the winch operator survived the accident.

This event insinuates itself into a number of other high profile events that are finally reaching the attention of Congress and are currently under careful consideration after being downplayed for years by the Coast Guard and the towing industry.

The Significance of the Problem

First, consider this paragraph taken from page 29 of the full NTSB report:

"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 379 explosions or fires occurred on barges or towboats during the same period killing 14 people."

One common feature that most construction barges, dry cargo barges, tugboats, and towboats have in common is that they are uninspected vessels.
The Accident

On Oct. 12, 2006, the *uninspected* towing vessel MISS MEGAN was pushing two *uninspected* 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 which carried creosote pilings and other supplies for the job. The MISS MEGAN was secured astern of 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 barge and used for mooring) on the ATHENA 106 suddenly 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 and another barge worker was missing and presumed dead. The MISS MEGAN deckhand and one barge worker, the winch operator, survived. *A second point in common was that all the fatalities were Jones-Act seamen.*

"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. If the ATHENA 106 crew had used the available steel pin lying on the deck next to the spud to secure the retracted spuds during their transit, the pin would have prevented the aft spud from accidentally deploying. 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 failed—as it did.

Contributing to the accident was the failure of Central Boat Rentals to require, and the MISS MEGAN’s 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 MEGAN master or the deckhand checked whether the spuds were 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 employees on its barges* to use the securing pins to hold spuds safely in place before transiting from one site to another.

GCMA Criticizes the Coast Guard for Not Requiring Equipment Training

Our Association criticizes the Coast Guard’s longstanding inattention to safety and vocational training for lower-level personnel, especially persons performing engine room duties on towing vessels. We extend our criticism to include the lack of training for operating equipment required to raise and lower spuds on barges that are equipped with them. While we believe the NTSB correctly places the burden of contributing to the accident upon both the towing vessel master and the deckhand for not checking to see that both spuds were “pinned,” it fails to mention that mariners need to be trained and checked out to operate all sorts of equipment before being expected to operate or even check it. In this case, the equipment was a diesel engine powered deck winch that did not even have an instruction manual. The Coast Guard consistently ignored the lack of training in the past and continues to do in regulating our lower-level mariners. Here are several notable examples:

Example #1: The Coast Guard “assumed” all towing vessel officers knew how to use radar and every towing vessel had charts. The Bayou Canot accident proved this was an incorrect assumption that had to be remedied by requiring attendance at radar school and by requiring charts and publications. This was pure ignorance and lack of knowledge about the industry they were regulating.

Example #2: The Coast Guard assumes that all towing officers can figure out how to use fancy new Automatic Identification System (AIS) electronic equipment without formal training. They ordered expensive equipment installations on thousands of towing vessels without requiring adequate training in its use.

Pertinent NTSB Recommendations

Recommendations the NTSB made as a result of this accident investigation include:
To the Occupational Safety and Health Administration:
• Review and update your Memorandum of Understanding with the Coast Guard to specifically address your respective oversight roles on vessels that are NOT subject to Coast Guard inspection. (Recommendation #M-07-4)
• Direct the Maritime Advisory Committee for Occupational Safety and Health (MACOSH) to issue the following documents 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. (Recommendation #M-07-5)

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. (Recommendation #M-07-6).
• 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. (Recommendation #M-07-7)

[GCMA Comment: Two memoranda of understanding between these two Executive Branch agencies in 1982 and 1996 failed to provide effective workplace safety and protection to mariners serving on uninspected vessels including barges. The death toll, as well as reported and unreported injuries, is unacceptable and must be addressed. It is time to reconstitute, reassign, and provide adequate resources to inspect currently neglected merchant vessels including 5,200 tugs and towboats, 17,000 dry cargo barges, and 4,000 “work barges” manned by our lower-level mariners.)

Report’s Importance to All Towing Vessel Personnel

The preceding summary does not do justice to the full report available on the NTSB website. These important long-term problems must be corrected:
• Deck barges that carry construction equipment such as ATHENA 106 must become subject to inspection. Unless uninspected barges are brought under an effective inspection system, safety in the workplace and the accident rate will not improve.
• Small towing vessels, even those less than 26 feet in length used in moving construction equipment must be inspected and their operators trained and licensed. This directly opposes lobbying efforts by AWO on behalf of certain of their members.
• If equipment is installed on uninspected barges, mariners must be trained to operate and perform preventive maintenance on that equipment – from electronics to engineering and deck machinery.
• Other special purpose work or production barges, including barges with living quarters on them will that are not inspected should be regulated and inspected.
• Congress ordered the Coast Guard to inspect “uninspected” towing vessels in 2004. However, three years later, the Coast Guard still has not proposed the new regulations. Unfortunately, promulgating final regulations for 5,200 towing vessels is still 15 years away.
• Mariners work on as many as 17,000 dry cargo barges that are also “uninspected” vessels. The Occupational Safety and Health Administration (OSHA) regulations prevail in areas not regulated by the Coast Guard. Yet, OSHA appears powerless to conduct meaningful and timely safety inspections unless the vessel is tied to the dock, fully accessible to their land-based inspectors, and a written complaint is on file. Other OSHA regulations, cited above, almost guarantee that these vessels will never be subjected to an inspection until after a catastrophe. In the meantime, our mariners remain at risk. We note that the Coast Guard does not even require minimal lifesaving gear be provided on these uninspected barges. Consequently, neither agency effectively protects our mariners!

[GCMA Comment: We believe that this longstanding gap in regulatory supervision over the towing industry requires immediate Congressional action rather than simply adjusting memoranda of understanding between two Executive Branch agencies overly influenced in the past by industry lobbyists.)

• The Coast Guard inspects some barges under 46 CFR Subchapter I as “Miscellaneous Vessels.” They inspect floating drilling rigs under Subchapter I-A, “Mobile Offshore Drilling Units.” They also inspect tank barges
under 46 CFR Subchapter D, “Tank Vessels” or 33 CFR Subchapter O. Our concern in this report is not for these vessels because their mariners have an acceptable standard of regulatory protection.

- Death and injury on uninspected inland drilling barges was the subject of a famous case that reached the U.S. Supreme Court and was decided in early 2002. This case explored the relationship between OSHA and the Coast Guard and ultimately left regulation of uninspected vessels up to Congress. **Uninspected vessels continue to be an area in which the absence or conflicts of regulations must be addressed.**

**Athena’s Short Term Significance**

Of course, not all deck barges are “spud barges” like the ATHENA 106; and this was a unique accident. Yet, at any time, a tugboat or towboat officer or even a deckhand may be faced with the job of moving or mooring a spud barge. This includes understanding and safely operating deck equipment such as winches and associated parts. From a safety aspect, and in the absence of any specific regulations, from now on, it will be absolutely essential for our licensed and unlicensed mariners to remember to “pin” every raised spud in the “up” position so it cannot possibly drop – even in short field moves. That’s the simple, easy lesson in safety that six men paid for with their lives. It is a short-term safety lesson we urge each of our readers to heed. Yet, regulations seem to sprout from fatal accidents. and there is more to this than meets the eye.

There will be other important lessons that come from this accident that will apply to other loosely-regulated “work barges” that the Coast Guard and OSHA have inefficiently and ineffectively regulated or flat-out refused to regulate over the years.

**When the Coast Guard Refuses to Penalize Violators**

The NTSB report on ATHENA 106 shows in crystal clear fashion how the Coast Guard and OSHA failed to effectively protect maritime workers on the ATHENA 106. OSHA did visit the ATHENA 106 when it returned to port after the accident and did cite the owners for “serious violations.” The penalty, whatever its undisclosed amount, did absolutely nothing for the deceased mariners and their families!

GCMA also filed numerous complaints with our local Marine Safety Unit when another local employer placed its maritime workers at risk by taking advantage of the “uninspected” nature of their manned work barges. They under manned their manned tug/barge combinations, sent inland push boats into exposed offshore waters in rough weather, violated the 12-hour rules, and failed to repair a broken sanitation system and pumped raw sewage overboard for months on end. Despairing of action by the Coast Guard either locally or from the Coast Guard Hearing Office in Arlington, VA, at the national level, we turned our file over to auditors from the Department of Homeland Security Office of the Inspector General on Mar. 5, 2007 along with our other information about investigations. In addition, GCMA leveled other complaints against the way that the Coast Guard enforces hearing protection regulations and regulations protecting mariners from the hazards of asbestos. One of our GCMA Directors filed a case in Federal district court against his employer on this issue. Neither the Coast Guard nor OSHA protected him against egregious asbestos exposure in his workplace on board an oilfield liftboat.

**Safety Management System Recommendations**

The American Waterways Operators (AWO), the towing industry’s trade association and the Coast Guard currently are grappling with the task of putting together a viable safety management system (SMS) for the entire towing industry to upgrade their existing “Responsible Carrier Program.” AWO hopes to base this SMS upon the base established by their existing Responsible Carrier Program (RCP). However, although it may represent 80% of the tug and barge industry, AWO does not represent the entire industry – including possibly more than 1,200 tug and towboat vessel owners. Yet the Coast Guard failed to mobilize the entire tug and industry in its rulemaking. Nevertheless, the NTSB ATHENA 106 report makes it clear that a safety management system also may well be required for “work barges” in the future.

[GCMA Comment: We agree with NTSB that an effective safety management system should extend to all uninspected barges including 17,000 dry cargo barges and 4,000 work barges that the Coast Guard, OSHA, and AWO have ignored for far too long.]

We have had complaints from our mariners about AWO’s existing safety management system (i.e., the
“Responsible Carrier Program”). One towing vessel Master, also a GCMA Director, finds that the Responsible Carrier Program already transfers new administrative duties directly to licensed personnel on towing vessels without providing adequate support by the office and field supervisory staff:

“...We like many things about the American Waterways Operators’ Responsible Carrier Program (RCP). RCP has helped promote safety. However, as you can see, this has become more a safety maintenance system than a physical inspection system in design.

“As Captain, I do not appreciate the shift of responsibility from management to crew. I do not think RCP should be used as a substitute or a model for a physical inspection of towing vessels for the following reason. The RCP does not take into account the time needed to conduct drills, hold meetings, and do all the required paperwork. The crew off-watch must participate on its own time in this additional work.

“As Captain, I am not left in a position to make the RCP a priority over my boat’s performance. The real world comes first! If there is not enough time in a hitch to complete the REC requirements they simply remain unfinished.

I have been pressed to complete documents with a "satisfactory" report when weather or other factors; prevented us from actually conducting drills or holding meetings. It forced me to work over the 12-hour work rule many times.

I say this in confidence. All the enclosed (24) documents would no doubt be considered sensitive proprietary materials to AWO and others including my employer. However, I need to show them to you in hopes they help you understand the paperwork required by the RCP and will bring to light some of the hidden problems it causes for working mariners”

“Oh, yes not to mention five men, 24 hours per day, 365 day a year must operate and maintain a very active towing vessel. This includes engine and deck maintenance, shopping for food and boat supplies, carrying them back to the boat, traveling, and – of course – all the administrative work...”

Unfulfilled Promise of the OSH Act

“The Congress declares it to be its purpose and policy...to assure as far as possible every working man and woman in the nation safe and healthful working conditions and to preserve our human resources...” [79Sec. 651, OSH Act, 1970]

The Coast Guard ignored and failed to apply the Occupational Safety and Health Act effectively to maritime enterprises for far too long. Starting with a Memorandum of Understanding between the Coast Guard and OSHA signed on March 8, 1983, OSHA accepted the “...standards and regulations ...generally set forth at 46 CFR Chapter 1, and in the Coast Guard’s Marine Safety Manual and in its Navigation and Vessel Inspection Circulars.” Of these cites, only the regulations contained in the Code of Federal Regulations are enforceable and contain sanctions and penalties. Furthermore, the Memorandum stated that “Based on OSHA’s interpretation of section 1(b)(1), and as a result of the Coast Guard’s exercise of its authority...OSHA has concluded that it may not enforce the OSH Act with respect to the working conditions of seamen aboard inspected vessels.” “Nothing in this MOU pertains to uninspected vessels.” Consequently, tugs, towboats, dry cargo barges, and various other work barges remained subject to OSHA. Consequently, most of these vessels effectively remained outside OSHA’s purview for over 30 years and still are essentially unregulated today.

In several areas such as hearing protection and asbestos removal and abatement, the Coast Guard has issued “guidelines” such as NVICs rather than enforceable regulations as OSHA has done. This failure to use enforceable regulations instead of “guidelines” leaves our mariners at risk. In examples covering adequate protection of deck openings (such as leaving manhole covers open), we searched in vain for any Coast Guard regulation whatsoever­­ even on inspected vessels. On the other hand, OSHA covers this area with prescriptive regulations in appropriate and enforceable regulations in as it should be covered to protect our mariners in regulations like 29 CFR 1910.23. However, as luck would have it, OSHA could not enforce this regulation on an inspected vessel. OSHA’s performance on protecting the mariner who fell through an open manhole cover on the uninspected dry-cargo pulpwood barge cited above was less than stellar. [10GCMA Report #R-349, Protecting Mariners’ Hearing]

This NTSB ATHENA 106 report should be an important step in drawing attention to a situation that received far too little attention. The statistics regarding fatalities are alarming enough. Add to that, the Coast Guard’s penchant for ignoring the timely filing of personal injury reports that GCMA also brought to the Inspector General’s attention earlier this year. Whether injured Jones-Act seamen were treated or cheated, it happened on an individual basis with most of the gruesome details often withheld by confidentiality agreements.

In addition, the desperate and primitive working conditions on many substandard uninspected dry cargo barges also need attention as the remainder of this report illustrates. We hope that the ATHENA 106 NTSB accident report will help draw a connection between the work barges and dry cargo barges as “uninspected vessels” and dangerous workplaces.
The repercussions of this accident may be long-lasting. We believe this is one advantage of having the National Transportation Safety Board conduct ALL maritime safety accident investigations using full-time professional accident investigation specialists instead of the Coast Guard current and flawed investigative system that suffers from constant rotation of personnel and the shortage of professional investigators. We reinforce the message we brought to the attention of Congress in our report on “investigations.”

"["GCMA Report #R-129. GCMA Report to Congress: How Coast Guard Investigations Adversely Affect Lower Level Mariners."

THESE OSHA LAND-BASED WORKPLACE PROCEDURES ARE NOT WELCOME IN THE MARITIME INDUSTRY

[Source: OSHA: Discounted Lives. By Mike Casey, Kansas City Star, Dec. 11, 2005. To reach Mike Casey, call (816) 234-1305 or send e-mail to mcasey@kcstar.com. Copyright 2005, Knight Ridder.]

Workplace deaths can devastate families, but OSHA fines are often modest—if employers 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—which had a fatal accident only four years earlier—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” — removing the word “willful” in describing the violations—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, Kan., 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.
MEMO TO: Jim Wilson, Investigations  
FROM: Richard A. Block  
March 14, 2002

I received a call from Captain Wilbert Eskine who works for BJ Services. He told me that his towboat/barge combination is now working near the mouth of the Mississippi River. The question (problem) is one of safety and has to do with the location of this uninspected towing vessel attached to an industrial vessel that is supposed to operate.

It is understood that the vessel operates in two places that would be shown on a block chart. Both places are reportedly in "state waters".

One location is Chandleur Sound, Block 58. As Captain Eskine said, once he leaves the safety of Bayou Baptiste Collette he is "committed". He must travel 3 1/2 hours in with a flat-bottom tow to location. The Chandleur Islands are so badly eroded that they present no protection from the wind from the southern and eastern quadrants. If the weather changes, he is out in the middle of nowhere and 3 1/2 hours from safety. If he must run over 12 hours, he has to turn control of the vessel over to an unlicensed person. This is presently the problem that may involve a possible civil penalty.

The barge normally has two spuds he can drop in 20 feet of water. However, one of the spuds is broken and the company has been reluctant to repair it...like it's still broken. He has filed a complaint with the company safety officer in Houston but, as of Friday afternoon, nothing has been done.

The second location where they are working is in West Delta Block 84 or 41. One of these blocks actually shows he is on land. He believes it is really West Delta Block #82 in 12 feet of water. The problem is that this area, although it is in shallow water is open to ground swells from the Gulf that often threaten to break the barge from the tow or, to quote: "The swells are tearing us up."

These vessels normally work in protected waters and Captain Eskine questions the safety of sending these vessels into unprotected waters.

I would appreciate it if you could work with your "inspection" people and see what you can or cannot do to protect our mariners.

[Signature]

33 ENCLOSEMENT #2A
§45.171 Purpose.

(a) This subpart establishes a special load line regime under which certain unmanned, river-service, dry-cargo barges may be exempted from the normal Great Lakes load line requirements while operating on certain Lake Michigan routes. Depending upon the route, the barge may only need a limited service domestic voyage load line, or may be conditionally exempted from load line assignment.

(b) Except as provided in this subpart, barges operating on Lake Michigan must have either an international load line assignment issued in accordance with the International Convention on Load Lines, 1966, as amended, or a Great Lakes load line assignment issued in accordance with the requirements of this part.

(c) The requirements of this subpart are summarized in Table 45.171:
### Table 45.171:
Load Line Requirements for Dry Cargo River Barges Operating on Lake Michigan

<table>
<thead>
<tr>
<th>Voyages between Calumet Harbor, IL and:</th>
<th>Burns Harbor, IL</th>
<th>Milwaukee, WI</th>
<th>St. Joseph, MI</th>
<th>Muskegon, MI</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Load line requirement</td>
<td>Conditionally exempted from load line requirement</td>
<td>&quot;First service domestic round&quot; load line</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Where to register/apply</td>
<td>Excepted cargoes must be registered with the USCG Marine Safety Unit - USA Painted Brand, Milwaukee, WI, 53227</td>
<td>Apply for load line at ABS Americas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) Eligible barges</td>
<td>Dry cargo river barges</td>
<td>Built and maintained in accordance with ABS Rules</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Length-breadth ratio less than 22</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>All weathertight and watertight closures are in proper working condition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4) Freeboard requirement</td>
<td>All barges: Freeboard must be at least 24 inches (610 mm)</td>
<td>Open-hoister barges: Minimum height at freeboard must be at least 14 inches (355.6 mm)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5) Tow limitations</td>
<td>Tugboat must be unscrewed</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>No more than 6 commercial tugs per hour</td>
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<td></td>
<td></td>
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<tr>
<td>6) Cargo limitations</td>
<td>Dry cargo only</td>
<td>Liquid cargo, except oil or tar products, are prohibited</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>No hazardous materials</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>7) Weather limitations</td>
<td>&quot;No weather&quot; only</td>
<td>Ice conditions: adverse conditions that impair steer or access to shelter</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sustained winds:</td>
<td>Sustained winds:</td>
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<tr>
<td></td>
<td>18 tbs from NE, E, SE</td>
<td>18 tbs from N, NW, W, NW</td>
<td></td>
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<tr>
<td></td>
<td>21 tbs from N, NW, W, NW</td>
<td>21 tbs from NE, E, SE</td>
<td></td>
<td></td>
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<tr>
<td>8) Pre-departure plans:</td>
<td>Required - as specified in § 46.181</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9) Towboat requirements</td>
<td>(a) Power</td>
<td>Sufficient to handle tow, but at least:</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>1,022 HP</td>
<td>1,903 HP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(b) Communication system:</td>
<td>Recommended - § 46.186(a)</td>
<td>Recommended - § 46.186(a)</td>
<td></td>
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<tr>
<td></td>
<td>(c) Catg wheel:</td>
<td>Recommended - § 46.194(a)</td>
<td>Recommended - § 46.194(a)</td>
<td></td>
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<tr>
<td></td>
<td>(d) Operational plan:</td>
<td>Recommended - § 46.197</td>
<td>Recommended - § 46.197</td>
<td></td>
</tr>
</tbody>
</table>

| (a) | All weather tight and watertight closures (doors, gaskets, covers, etc.) must be in proper working condition. | | |

### §45.173 Eligible barges.

Only barges meeting the following requirements are eligible for the special load line regime under this subpart:

(a) Unmanned, river service, dry-cargo barges;

(b) Barges that have been designed and built to at least the minimum scantlings of the American Bureau of Shipping River Rules which were in effect at the time of construction;

(c) Barges with a length-to-depth ratio less than 22;

(d) Barges on the Milwaukee route must not be more than 10 years old; and

(e) All weather tight and watertight closures (doors, gaskets, covers, etc.) must be in proper working condition.

### §45.175 Applicable routes.

This subpart applies to the following routes, including intermediate ports, on Lake Michigan, between Calumet Harbor, IL, and—

(a) Milwaukee, WI (the "Milwaukee route");

(b) Burns Harbor, IN (the "Burns Harbor route");

(c) St. Joseph, MI (the "St. Joseph route"); and

(d) Muskegon, MI (the "Muskegon route").
§45.177 Freeboard requirements.
(a) All barges must have a minimum freeboard of 24 inches (610 mm).
(b) Additionally, open hopper barges must have a combined freeboard plus cargo box coaming height of at least 54 inches (1,372 mm).

§45.179 Cargo limitations.
(a) Only dry cargoes may be carried.
(b) Hazardous materials, as defined in part 148 of this chapter and 49 CFR chapter 1, subchapter C, may not be carried.

§45.181 Load line exemption requirements for the Burns Harbor and Milwaukee routes.
Barges operating on the Burns Harbor and Milwaukee routes may be conditionally exempted from load line assignment provided that the following requirements are met:

(a) Registration. Before the barge's first voyage onto Lake Michigan, the owner or operator must register the barge in writing with the Commanding Officer, Marine Safety Unit Chicago, 355A Plainfield Road, Willowbrook, IL, 60527. The registration must include the following information:
   (1) Barge name and official documentation number;
   (2) Owner and operator (points-of-contact, company addresses and telephone numbers);
   (3) Service route (Milwaukee and/or Burns Harbor);
   (4) Design type (covered/uncovered hopper, deck, etc.);
   (5) External dimensions;
   (6) Types of cargo; and
   (7) Place built and original delivery date.

(b) The registration must include a statement certifying that:
   (1) The barge has been designed and built to at least the minimum scantlings of the ABS River Rules which were in effect at the time of construction; and
   (2) The owner or operator agrees to maintain the barge in serviceable condition and comply with the applicable provisions of 46 CFR part 45, subpart E.

(c) Expiration. Registration is valid only until the latest of the following events:
   (1) The tenth anniversary of the delivery date (for barges on the Milwaukee route),
   (2) The barge no longer is fit for this service (due to damage), or
   (3) The barge changes ownership or operators (registration is not transferable to new owners or operators; the barge must be re-registered if it is to continue in Lake Michigan service).

(d) Notification. The owner or operator of an exempted barge must notify the OCMI of the transfer of ownership or change of operator, withdrawal from Lake Michigan service (due to damage, age, or other circumstances), or other disposition of the barge.

§45.183 Load line requirements for the St. Joseph and Muskegon routes.
(a) Load line certificate. (1) The load line issued under this subpart must be a limited-service, domestic-voyage load line.
   (2) Except as provided under paragraph (b)(2)(vi) of this section, the term of the certificate is 5 years.
   (3) The load line certificate is valid for the St. Joseph and Muskegon routes, and intermediate ports. However, operators must comply with the route-specific requirements on the certificate.

(b) Conditions of assignment. (1) An initial load line survey under §42.09-25 of this chapter and subsequent annual surveys under §42.09-40 of this chapter are required.
   (2) At the request of the barge owner, the initial load line survey may be conducted with the barge afloat if the following conditions are met:
      (1) The barge is less than 10 years old;
§45.185

(1) The draft during the survey does not exceed 15 inches (380 millimeters); (2) The barge is empty and thoroughly cleaned of all debris, excessive rust, scale, mud, and water. All internal structure must be accessible for inspection; (iv) Gaugings are taken to the extent necessary to verify that the scantlings are in accordance with approved drawings; (v) The hull plating (bottom and sides) and stiffeners below the light waterline are closely examined internally. If the surveyor determines that sufficient cause exists, the barge be drydocked or hauled out and further external examination conducted; and (vi) The initial load line certificate is to be issued for a term of 5 years or until the barge reaches 10 years of age, whichever occurs first. Once this certificate expires, the barge must be drydocked or hauled out and fully examined internally and externally.

§45.186 Tow limitations.

(a) Barges must not be manned;
(b) No more than a total of three barges per tow may operate on the Milwaukee, St. Joseph, and Muskegon routes. A mixed tow of load-lined and exempted barges is still limited to three barges on those routes.
(c) Tows must not be more than 5 nautical miles from shore.

§45.187 Weather limitations.

(a) Tows on the Burns Harbor route must operate during fair weather conditions only.
(b) The weather limits (ice conditions, wave height, and sustained winds) for the Milwaukee, St. Joseph, and Muskegon routes are specified in §45.171, Table 45.171.
(c) If weather conditions are expected to exceed these limits at any time during the voyage, the tow must not leave harbor or, if already underway, must proceed to the nearest appropriate harbor of safe refuge.

§45.191 Pre-departure requirements.

Before beginning each voyage, the towing vessel master must conduct the following:
(a) Weather forecast. Determine the marine weather forecast along the planned route, and contact the dock operator at the destination port to get an update on local weather conditions.
(b) Inspection. Inspect each barge of the tow to ensure that they meet the following requirements:
(1) A valid load line certificate, if required, is on board;
(2) The barge is not loaded deeper than permitted;
(3) The deck and side shell plating are free of visible holes, fractures, or serious indentations, as well as damage that would be considered in excess of normal wear;
(4) The cargo box side and end coamings are watertight;
(5) All hatch and manholes dogs are in working condition, and all covers are closed and secured watertight;
(6) All voids are free of excess water; and
(7) Precautions have been taken to prevent shifting of cargo.
(c) Verifications. On voyages north of St. Joseph, the towing vessel master must contact a mooring/docking facility in St. Joseph, Holland, Grand Haven, and Muskegon to verify that sufficient space is available to accommodate the tow. The tow cannot venture onto Lake Michigan without confirmed space available.
(d) Log entries. Before getting underway, the towing vessel master must note in the logbook that the pre-departure barge inspections, verification of mooring/docking space availability, and weather forecast checks were performed, and record the freeboards of each barge.

§45.193 Towboat power requirements.

The towing vessel must meet the following requirements:
(a) General. The towing vessel must have adequate horsepower (HP) to handle the tow, but not less than the amount specified for the routes below.
§ 45.195 Additional equipment requirements for the Muskegon route.

Towboats on the Muskegon route must meet these additional equipment requirements:

(a) Communication equipment. Two independent voice communication systems in operable condition, such as Very High Frequency (VHF) radio, radiotelephone, or cellular phone. At least two persons aboard the vessel must be capable of using the communication systems.

(b) Cutting gear. Equipment that can quickly cut the towline at the towing vessel. The cutting gear must be in operable condition and appropriate for the type of towline being used, such as wire, polypropylene, or nylon. At least two persons aboard the vessel must be capable of using the cutting gear.

§ 45.197 Operational plan requirements for the Muskegon route.

Towing vessels on the Muskegon route must have on board an operational plan that is available for ready reference by the master. The plan must include the following:

(a) The cargo limitations, the general operational requirements, and the special operational requirements of this subpart.

(b) A list of mooring and docking facilities (with phone numbers) in St. Joseph, Holland, Grand Haven, and Muskegon, that can accommodate the tow.

(c) A list of towing firms (with phone numbers) that have the capability to render assistance to the tow, if required.

(d) Guidelines for possible emergency situations, such as barge handling under adverse weather conditions, and other emergency procedures.

APPENDIX A TO PART 45—LOAD LINE CERTIFICATE FORM

GREAT LAKES LOAD LINE CERTIFICATE

No. Issued under the authority of the Commandant, U.S. Coast Guard, United States of America, under the provisions of the Act of August 27, 1935, as amended to establish load lines on the Great Lakes of North America, and the Load Line regulations in force on Nov. 18, 2010, duly authorized by the Commandant to issue said load line certificate.

Ship Certificate No. 
Official No. 
Length (LBP) 
Gross tonnage 
Port of registry 

Type of Ship: 
TYPE "A" 
TYPE "B" 
TYPE "B" with increased freeboard

FREEBOARD FROM DECK LINE

Midsummer ____________________________ M5 Summer ____________________________ S Intermediate ____________________________ I Winter ____________________________ W

LOAD LINE ____________________________ above S 
__________________________ above S

Upper edge of the trough center of diamond below S 
__________________________ above S

below S 

Increase for salt water for all freeboards 

The upper edge of the deck line from which these freeboards are measured is __________ inches above or below the top of the ______________ deck at side.

This is to certify that this ship has been surveyed and the freeboards and load lines shown above have been found to be correctly marked upon the vessel in manner and location as provided by the load line regulations of the Commandant, U.S. Coast Guard, applicable to the Great Lakes.

This certificate remains in force until ____________________________.

Issued at ____________________________ on the ____________________________ day of ____________________________.

(Here follows the signature, seal, if any, and the name of the authority issuing the certificate.)

NOTES

(1) In accordance with the Great Lakes Load Line Regulations the diamond and

1Upon the expiration of the certificate, renewal must be obtained as provided by the Great Lakes Load Line Regulations and the certificate so endorsed.