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Asserting our right "…to petition the Government for redress of grievances."
Amendment 1, U.S. Constitution, Dec. 15, 1791

DEPLORABLE TREATMENT OF "LIMITED-TONNAGE" MARINERS
(Don't Count On Corporate Compassion or Coast Guard Concern: True Stories of Our Dead, Injured & Cheated Mariners)

Edited by Capt. Richard A. Block, Secretary, National Mariners Association

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EXECUTIVE SUMMARY

There are in excess of 210,000 certificated merchant mariners in the United States. Of this number, approximately 126,000 are "limited-tonnage" mariners serving on vessels of less than 1,600 gross tons.

The towing industry is an important segment of the U.S. Merchant Marine and employs at least 32,000 people on an estimated 6,100 towing vessels. The Government predicts that waterborne commerce will increase substantially in the next decade. Nevertheless, the marine industry faces a growing shortage of personnel to man its vessels. Although many industry leaders don't seem to have a clue as to the causes of the underlying problem, this paper provides anecdotal evidence from a number of "limited-tonnage" mariners that deserves attention.

In 1996, **American Inland Mariners Association**, a predecessor of NMA rallied a large number of mariners to respond to proposed changes in licensing regulations that went into effect in 2001. As a result, over 800 comments were submitted to the public rulemaking docket. Although a number of serious issues were raised, many were poorly handled after the release of the resulting Final Rule because of subsequent mismanagement by the Marine Safety Directorate at Coast Guard Headquarters, many of the Coast Guard's Regional Exam Centers, and above all by the National Maritime Center.(1) *[(1)Refer to NMA reports to Congress #R-428-D and #R-428-D, Rev. 1.]*

In 1998, **Pilots Agree,** a grass roots mariner organization with a reported membership of 1,500, staged a job action when the management of towing vessel companies refused to meet with its organizers to discuss working conditions. Although the strike eventually was broken, so was the morale of mariners in mid-America and with it went the myth that management truly respected its towing vessel officers.

In June 2000, our Association published a book titled <u>Mariners Speak Out on Violations of the 12-Hour Work Day</u>. The book, presented to senior Coast Guard officials at District and national Headquarters level, was a snapshot of conditions submitted by 57 mariners. The book is posted on our website as our report #R-201. The Coast Guard Marine Safety Directorate under Rear Admiral Pluta ignored the book and refused to investigate its allegations. This paper goes beyond our Report #R-201 and is why we renumbered it as #R-202.

ISSUE: MAINTENANCE AND CURE EXPLAINED

By Mark L. Ross, Esq.

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Maintenance and Cure

Maintenance. As a matter of law, a seaman is entitled to maintenance and cure from his employer if he becomes injured or ill while working aboard his vessel. In some circumstances, a seaman may be entitled to maintenance and cure if hurt while working in the course of his employment even if off his vessel.

"Maintenance" is a form of seaman's workers' compensation. Maintenance is a daily stipend, generally in the $15 to $20 range. However, if you can show your living costs are more than $15 to $20 per day, as is usually the case, you can prove what your actual living expenses are to a court and get an award for the amount. Generally, maintenance includes expenses like room and board that you would not have to pay if you still worked aboard your vessel. Shoreside costs like clothes cleaning bills would not be included under maintenance.

A boat company must pay an ill or injured seaman maintenance from the day he became ill or injured until he recovers. Alternatively, a boat company must pay its ill or injured seaman maintenance until a doctor says the seaman has reached maximum medical cure. <u>Maximum medical cure is the point where although a seaman may still be ill, a doctor says he cannot do anything more to improve the seaman's condition</u>.

If the question of whether a seaman has reached maximum medical cure is disputed by the boat company and the seaman, a court can decide the issue. Generally, a court will favor the opinion of the doctor who has actually treated the seaman, as opposed to a company "independent medical examiner" physician who may have only seen the seaman once or twice.

Cure. Cure is a maritime term meaning that a boat company has to pay a seaman's medical bills arising out of the illness or injury the seaman suffered while on duty aboard his vessel. A boat company must pay 100% of the seaman's medical bills even if the seaman has health insurance. The boat company has to pay 100% of the injured or ill seaman's medical bills <u>until the seaman reaches maximum medical cure</u>.

Defense to payment of maintenance and cure: Concealment and misconduct. A boat company can avoid paying maintenance and cure for only two reasons. First, a boat company does not have to pay maintenance and cure if they can show the seaman lied on his employment application about his health. A common example is if a seaman says he hurt his back while working. If the boat company finds that the seaman hurt his back before working for that company, but denied any prior back injury on his employment application, the boat company could refuse to pay maintenance and cure for the second back injury. The prior injury must be directly related to the injury or illness at issue, however, and the boat company's employment application must clearly ask the seaman about the prior illness or injury.

Second, a boat company can avoid paying maintenance and cure if a seaman's injury or illness results from "misconduct." Most "misconduct" cases involve someone getting sick or hurt due to misuse of drugs or alcohol. Courts have similarly ruled that a seaman cannot get maintenance and cure from illnesses caused by sexually transmitted diseases or from active AIDs since those are likewise deemed to result from "misconduct."

This article is not intended to be a complete discussion of this often complicated area of seaman's rights. The National Mariners Association wants to inform its mariners that these rights and remedies exist so that, if necessary, they can ask their employers or an attorney about their rights to maintenance and cure.

CASE #1: DEFICIENT MANNING & ILLEGAL WORK-HOURS WRECKS CAPTAIN'S LIFE AND CAREER (THE VERRET CASE)

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Our Association's Role in Protecting Our Mariners

Since this case involved members of our Association and was an egregious violation of Federal work-hour statutes (i.e., the 12-hour rule), we followed every step of this case as it unfolded and prepared this report to inform our mariners. In addition, we shared this report with Congressional oversight committee staffs.

In June 2000, our Association prepared a book titled Mariners Speak Out on Violations of the 12-Hour Workday[1] that we call our "Yellow Book." We documented 57 written complaints by 57 "limited-tonnage" mariners, many in their own handwriting and presented a copy of this book to RADM Paul J. Pluta in May 2000 when he was the Eighth Coast Guard District Commander.

Our "Yellow Book" reported for the first time that a large number of violations of existing work-hour statutes that occurred in both the offshore oil and the towing sectors of the maritime industry. These are sectors where our "limited-tonnage" licensed and unlicensed mariners serve on commercial vessels of less than 1,600 gross register tons. Our mariners, for the most part, are not represented by established maritime labor unions with the power to bargain for a contract with their employers. Therefore, they must accept whatever is offered to them, serve at the pleasure of their employers as "at will" employees, and may be terminated for any reason whatsoever and at any time. *[[1]NMA Report #R-201.]*

Previously, on May 11, 2000, in a letter to Congressman "Billy" Tauzin, RADM Paul Pluta stated in part: "Recently my staff conducted an informal survey of a cross section of Eighth Coast Guard District Marine Safety Offices to get a feel for the volume of 12-hour rule complaints we receive. This survey indicated that the Eighth District Marine Safety Offices have received very few complaints involving mariners being forced to work more than 12 hours. However, when we receive such a complaint, it is aggressively investigated and appropriate action taken…" Our Association never saw evidence of such actions on the part of the Coast Guard and, shortly thereafter delivered copies of the "Yellow Book" to both RADM Pluta and Congressman Tauzin. Admiral Pluta later became Assistant Commandant for Marine Safety where he actively "stonewalled" the book that clearly refuted parts of his letter to Congressman Tauzin.

Based our experience, licensed mariners seldom report work-hour violations because they fear they will lose their jobs if they complain about them. Through a loophole in the Fair Credit Reporting Act and as a result of the close-knit nature of the sectors of the maritime industry that employ our limited-tonnage mariners, being fired by one employer, whether justified or not, can lead to a mariner being "blacklisted" throughout the entire industry. This is an unwarranted waste of experienced manpower in increasingly short supply. It has a long-lasting and devastating effect on mariner morale.

After his promotion to the post of Chief of Marine Safety (etc.) at Coast Guard Headquarters, Admiral Pluta never stopped smiling for a moment while stonewalling our mariners' earnest efforts to have his agency actively enforce existing work-hour regulations. To make matters worse, large numbers of unlicensed mariners like deckhands, tankermen, "deckineers," and unlicensed engineers have no federal work-hour protection whatsoever. These mariners may be called upon to work almost unlimited hours with little if any rest – not unlike the sailors in Richard Henry Dana, Jr's Two Years Before the Mast written in 1840..

The American Waterways Operators (AWO), an industry trade association, "recommends" that its 200+ member companies not exceed a 15-hour workday for unlicensed personnel. We reported to Congress, the Coast Guard, and the Towing Safety Advisory Committee that such work-hours are excessive and can translate into a 105-hour workweek or more. The Coast Guard still chooses to ignore the problem[1] and, never saw any need to ask Congress for legislation to correct the situation and protect our mariners from exploitation. Our Association repeatedly asked Congress to set the same work-hour limits for unlicensed mariners as it has established for officers of towing vessels.[1] *[[1]Refer to NMA Report #R-350, Rev.6, Issues "H" & "K"]*

Training Towing Vessel Officers Became a National Issue After 1993

Captain Collins Verret, a career tugboat Captain suffered a debilitating stroke at sea on Dec. 3, 2000. One of the principal causes of his stroke was that his company expected him to train his newly licensed mate how to move anchors for the pipe-laying barge **Midnight Brave** while they still expected to stand his own watch and be

responsible for all aspects of managing his towing vessel.

The law that governs officer work-hours on towing vessels states: "Subject to exceptions, 46 U.S. Code §8104(h) permits a licensed master or mate (pilot) operating a towing vessel…to work not more than 12 hours in a consecutive 24-hour period except in an emergency.[1] The Coast Guard interprets the law, in conjunction with its other provisions, to permit licensed masters or mates (pilots) serving as operators of towing vessels that are ***not*** subject to the provisions of the Officers' Competency Certificates Convention, 1936,[2] to be divided into two watches regardless of the length of the voyage". *[[1]46 CFR §15.705(d). [2]Towing vessels in coastwise service of less than 200 gross register tons, such as the M/V Mohawk Brave, are not subject to this convention.]*

The practical effect of this work-hour statute and regulation requires the second in command to be a competent boat handler fully able to handle any situation that may arise while he is on watch. Otherwise, the two-watch system will not work as intended. However, some employers manage to rationalize all sorts of excuses for extending work-hours and are seldom challenged by Coast Guard officials unless there is an investigation related to an accident.

The master is fully responsible for setting the vessel's watch schedule. If the master, in sole command of the vessel, finds that he must take the time to assist or supervise a mate who is either inexperienced or not competent to safely perform all or part of his job, he automatically violates the "12-Hour Rule" if he must remain on duty beyond his established watch unless there is a true emergency that could not have been foreseen and planned for. Coast Guard Policy Letter G-MOC#4-00, Change 1[1] goes into even more detail on the responsibilities of the master and the employer. *[[1]Refer to NMA Report #R-370, Rev. 3]*

In the testimony given by the company operations manager and personnel manager, the job of anchor handling is a specialty that requires an experienced deck crew and pilothouse personnel. These company officials stated that they would ***never*** assign an unqualified mate who was not fully capable of maneuvering the vessel or handling anchors to work alone with a qualified master. Nevertheless, they did exactly that to Captain Verret in this case.

Captain Verret was a fully qualified master with 46 years experience on the water with most of that time spent serving on uninspected towing vessels in domestic and foreign waters. Company managers claimed that Captain Verret was the person responsible for reporting on the qualifications or shortcomings of his mate since he worked with him on a daily basis. Yet, the "at will" status of Captain Verret's employment led him to avoid "rocking the boat." Although he did ***ask*** for an experienced mate but had to settle for a man he could work with but was ***NOT*** fully trained in the specialized and demanding job of "***anchor handling***."

Testimony revealed that the company, although it operated more than 100 vessels, had no established training routine for advancing from mate to master, even on vessels where the difficult and dangerous job of anchor handling was a specialty. Apparently, after an experienced deckhand earned his Coast Guard mate's license, he was free to continue to serve as a deckhand and spend his own off-duty time observing the licensed officers perform their duties. However, anchor handling is not only difficult but hard work as well. This discouraged many company employees from seeking anchor-handling work until, following this accident, the company finally offered incentive pay for this type of work.

While the company claimed that Captain Verret's mate was fully qualified in all respects to handle anchors, neither the mate (in his own testimony under oath) nor Captain Verret agreed with that assessment. In fact, Captain Verret complained about having to train a new mate as well as operate and manage the boat because he knew he would have to spend well in excess of 12 hours at work each day to stand his own watch and, in addition, watch over his new mate. In addition Captain Verret's brother-in-law, Capt. Frank Billiot, who also worked for the same company at the time, was a fully qualified and experienced anchor handler and specifically asked to be assigned to work with Captain Verret on this job – but was sent on a different boat up the east coast.

The manner of training pilothouse personnel became a national issue following the Amtrak disaster at Bayou Canot, AL, in Sept. 1993. Following the accident caused by a barge pushed by the towing vessel Mauvilla that struck a railway bridge killing 47 train passengers and Amtrak crewmembers, new licensing regulations were adopted and went into effect on May 21, 2001. The purpose of these new regulations was to provide adequate training for persons who advance from deckhand to towing vessel officer and serve in the pilothouse in a meaningful apprenticeship program. While these regulations were not in effect at the time of Captain Verret's stroke and would not be fully in effect in the industry before May 21, 2006, this accident is an excellent example of why such regulations are necessary.

After May 21, 2006, a deckhand with a total of 18 months service on deck on a vessel, of which 12 of those months must be on a towing vessel, may be given his first formal opportunity to advance into the pilothouse for training purposes only. To be accepted for pilothouse training, the deckhand must demonstrate his interest in

advancement by first passing a written Coast Guard examination. Essentially, this examination is the same exam the Coast Guard has given since 1975 although, through the years, many of the questions became more difficult in light of new regulations. In any event, the exam involves the same subjects that all existing towing vessel masters and mates were tested on. Some training schools now offer brief (120-hour) Coast Guard approved courses to pass the exam to obtain a new apprentice mate (steersman) "learners permit" while home study and testing at a Regional Exam Center still remains an alternative.

The new apprentice mate/steersman "learners permit" does ***not*** authorize its holder to operate a towing vessel alone. There must always be a fully licensed towing vessel officer, either a master or a mat/pilot, in the pilothouse and a fully licensed master in charge of the vessel. To help ensure that meaningful training takes place, an apprentice mate/steersman must maintain a detailed Towing Officer Assessment Record (TOAR).(1) The purpose of this TOAR is to ensure that the apprentice mate/steersman demonstrates to a Designated Examiner that he is capable of handling the vessel and performing any tasks that vessel is assigned to undertake. One such task ***should be*** anchor handling that is widely practiced in pipe-laying and other practical areas of offshore marine construction. Although these requirements were strengthened and updated by a TSAC working group in Oct. 2011, they still do not include anchor handling! *[(1)Refer to NMA Reports #R-287-A thru D.]*

At the end of his formal apprenticeship, and after making formal application to the Coast Guard and turn in his completed TOAR and provide sea service letters documenting 360 actual days of sea service as an apprentice, and the required time spent on each route he worked (described in these broad terms: oceans; near-coastal; Great Lakes and inland; and western rivers), he will receive a license as mate/pilot of towing vessels without further formal schooling or examination. However, if the Coast Guard catches an apprentice operating a towing vessel without a supervising master or mate/pilot in the pilothouse with him, he can lose his authority to be trained as can the master or mate that is supposed to be on watch at the time. Following the M/V Mel Oliver collision with the T/S Tintomara in July 2008, both the Coast Guard and Congress became more attentive to work-hour violations and licensing issues. *[Refer to 46 CFR §11.465 & 11.466.]*

The purpose of these new regulations is to allow a year devoted to formal, hands-on training in the pilothouse for a deckhand with at least 1½-years experience on deck. It will also mean that a company must pay for an "extra man" to train in the pilothouse if they expect to generate any new trained personnel rather than steal them from their competitors. "Good" towing companies started apprenticeship programs while the usual crowd of "substandard operators" often tried to "pencil-whip" the new regulations. Unfortunately, if the past is any guide to the future, the Coast Guard is likely to bend to the wishes of industry to relax enforcement and punish delinquent mariners in the well-oiled administrative justice system whenever something goes wrong. The administrative justice system is not "mariner-friendly".(1) *[(1)Refer to NMA Report #R-204, Rev. 3.]*

An NTSB "Most Wanted" Safety Recommendation: Scientifically-Based Hours-of-Work Regulations

Work-hour violations are closely tied to fatigue and to a number of accidents throughout the entire transportation industry – including trucking, railroad, airline, and maritime sectors. This correlates closely with one of the National Transportation Safety Board's "Most Wanted" safety reforms "…to help eliminate fatigue as a causal factor in transportation accidents by studying the relationship between fatigue and accidents within the transportation industry; and updating each industry's hours-of-service regulations." Since 1989, the National Transportation Safety Board called for "scientifically-based hours-of-work" as one of their ten most wanted transportation safety improvements.(1) *[(1)NTSB Recommendation M-99-1.]*

Recent "crew endurance" studies by the Coast Guard reiterate that ***human beings need between seven and eight hours of uninterrupted sleep on a daily basis***. This does not appear to mesh well with the six hours on/six hours off duty (6&6) schedule and the 84-hour workweek the existing 12-hour rule allows. But, in the cases we cite in our "Yellow Book," and in this case in particular, the 12-hour rule is most noteworthy by the fact that it is violated so often and is rarely enforced and hardly ever investigated. In fact, the lack of an existing standardized logbook requirement makes the work-hour regulations violations virtually impossible to enforce.(1) This has been a long battle, and our Association and its members demanded changes. Congress supported our efforts by requiring "Official Logbooks" that require logging watch changes on all inspected vessels (including towing vessels) by amending 46 U.S. Code §11304 in 2010. Mariners will have to wait and see if the Coast Guard enforces or ignores the new law. However, we are determined that the sacrifices of Captain Collins Verret and his family will not have been made in vain. *[(1)Refer to Docket #USCG-2002-12581.]*

The Verret Family Tragedy: An "Inevitable" Fatigue Injury

On Dec. 4, 2000, Rita Billiot called to tell us that her brother-in-law Antoine Collins Verret, master of the anchor-handling tug M/V Mohawk Eagle owned at the time by Double Eagle Marine, was found unconscious in his cabin after suffering a stroke on the vessel while it was returning to an anchor-handling job for the pipe-laying barge Midnight Brave 60 miles offshore in the Gulf of Mexico. She reported that Collins was evacuated by helicopter to Lake Charles Memorial Hospital. Rita reported that the company called her sister Catherine, Collins' wife, about 6:00 a.m., and told her that her husband was "rather sick." She would later learn that this was an understatement and that Collins was, in reality, close to death.

A company representative, in trying to minimize the seriousness of the illness, provided additional details to Rita over the phone indicating that Collins' condition was extremely grave. Somehow, Rita in a near panic, managed to drive her sister, Catherine, at speeds approaching 80 mph, more than 150 miles to Lake Charles where Collins now lay in intensive care partially paralyzed, incoherent, and just barely conscious.

After several days as his condition stabilized, Collins was transferred by ambulance to the Terrebonne General Medical Center near his home in Houma, LA, where he would spend several weeks in the rehabilitation unit. It was at this point where friends, family, and eventually our Association's officers would first view the devastation caused by the stroke that left him paralyzed on his left side and barely able to speak.

Eleven years later, Collins remains paralyzed on his left side. He is wheelchair-bound, unable to walk without direct supervision, cannot write or use his left hand. Much water passed under the bridge in the years following his stroke. Collins Verret's story should provide food for thought for any mariner who chooses or is forced to do the work of two men, work long hours often under harrowing conditions, and to the point of exhaustion on the job.

According to testimony taken under oath, Collins was an exemplary mariner. During his 45 years of service in the marine industry, he had a clear Coast Guard record, a clean driving record, had never been involved in a serious accident. He was well liked by his company personnel manager who considered him a "friend" and was respected by both his crew as well as the customer he was working for. One crewmember went so far as to say that both of the barge captains on the Midnight Brave "loved" him. It was clear that when Barge-Captain Nini heard of Collins' stroke he moved heaven and earth to get an evacuation helicopter into the air and en route to the scene – with no delay and without any inane questions as to who would pay the bill. Collins is friendly and soft-spoken and was dedicated to performing whatever job he is given to the very best of his ability…as he proved by sacrificing his health in this case. This case can provide several very important lessons for our mariners. One of those lessons involves the stress and fatigue that working on commercial and largely unregulated towing vessels can cause.(1) *[(1) Refer to NMA Report #R-403.]*

In the mid-1990s, Captain John R. Sutton, President of the American Inland Mariners Association (AIM), made inquiries of many knowledgeable masters and river towboat pilots and found that their average lifespan was only slightly over 57 years. His study was as thorough as possible under the circumstances although admittedly not "scientific".

For "science" in Captain Verret's case, we rely on the sworn testimony of Dr. John Stirling Meyer, a researcher on stroke at the Veterans Administration Medical Center and Professor at Baylor College of Medicine in Houston, TX. Dr. Meyer presented an expert opinion that stated in part: "The fatigue, sleep deprivation, and stress experienced by Captain Verret, more probably than not, aggravated or contributed to his stroke." This testimony given in a 115-page deposition is so convincing that we forwarded a copy to the National Transportation Safety Board to consider as supporting evidence in their ongoing "scientific hours-of-work" project.(1) *[(1)NTSB Recommendation M-99-1.]*

Captain Verret was 59 years of age at the time of the stroke that left him permanently and completely disabled. "Disabled" means that Collins must spend the rest of his life in a wheelchair dependent upon his wife, Catherine, and other members of his immediate family as caregivers.

Our Association hears of many mariners that worked on boats all their lives with the intention of retiring from the industry someday – as Captain Verret planned to do in several years. Regrettably, many mariners develop health problems that force them out of the industry before they can reach an age covered by Social Security and/or Medicare. This is a result of the aging process accompanied by stressors unique to this industry including:

- unreasonably harsh working conditions;
- long-term vessel undermanning;
- working with untrained crewmembers including "green" deckhands prone to accidents;
- working excessively long hours;
- running the boat in rough weather, during hours of darkness and in fog with limited visibility;
- enduring years of poor diets;
- drinking unsanitary and impure drinking water;

- frequent interruptions of sleep by noise and vessel motion;
- years of smoking or being forced to live with exposure to second-hand tobacco smoke;
- high accident rates caused by dangerous and largely unregulated working conditions on uninspected towing vessels.[1] *[[1]Refer to GCMA Report #R-276, Rev.10.]*

These conditions help to explain why the "average" lifespan of a towing vessel officer may be shortened by years. For survivors, career ending medical problems may occur long before the date when Social Security and/or Medicare coverage kicks in. In addition, many "limited-tonnage" mariners work "off-and-on" for many different employers, live paycheck to paycheck, and have no viable plans to fund their retirement. Few boat companies offer pensions that have a reasonable expectation of rewarding years of loyal service! In fact, with so many mergers, buyouts, and other wheeling and dealing common to this industry, coupled with the cyclical nature of the towing and oil sectors, simply holding a job requires a high degree of good luck. "At-will" employment serves as a stark reminder to do as you are told and never "rock the boat." It is virtually unheard of to question policies dictated by mid-level executives who, like Collins' personnel director, never had any first-hand experience working on boats. Without this experience, it is easy to see why "the company's bottom line" took precedence over assigning a second trained and experienced mate to assist with the training duties dumped on Captain Collins Verret.

There are so many bumps and pitfalls in the job market facing our "limited-tonnage" mariners that ***union membership***, training, insurance, and the other plans that membership offers provide the only organized cure to these ills on the horizon. Above all, union membership requires mariners to face these issues squarely and work together with other company employees and not at cross purposes to solve problems that employers and regulators ignored for years and, most likely, will continue to ignore. The new towing vessel inspection regulations proposed in August 2011 after seven years in the making offer very little in the way of ameliorating working conditions.

This story reinforces and updates the letters written by dozens of our mariners relating the true stories of violations of work-hours statutes in our "Yellow Book". We watched in shock and amazement as the Coast Guard at the Eighth District and at the national level ignored constant violations of the laws designed to protect our mariners. We heard the President of the Offshore Marine Services Association (OMSA), a trade association representing offshore vessel owners, deny that work-hour violations even exist. We watched the National Offshore Safety Advisory Committee (NOSAC), a federal advisory committee appointed by the Secretary of Transportation, cater to industry wishes and do its best to sidetrack and dismiss our allegations of work-hour violations. This came to a boil in April 2002 when a dozen of our Association directors and members traveled to Coast Guard Headquarters and dumped NOSAC's bungling mess into the Coast Guard's lap claiming, after wasting 1½ years, that it had no power to investigate our claims. In spite of promises extracted from RADM Pluta, the Coast Guard never investigated a single one of the 57 separate claims about the ongoing statutory violations. The Coast Guard apparently has no plan to have the owners of uninspected towing vessels or offshore supply vessels "clean up their act" by adequately manning their vessels and stop overworking their personnel.

Finally, in Feb. 2003, our Association pulled the problem from the Coast Guard and brought it directly to the attention of the media and several Congressional oversight committees and kept our focus on the problem ever since.[1] *[[1]Refer to NMA Report #R-350, Rev. 6.]*

An Injured Mariner Must Have First Class Legal Representation

This report will give our mariners an idea of the problems a seriously injured mariner faces to obtain the care and attention he rightfully deserves following an accident.

Captain Verret's sister-in-law, Rita Billiot, called us on behalf of her family for advice. Our Association recommended that her family seek legal counsel from Mark L. Ross, Esq. Mr. Ross visited with the family at the hospital in Lake Charles, LA, on the day after the accident and took charge of the situation to ensure that Collins' immediate and long-term medical needs were attended to. In doing so, he sought to work with the company, R& B Falcon, and its insurer. The vessel itself was in the process of being transferred from one owner to another.

When the attorneys for the new owners, Delta Towing made things difficult in a number of ways, Attorney Mark Ross filed a lawsuit and brought the matter to a head. In the meanwhile, Delta Towing procrastinated and failed to come forward with the mate, a key witness to this tragic event, for almost two years. During this time, Collins and Catherine and their family were left to their own limited means to do their best to try to cope with their shattered lives. This part of the story is unforgivable on the part of Delta Towing (as successor to R&B Falcon). Our Association condemns the hardship that this company and its attorneys perpetuated.

In acknowledging the referral of this case, Attorney Ross reminded our Association's officers that he owed his undivided allegiance to his client, Collins Verret and his family, and that he would do his best to secure a fair and

full monetary settlement for them so that they could try to pick up the pieces of their lives.

Since this was the most horrendous example of a violation of the 12-hour statute we witnessed to date, ***we hoped that a victory in court based on violations of the 12-hour rule would prove once and for all that all licensed mariners were clearly entitled to protection under the law. This did not happen because this case, like so many others finally was settled quietly "out of court."*** Consequently, the towing company can say it broke no laws, is guilty of nothing, and settled amicably with their former employee. It's the truth, but it is certainly not the whole truth. This is why we examined this case so carefully.

Nevertheless, the final settlement did ensure that Captain Verret and his family would receive compensation for damages – following 2½ years of privation, anxiety, additional stress, and suffering. Sadly, the damage done to Collins and his family can never be repaired or restored.

If a Judge had arrived at a decision after court proceedings, his decision might have set a clear precedent all injured mariners could look to. But, at this point, we believe it would be best to replace the existing 12-hour statute by "scientifically based hours-of-work regulations" not only for officers but also for other crewmembers as well. A twelve-hour workday limit takes into consideration certain "human factors" that cannot be denied. But ***Congress, rather than the Coast Guard, will have to order a 12-hour workday for unlicensed crewmembers because the Coast Guard lacks the authority to do so***. Our Association formally requested that Congress take this action.(1) *[(1) Refer to NMA Report #R-350, Rev. 6, Issues "H" & "K".]*

Our Association asserts that any new work-hour statutes should be based on suitable scientific studies. Congress ordered and received a Coast Guard Crew Endurance Management Study (CEMS) in 2005. While the science was excellent, the results did not justify using CEMS procedures as a substitute for adequate vessel manning. In public meetings, in October 2011, industry leaders show no willingness to find a way to provide for a proven human need for 7 to 8 hours of uninterrupted sleep for their mariners in any 24-hour period. For the present, the NTSB recommendations for scientifically based hours of service regulations are just that – ***recommendations***. They will remain a pipe dream unless Congress takes action and the Coast Guard enforces it. Limited-tonnage mariners who take a stand on this issue and refuse to be a party to breaking existing work-hour laws and regulations(1) will fight a losing battle until the law is changed and the Coast Guard enforces it. The existing 84-hour workweek that employers violate with impunity and the Coast Guard refuses to enforce must change. Unfortunately, it often takes a disaster to bring about changes. Even then, the last clear work-hour disaster that took out the I-40 Bridge at Webbers Falls, OK, along with 14 lives and $30,000,000 in damage apparently was not enough.

Ungrateful Company Owners and Officials

*[**Source:** Article by Rita Billiot in Newsletter #8]*

I am prompted to write this letter after what happened to my brother-in-law, Collins Verret.

Collins has been a mariner all his life. He's in his late 50s. He was working on the boat when he had a stroke. Crewmembers found him on the deck in his room,(1) where he had gone to try to get some rest after working far beyond his normal shift.(2) He is left-handed; now he is paralyzed on his left side and confined to bed and a wheelchair. ***[Editorial notes:*** *(1)See "Lies, Ignorance, or Incompetence?" below. (2)The "truth" is that he had worked for almost 48 hours without meaningful relief. This was revealed in depositions taken two years after the stroke.]*

He was being overworked on the job. Nobody cared that he could not get the rest he needed, and did not eat right. He is now is a man that is not able to do anything for himself anymore. He is depressed all the time, feels useless because he cannot support his family anymore. His son had to drop out of school to help his mother, who is not well herself, to take care of his dad…

What gets to me the most is that not one of the company owners or officials from the company office ever went to the hospital to see about him. They have not as much as called. They even tried to get out of paying his benefits by saying that it was not an "at fault" incident. Might I say though, that members of our Association did go see about him and have kept up with his progress.

With all I have seen with my husband being a mariner (and my brother and brother-in-law were also mariners), these company "higher ups" are the most unappreciative, ungrateful, unconcerned bunch of employers I have ever seen. They could care less about what happens to these men when they get hurt while working for them or get fired for a stupid reason, as happened to my husband.(1) As long as they have their bills paid, drive their nice vehicles, go home to their fancy houses in the best neighborhoods, eat at the finest restaurants, they simply don't care. They need to remember one thing though. It's our husbands, the men who sweat and risk their lives and licenses that make possible the owners big fat paycheck. *[(1)R&B Falcon fired her husband for refusing to leave port on an international voyage until his tug's navigation equipment was repaired. He finally sued and recovered for wrongful termination.]*

Who am I? I am a concerned wife of a seaman who is fed up with the abuse and the neglect from these companies. I am staying in contact with our Association to try to put a stop to these companies that are abusing and neglecting their employees. Since there are "rules and regulations" for the mariners to follow and there should be "rules and regulations" for these companies to be held accountable for as well. They need to be held accountable for breaking the rules just like the seaman are when something happens on a boat. Sincerely, Rita Billiot.

Lies, Ignorance, or Incompetence?

Somewhere around 11:30 on the evening of Dec. 2, 2000, in very rough weather while returning to the pipe-laying barge they were servicing, the mate of the tug Mohawk Eagle on reaching the pilothouse found the tugboat plowing through heavy seas on automatic-pilot with Captain Verret lying on the pilothouse floor. One deckhand was told later that morning that he heard that Collins "…was laying on his knees by the chair holding on." The mate asked if Collins hurt himself and Collins reportedly said, "no" and that he was simply tired and just wanted to sleep. The mate found this highly unusual, said he suggested that Collins go below to his cabin but reported receiving a reply that it was too rough to go below. The mate gave him a pillow and left him lying on the deck. Collins had suffered a stroke that the mate apparently did not recognize.

For the next six hours, Collins continued lying on the pilothouse floor, apparently asleep. It was only when the pipe-laying barge called at 05:30 the next morning to start the day's work that the mate attempted to arouse Collins but was unable to do so. When his deckhand reported for duty at watch change, he had him call the cook and asked him to bring Collins' sleeping bag to the pilothouse. The cook examined Collins and immediately concluded that he was seriously ill. He, thereupon, reminded the mate he was now the captain of the vessel, and urged him to call the barge captain to ask the Emergency Medical Technician (EMT) assigned to the lay barge to examine Collins – which he did as well as calling his office.

The mate maneuvered the tug near the barge and the EMT made a harrowing leap in 6-8 foot seas and proceeded to examine Collins on the deck of the pilothouse and, following a detailed examination, declared that he had suffered a stroke. The barge captain, who knew and had great respect for Collins, <u>immediately</u> called for a commercial evacuation helicopter that set out promptly for the barge. Three riggers and three tug crewmembers put Collins in a litter basket, carried him down to the after deck, and transferred him by personnel basket to the lay barge from which the helicopter brought him ashore.

The delay in determining that Collins had suffered a stroke was critical to his recovery and could have taken his life. According to the expert testimony of Dr. Meyer: "The delay of six hours prior to his receiving medical attention, more probably than not, denied him the benefits of TPA therapy, as the earlier the TPA treatment is administered <u>within three hours</u> for ischemic stroke the better the outcome."

The family was told, and believed, that Collins had suffered a stroke in his stateroom sometime during the night. It only became apparent in a deposition given <u>under oath</u> more than two years later that Collins had really collapsed in the pilothouse as the vessel was running on autopilot and was left to lie where he fell for more than six hours without summoning medical attention from the nearby barge or from the Coast Guard. One story recited by one of the deckhands indicated that he sat for a while in the pilothouse with the mate in the dark while Collins lying on the deck and that Collins responded to their questions. Collins recalls nothing of events after about 11:00 in the evening or of his stroke until he was revived in the hospital. The mate, however, denied that the deckhand ever sat in the pilothouse that night. When Catherine heard the mate's statement under oath in the deposition two years after the fact, it was "as if he had cut my heart out."

Dr. Meyer, a renowned stroke treatment specialist, stated clearly in his testimony that giving TPA therapy after the initial three-hour window of opportunity passes can clearly endanger the life of the patient. However, it appears that there was no clear transfer of information as to when the stroke occurred (was it at 11:30 p.m. or 5:30 a.m.?). Consequently, Collins received the TPA treatment far beyond the "window of opportunity" on his arrival at Lake Charles Memorial Hospital. This late treatment alone could have killed him – but, fortunately, did not.

The irony is that the mate had taken two complete first aid and CPR classes earlier in the year during his licensure and later as a part of his STCW training. Yet, he either failed to recognize the signs of stroke that he should have learned in school or failed to take decisive action and call either the barge or his home office for six hours. Was it gross incompetence or plain ignorance…we may never know – but there certainly were a number of lies and other misleading information that needed to be unraveled!

Big Deals in the Making

Collins' stroke was probably the last thing on the minds of the executives of the large corporation that Collins

worked for as Dec. 2000 turned into Jan. 2001. Only recently had R&B Falcon consolidated a number of smaller local towing companies including Double Eagle into one large local towing conglomerate when they were forced to turn over control of their vessels to another large company for reasons recited in the following news article.

Merger Results in New Vessel Company

*[**Source:** By Bill Evans, The Waterways Journal, Feb. 19, 2001, pgs 3, 6.]*

A recently concluded merger of major players in the international oil and gas industry and a joint-venture with two Louisiana businessmen has resulted in creation of Delta Towing LLC, operators of a 202-vessel fleet of inland tugs and towboats, offshore tugs, crewboats, and service barges, with another 10 crewboats under construction.

Transocean Sedco Forex, Inc. on Jan. 31, 2001 announced closing of its merger with R&B Falcon Corp., creating an offshore drilling contracting firm with a megafleet and worldwide operations. Both Transocean Sedco Forex and R&B Falcon are Houston, TX-based companies.

Prior to the merger, Transocean Sedco Forex billed itself as the world's largest offshore drilling contractor. The firm's stock is traded on the New York Stock Exchange under the symbol "RIG." R&B Falcon Corp. operates the world's largest fleet of marine-based drilling units servicing the international oil and gas industry.

Because Transocean Sedco Forex is a foreign-owned corporation chartered in the Cayman Islands, under terms of the Jones Act the firms were required to either spin off the R&B Falcon marine transportation fleet or limit its ownership in the fleet to no more than 25 percent.

Delta Towing LLC was formed as a joint venture between Transocean Sedco Forex, R&B Falcon, and Gary and Laney Chouest, principals in Edison Chouest Offshore of Galliano, LA. The joint venture became effective upon conclusion of the Transocean/R&B Falcon merger Jan.31. Under the joint venture agreement, Delta Towing will own and operate the former R&B Falcon marine transportation fleet, consisting of 72 inland tugs and towboats, 34 offshore tugs, 28 crewboats plus the 10 under construction, and 66 service barges. The fleet includes two additional vessels, but Lonne Thibodeaux, Edison Chouest Offshore director of corporate communications, said last week he was unsure of their type. In addition, Delta Towing charters another 15 vessels, he said.

“The vessels will operate both inland and offshore, in both oilfield and general towing service,” said Thibodeaux. Details of the planned operation including any vessel name change plans were not immediately available. R&B Falcon will receive $80 million in the form of a secured contingent note, plus other contingent consideration, and will retain 25% ownership in the operation, the firms said in an earlier announcement.

"This acquisition clearly fits with our current expansion plans into the inland and river services market," said Gary Chouest in the announcement.

Calling the R&B Falcon marine fleet "a welcome addition to the existing Chouest fleet," Laney Chouest said "The transaction will accomplish the Chouest goal of becoming a full marine supplier offering a full range of services, complementing our sizeable number of new-generation deepwater service vessels and the remainder of our 'blue-water' fleet with a large fleet of inland 'brown-water' vessels." Edison Chouest Offshore operates more than 120 vessels and employs more than 3,000 people worldwide.

The Lawsuit

1. Factual Background.

In Dec. 2000, Antoine Collins Verret was a 59-year old resident of Houma, LA, a life-long licensed mariner and captain of the anchor-handling tugboat M/V Mohawk Eagle, a vessel then operated by R&B Falcon Marine. In Jan. 2001, R&B Falcon and two other marine companies became Delta Towing LLC.

In late 2000, mate Leroy "V" began to work aboard the anchor handling vessel M/V Mohawk Eagle. Mr. V obtained his mate's license in Feb. 2000, but had little or no experience handling anchors. As more fully explained below, Delta's decision to burden Captain Verret with an untrained “relief” pilot forced Captain Verret to work well over 12 hours a day. This stress in turn eventually caused Captain Verret to suffer a stroke on Dec. 2, 2000 that left him wheel chair bound and permanently disabled.

a. Delta tells Captain Verret to train new mate in anchor handling techniques.

In late 2000, Delta assigned Mr. V to act as Captain Verret's relief pilot aboard the M/V Mohawk Eagle, and was the first anchor-handling vessel on which Mr. V had worked. Since Mr. V had little or no experience in anchor handling operations, Delta directed Captain Verret to train Mr. V. ***Delta had no program, procedures, tests, or written materials of any kind on how to train newly licensed mates to become relief pilots on anchor handling tugs***. Additionally, Delta did not give Captain Verret any help to train his own “relief” pilot. Delta had the option

of pairing Captain Verret with an experienced relief pilot while training Mr. V. Both Captain Verret and his experienced relief could then take turns training Mr. V. However, Delta chose to let the burden of training Mr. V rest with Captain Verret alone.

Captain Verret had to teach Mr. V to use the winch controls, hook buoys, and pick up anchors. Captain Verret first let Mr. V watch him perform these tasks, then try himself so Mr. V could get the feel for it. A M/V Mohawk Eagle deckhand recalled that since Mr. V did not know how to perform anchor-handling operations, "the old man (Captain Verret) had to be up long hours showing him, teaching him, you know."

b. Captain Verret had to work excessive hours to do his job and then train his own "relief" pilot.

As experienced offshore mariners know, an anchor handling vessel can work up to 24 hours a day. A M/V Mohawk Eagle deckhand recalled the vessel ran anchors for the lay barge Midnight Brave near High Island, West Cameron Block, Gulf of Mexico on the day Captain Verret suffered his stroke. The deckhand said the vessel was running anchors, "24 hours a day, constantly running anchors with them." Mr. V, the relief pilot, likewise recalled, "one time I was pulling anchors, I stayed in the doghouse for six hours, oh yeah, and it was rough." Until Captain Verret trained Mr. V to at least some minimal level of anchor handling skill, Captain Verret was the only person on the M/V Mohawk Eagle who could perform all of the vessel's anchor handling assignments.

Mr. V felt that Captain Verret taught him how to pull anchors after two days of intensive training. During these first two days of training, Captain Verret worked his own two six-hour shifts and then trained Mr. V. Mr. V recalled he could sleep while off duty but that Captain Verret, "yeah, the first two days he had to watch me, you know." However, after only two days of training, Mr. V could not place or take away anchors from a barge. Captain Verret had to perform those tasks during Mr. V's shifts. Likewise, Mr. V could not set up the vessel's tow cable to tow a barge.

R&B Falcon's former personnel manager agreed in sworn deposition testimony that if a trainee-mate cannot put or take anchors off a barge, nor set up a tow, then that mate should not serve as a relief pilot on a working anchor handling tug.

Mr. V knew that some vessel captains do not like to train new mates but prefer to work with experienced relief pilots, "...because they don't like to lose no sleep, and they like to get their rest". Mr. V acknowledged that many captains prefer to work with an experienced relief pilot because he, "…can do his own job, you know, so he (the captain) can get rest and not worry about what's going on out". Mr. V understood that with an inexperienced, trainee relief pilot on board a vessel: “Well, the captain is going to stay up and wonder if he can do the job, you know, oh yeah. Because he's always going to have in the back of his mind if something is going to happen or not. When a captain is compelled to train his own supposed “relief” pilot," …they can be up 24 hours…"

c. Captain Verret had to stay up almost 24 hours before his stroke to navigate his vessel due to his "relief” pilot's inexperience.

Delta assigned Mr. V to be Captain Verret's supposed relief pilot for the last time the week of Nov. 26, 2000. On Dec. 1, 2000, shortly after midnight, the M/V Mohawk Eagle departed the Gulf of Mexico and sailed to Port Arthur, TX, to repair the gear box on the vessel’s winch. Mr. V dial not know Port Arthur. Captain Verret, therefore, brought the vessel into port. A former M/V Mohawk Eagle deckhand confirmed Captain Verret had to take the vessel into Port Arthur because, "Leroy, he didn't know his way in there too good..."

Captain Verret attempted to take a short nap while the vessel was in Port Arthur, but repairs were quickly performed and the vessel was soon headed back out to sea.

While in Port Arthur, Captain Verret did have the chance to call his wife, Catherine, to say hello. Among other topics, Captain Verret told his wife that he had been working with little sleep over the last several days and looked forward to the end of his shift.

Captain Verret took the M/V Mohawk Eagle out of Port Arthur given Mr. V's lack of familiarity with the area. Additionally, Captain Verret believed he should pilot the vessel because of bad weather. By Dec. 2, 2000, an already-exhausted Captain Verret had been working with little opportunity for rest for the better part of the entire day. A former M/V Mohawk Eagle deckhand estimated Captain Verret remained at the wheel or was otherwise on duty the day of his stroke, "...at least 18 to 24 hours..."

d. Mr. V finds Captain Verret collapsed can the pilot house floor and leaves him there.

At 11:00 p.m. the evening of Dec. 2, 2000, Mr. V went to the M/V Mohawk Eagle's pilothouse. Mr. V found Captain Verret lying on the pilothouse floor. At the time, the vessel was sailing through the storm-tossed seas of the Gulf of Mexico at night on automatic pilot. Mr. V did not try to get Captain Verret any medical aid, contact

other crewmembers, or radio Delta Towing. Instead, Mr. V supposedly asked Captain Verret if he fell. Mr. V then got Captain Verret a pillow so he could "sleep" on the pilothouse floor. Captain Verret was not "sleeping" but had suffered a stroke.

Mr. V sailed on to the lay barge Midnight Brave, arriving at 24:00 hours, Dec.2, 2000, an hour after finding Captain Verret on the pilothouse floor. Mr. V left Captain Verret on the floor until 6:30 a.m. the next morning while he circled the lay barge due to heavy seas. Mr. V did not radio the Midnight Brave's crew that he found Captain Verret laying on the pilothouse floor although the lay barge had a paramedic among its crew.

At 6:30 a.m., Mr. V tried to waken Captain Collins to begin his shift. However, Captain Verret could not get up. Mr. V began to realize something was amiss with Captain Verret. He, therefore, finally radioed the lay barge, and the barge's paramedic came aboard the M/V Mohawk Eagle and quickly confirmed that Captain Verret had suffered a stroke.

Mr. V held a U.S. Coast Guard mate's license for motor vessels not exceeding 200 tons. Mr. V's license required him to be trained in First Aid and CPR and recognize the symptoms of a stroke. Delta Towing supposedly held safety meetings and distributed written materials to its employees on how to recognize and respond to strokes. Mr. V could have radioed for a medevac helicopter to meet him at the lay barge to evacuate plaintiff. When the Midnight Brave's captain called an Acadian Air Ambulance helicopter to evacuate Captain Verret, it took the helicopter only 37 minutes flying time to arrive at the lay barge. Prompt medical treatment, including an anticoagulant injection given within three hours of Captain Verret's stroke, could have reduced or eliminated permanent neurological damage to Captain Verret. However, because of Mr. V's inability to recognize or respond to Captain Verret's predicament, his medical care was needlessly delayed for over nine hours. Captain Verret is now consigned to a wheel chair with left arm and leg paralysis.

2. Legal issues.

a. Mr. V's inexperience rendered the M/V Mohawk Eagle "unseaworthy."

Delta's decision to burden Captain Verret with an unqualified, trainee "relief" pilot rendered the M/V Mohawk Eagle "unseaworthy" as a matter of law. The law holds that an owner is responsible to his seaman-employees, including the captain, for injuries caused by a vessel's unseaworthiness. A vessel can be unseaworthy when its crew is inadequate or incompetent. A vessel owner's duty to provide a competent crew is absolute and non-delegable. The vessel owner can be liable for a vessel's unseaworthiness regardless of the vessel owner's negligence or failure to exercise reasonable care. Delta knew Mr. V could not perform the duties of an anchor handling relief pilot since Delta directed Captain Verret to train Mr. V.

b. Delta committed a statutory violation of the 12-Hour Rule.

Delta's decision to burden Captain Verret with a trainee relief pilot forced Captain Verret to work well over 12 hours a day pulling his own shifts and then training and supervising Mr. V. Until Captain Verret taught Mr. V minimum anchor-handling skills, Delta put Captain Verret in a position where he was forced to work continuously.

46 U.S. Code §8104(h), known as the "12-Hour Rule" says: (h) On a vessel to which section 8904 of this title applies, an individual licensed to operate a towing vessel may not work for more than 12 hours in a consecutive 24-hour period except in an emergency.

46 U.S. Code §8904 applies to a towing vessel like the M/V Mohawk Eagle.

c. USCG interpretation of 12-Hour Rule.

The United States Coast Guard has issued a Policy Letter regarding the 12-Hour Rule, G-MOC Policy Letter 4-00, entitled, "Watchkeeping and Work-Hour Limitations on Towing Vessels… The Coast Guard's Policy Letter, among other things, defines the period of rest to which semen are entitled by law: *(c) Rest* means a period of time during which the person concerned is off duty, is not performing work, including administrative tasks... **and is allowed to sleep without being interrupted**.

The Coast Guard further mandates: (f) 46 U.S. Code §8104(h) establishes that operators of towing vessels subject to 46 U.S. Code §8904 are not permitted to work in excess of 12 hours in any consecutive 24-hour period, except in an emergency.

Captain Verret and relief pilot Mr. V were supposed to work six-hour alternating shifts. Captain Verret therefore should have had the opportunity to enjoy up to six hours of uninterrupted sleep, consistent with the Coast Guard's mandate that: (b) The hours of test may be divided into no more than two periods, of which one must be at least 6 hours in length.

However, Captain Verret rarely, if ever, enjoyed six hours of uninterrupted sleep from the time Mr. V came on board his vessel.

d. Other courts have found that violations of the 12-Hour Rule have caused a seaman's stroke or other illness.

The courts previously found that violations of the 12-Hour Rule caused or contributed to a seaman's stroke, illness or accident. The court in *Smith v Cameron Crews, Inc.,* 348 So.2d 179 (La. App. 3d Cir. 1977), found that the stress resulting from an undermanned boat working in the Gulf of Mexico contributed to the towboat captain's stroke. The vessel's Certificate of Inspection required the vessel be manned with two licensed operators and two deckhands when operating more than 12 hours a day. The vessel never had more than the plaintiff and one deckhand aboard regardless of how long; the vessel operated.

The plaintiff presented the medical testimony of his treating physicians that many things can contribute to stroke and heart attack and, "...that the stress of the job in the Gulf of Mexico was one contributing factor among many..." The court found that since, "...the strain of being on call often 24 hours a day was very stressful", that the violation of the boat's manning certificate contributed to the plaintiffs stroke.

The court in *Elms v. Crowley Marine Service, Inc.,* 1997 A.M.C. 835 (W.D. Wash. 1996), found that a seaman's fall from a barge in tow resulted from fatigue caused by continuous violations of the 12-Hour Rule. In *Bradt v. United States, et al,* 122 F.Supp. 190 (E.D.N.Y. 1954), aff'd, 221 F.2d 325 (2d Cir. 1955), the court held that the plaintiff, Bradt, "...suffered tuberculosis as the result of the pattern of overwork enforced upon him because of the consistent undermanning of the vessel." Similarly, in *Gajewski v. United States, et al,* 540 F.Supp. 381 (S.D.N.Y. 1982), the court found that the plaintiff's pulmonary embolism resulted from the constant violations of the maximum work hour limitations and concluded, "The excessive hours tolled by Mr. Gajewski aboard the Neches constitute a patent violation of the Jones Act…"

e. Vessel owners have a duty to provide seamen with prompt medical care.

The U. S. Supreme Court has long held a seaman's employer liable for damages resulting from his failure to promptly provide an injured or ill seaman prompt medical care: "The duty to provide proper medical treatment and attendance for seamen falling ill or suffering injury in the service of the ship has been imposed upon the ship owners by all maritime nations". *The Iroquois,* 194 U.S. 240, 241042, 24 S.Ct. 640 (1904). A shipowner may be sued for his negligent failure to provide his seamen prompt medical care. *Cortes v. Baltimore Insular Line, 287 U.S. 367, 376, 53 S.Ct. 173(1932); Motts v. M/V Green Wave, 210 F.3d 565 (5th. Cir. 2000); De Centeno v. Gulf Fleet Crews, Inc*, 798 F.2d 138, 140 (5th Cir. 1986*); Holliday v. Pacific Atlantic Steamship Co.,* 197 F.2d 610, 613 (3d Cir. 1952*); Fitzgerald v A.L. Burbank & Co.,* 451 F.2d 670, 679 (2d Cir. 1971), *Olsen v. American Steamship* Co., 176 F.3d 891, 895 (6th Cir.1999)

Mr. V's failure to promptly recognize and obtain treatment for Captain Verret when he found him on the pilothouse floor caused or worsened plaintiff's current permanent and total stroke-related disabilities. In the case of *Motts v. M/V GREEN WAVE,* 50F.Supp. 2d 634 (S.D. Tex. 1999), affirmed in part and reversed in part, 210 F.3d. 565 (5th Cir. 2000), the court discussed a vessel's failure to obtain medical care for a vessel engineer, Motts, who suffered a fractured pelvis in the waters of Antarctica. Mutts died after arriving back in the United States.

The captain of Motts' vessel never told an assisting U.S. Coast Guard vessel, the M/V Polar Star, about the seriousness of Mott's injuries; "Incredibly, while Captain Peter Stalkus and Chief Mate Christopher Murray suspected by now that Mr. Motts had sustained a serious fracture...no mention of this was made to the attending Polar Star". Since, like the lay barge Midnight Brave, the U.S. Coast Guard's Polar Star was equipped with trained medical personnel, the court found the defendants' failure to advise the Polar Star that Motts "required immediate medical assistance" to be "inexplicable" and "remarkably negligent." The court held: "The Court finds that the Master and Chief Mate were not competent to evaluate and determine appropriate medical care for a crewmember, and this ***incompetence*** was negligent and/or rendered the M/V Green Wave unseaworthy."

In *Holliday v. Pacific Atlantic Steamship Co.,* 197 F.2d 610,613 (3d Cir. 1952), the court found that the captain's delay of 15 hours or more in obtaining a physician for an obviously ill seaman negligence and a serious dereliction of duty owed the seaman. In short, no matter what the cause of an initial illness or injury on board a vessel, the seaman's employer must use every reasonable effort to obtain prompt medical care for the injured or ill seaman.

f. Settlement of the Verret case.

The damages claimed in the Verret lawsuit filed in the United Stated Federal Court in Lafayette, LA were

over $3,000,000. The counsel hired medical and economic experts that showed that Captain Verret's past and future medical costs alone exceeded $2,000,000. Fortunately, by gathering evidence and building up the facts of their case, the Verrets convinced Delta Towing and their insurers of the wisdom of settling Captain Verret's case before trial for a sum sufficient to take care of the Verrets' needs for the rest of their lives.

Conclusion

A shipowner’s failure to properly man a vessel with trained seamen can render the vessel unseaworthy. In addition, the shipowner can be found guilty of a statutory violation if its failure to properly man a vessel causes a seaman to suffer an injury or an illness like a stroke or heart attack.

A shipowner-employer must diligently obtain prompt medical care for the injured or ill seaman, regardless of the cause or any question of fault. A ship owner-employer's failure to do so can make him liable for any aggravation of the injury or illness caused by a delay or total failure to provide a seaman-employee prompt medical care.

CASE #2: PRESTON P. JOSEPH: MARINER SERIOUSLY INJURED ON THE JOB AND ABANDONED BY HIS EMPLOYER

[Eastern District of Louisiana Civil Action #01-3594]

***[Source:** Mark L. Ross, Esq., Lafayette, LA 70501. Tel: 337.266.2345; Fax: 337.266.2346.]]*

Introduction

In too many cases when mariners are injured on the job, they are left to their own devices to fend for themselves. Eventually, most angry and betrayed mariners turn through the yellow pages in the phone book and let their fingers do the walking to find an attorney. Somehow, the rest of the story often appears blurred after it turns into a legal battle between the seaman and his employer for the "pot of gold" that reportedly resides at the end of the rainbow. With the focus on the alleged "pot of gold," money appears to become the prize and the seaman's suffering becomes incidental. We disagree!

In our account of this case, the "prize" in no way compensates the injured seaman, Preston Joseph, for the pain and agony that he had to endure because of what we consider was the callous neglect demonstrated by his employer, Tidewater Marine, LLC, in compensating him for his painful injury. In a field with so many workplace injuries, our mariners increasingly must depend upon the work of astute trial lawyers to remind some employers of the need to develop a conscience beneath their corporate veil.

The Accident and Injury

"On December 16, 1998, plaintiff Preston P. Joseph was a crewmember of the M/V WAR ADMIRAL and working in the Gulf of Mexico, Block 62, Southwest Pass. (Preston) worked as the vessel's cook. While so employed, (Preston) slipped and fell in water on the floor of the vessel's walk-in cooler while moving leaking bottles of water from the cooler floor to a top shelf so that he could access the walk-in cooler.

"(Preston) has alleged that other crewmembers of the M/V WAR ADMIRAL placed the water bottles so as to obstruct (his) access to the walk-in cooler…(and that)…the placement of the leaking water bottles caused the floor to become slippery, was negligence and rendered the vessel unseaworthy."[(1)] *[[(1)] There is no malice implied in this legal statement.]*

Tidewater's Personal Injury or Illness Report dated Dec. 17, 1998 records that: "He was moving 2 cases of water from deck of walk-in cooler to top shelf and felt sharp pain in groin on right side." The report relates that his injury was in the form of a "right testicle swollen and lower back in pain."

This was a "slip, trip, and fall" type accident that is common in the workplace. The fact that this type of injury is common does not mean that it is not serious. This accident was both serious and painful.

Treatment

Preston was taken to Terrebonne General Medical Center in Houma, LA, immediately after the accident, as any responsible employer should reasonably be expected to do. Tidewater signed as the "Guarantor Employer" responsible for handling his medical bills at the hospital. While at the hospital, Preston was given "post accident" drug and alcohol testing with negative results proving that he was free of drugs and alcohol.

[NMA Comment: Had the tests been positive, the story (and possibly the treatment) would have ended here. Withholding medical treatment awaiting the results of such testing can add to the seaman's suffering.]

On the following day, Preston went home and sought further treatment by specialists in nearby Lafayette, LA, for "scrotal swelling and pain." One month after the accident he underwent surgery to repair a "massive hernia."

As months passed, Preston remained in pain and was unable to return to work. However, he and his wife kept Tidewater informed of the status of his disability as well as the fact that he could not return to work. On June 14, 1999, his treating surgeon told Tidewater that Preston remained under his care and was unable to return to work. Another physician confirmed his disability again on October 22, 1999.

Stiffed by His Employer

Tidewater refused several requests by Preston, his wife, and his attorney to pay him maintenance and cure. Over a year after the accident, even though Tidewater arranged for his initial medical treatment and was listed at

the hospital as Preston's guaranteeing employer and had received a constant stream of medical updates from his doctors, they claimed they still had to "investigate" his injuries before paying his maintenance and cure.

What is Maintenance and Cure? Know Your Rights

We want to keep our mariners informed of your basic rights under maritime law. From time to time, we will explain certain legal rights that, although settled many of years old, often are conveniently "forgotten" by boat operating companies.

Maintenance is a form of seaman's workers compensation. Maintenance is a daily stipend, generally in the $15 to $20 range. However, if you can show your living costs are more than $15 to $20 per day, as is usually the case, you can prove your actual living expenses to a court and get an award for that amount. Generally, maintenance includes expenses like room and board that you would not have to pay if you still worked aboard your vessel. Shoreside costs like clothes cleaning bills would not be included under maintenance.

A boat company must pay ill or injured seaman maintenance from the day he became ill or injured until he recovers. Alternatively, a boat company must pay its ill or injured seaman maintenance until a doctor says the seaman has reached ***maximum medical cure***. Maximum medical cure is the point where, although a seaman may still be ill, a doctor says he cannot do anything more to improve the seaman's condition.

If the question of whether a seaman has reached maximum medical cure is disputed between the boat company and the seaman, a court can decide the issue. Generally, a court will favor the opinion of the doctor who has actually treated the seaman, as opposed to a company "independent medical examiner" physician who may have only seen the seaman once or twice.

Cure is a maritime term meaning that a boat company has to pay a seaman's medical bills arising out of the illness or injury the seaman suffered while on duty aboard his vessel. A boat company must pay 100% of the seaman's medical bills even if the seaman has health insurance. The boat company has to pay 100% of the injured or ill seaman's medical bills until the seaman reaches maximum medical cure.

Defense, to payment of maintenance and cure-concealment and misconduct. A boat company can avoid paying maintenance and cure for only two reasons. First, a boat company does not have to pay maintenance and cure if they can show the seaman lied on his employment application about his health. A common example is if a seaman says he hurt his back while working. If the boat company finds the seaman hurt his back before working for that company, but denied any prior back injury on his employment application, the boat company could refuse to pay maintenance and cure for the second back injury. The prior back injury must be directly related to the injury or illness at issue, however, and the boat company's employment application must clearly ask the seaman about the prior illness or injury.

Second, a boat company can avoid paying maintenance and cure if a seaman's injury or illness results from "**misconduct**". Most "misconduct" cases involve someone getting sick or hurt due to misuse of drugs or alcohol. Courts have similarly ruled that a seaman cannot get maintenance and cure from illnesses caused by sexually transmitted diseases or from active AIDs since those are likewise deemed to result from "misconduct."

The foregoing is not intended to be a complete discussion of this often-complicated area of seamen's rights. Our Association wants to inform its members that these rights and remedies exist so that, if necessary, they can ask their employers or an attorney about their rights to maintenance and cure.

Tidewater's One-Time Payment

On Mar. 21, 2000, after Preston and his wife made repeated efforts to contact Tidewater to obtain maintenance and cure, Tidewater's claims manager, Sandy Duplantier, agreed to investigate Preston's well-documented accident and injuries. However, he was apparently in no rush to do so. On Nov. 20, 2000, six months after promising to investigate and years after the accident, Tidewater made a one-time maintenance payment of $3,870 covering the period from the date of the accident but only through Aug. 31, 1999 at a rate of $15.00 per day!

[NMA Comment: Each mariner should ask himself or herself this question. If I am out of work, can I survive on $15.00 per day (annually, $5,475)? Can you survive for two years waiting to receive this payment? Keep in mind that Tidewater is the largest operator of offshore supply vessels in the world. Now, consider the proposition of having to wait two years to be paid this pittance and then only after hiring a lawyer to even get this far. Shame on Tidewater; shame on this system.]

After Preston Joseph hired a lawyer, Tidewater agreed that, after examining the medical records, "…it appears that

Tidewater is obligated to pay maintenance and cure related to the hernia." Yet, Tidewater claimed that it had no knowledge whether Preston received any medical treatment after their arbitrary cut off date of Aug. 31, 1999 even though they had in their possession a report from Preston's physician dated Oct. 22, 1999 that he was scheduled to see a urologist to determine whether he might return to work. Tidewater unilaterally ceased to make any further maintenance and cure payments even though no doctor ever found that Preston had reached "maximum cure."

Down to the Wire

Because of the impending **statute of limitations**, Preston filed a lawsuit against Tidewater on Nov. 30, 2001…almost three years after the accident. Had he not done this in a timely manner, Tidewater would have been able to get by scot-free without shouldering its responsibility for this injured seaman. All you have to do is be callous enough to ignore the problem until it simply goes away. Of course, this can be a recipe for a four-digit problem to result in a six- or seven-digit solution.

[NMA Comment: Statutes of limitations for different laws and regulations are of different length. For a mariner wrongly prosecuted by the Coast Guard, for example, the limitation is as short as one month. In Preston's case, the statute of limitations kicked in three years after the accident. To determine when the time limit "tolls" for any given law, our mariners should contact an attorney. We recommend those attorneys who support our efforts to keep our mariners informed and lists them on our internet website.]

On Jan. 28, 2002, Preston's lawyer informed Tidewater that Preston's doctor recommended that he undergo further surgery but that he was financially unable to do so. The attorney demanded that Tidewater resume its maintenance and cure payments and requested that Tidewater disclose any medical records that would support a finding that he might have reached "maximum medical cure." Tidewater never produced any such evidence.

Preston's attorney provided Tidewater with medical records from July 2000 showing that Preston continued to complain of scrotal pain among related complaints and that he would "tentatively schedule surgery for Friday" that was never done. As of March 2001 another doctor found Preston complaining of "…severe testicle pain – unable to tolerate" and referred him to another physician to discuss removal of a testicle.

[NMA Comment: Although we spare our readers the graphic details, we want to point out that this is a particularly painful injury. The fact that the pain was constant and unbearable was just as clearly presented to Tidewater officials as it was to us. This case clearly shows that caring for injured employees does not rank as a very high priority for Tidewater. This should serve as a clear warning to other mariners who rely heavily on corporate compassion to care for them if they are injured.]

On Mar. 12, 2002, Preston's lawyer asked Tidewater to guarantee payment of Preston's treatment by a Lafayette urologist. However, Tidewater continued to respond that it needed more time to investigate and evaluate his request for maintenance and cure.

Heading For Court

As Tidewater continued to dither and delay, the lawsuit moved closer to a showdown in Federal District Court in New Orleans. As a large corporation, Tidewater has access to the best legal talent money can buy. However, when the case reaches court, the facts of a case and the law become determining factors. Issues that can have monetary value are tagged with a dollar amount.

An attorney must always seek the best possible settlement for his client. In doing so, he may have to make all sorts of compromises based on his best legal judgment as to how his case is developing. In many cases, the defendant (e.g., Tidewater) will make a settlement offer. If that offer is acceptable to the plaintiff (e.g., Preston Joseph) then the case will be settled and dismissed by the judge.

No Publicity

The dismissal rather than the "out of court" settlement may be all that appears in the public record. As far as any publicity is concerned, most private cases involving mariners receive little or no attention from the press because the general public couldn't possibly care less. As part of the settlement, the defendant may include a stipulation (i.e., agreement) that the terms of the settlement not be revealed. Since the settlement is not recorded in the court record, neither Preston nor his attorney can reveal the amount. That settles any curiosity about the size of

the "pot of gold" at the end of the rainbow. As a result of the out-of-court settlement, Tidewater was never "found guilty" of anything. They can trumpet this fact to their heart's content.

Our Association Assesses the "Pot of Gold"

Yes, Preston won…but it was no "cake walk" in spite of the number of legal precedents cited by his attorney. We are relieved that the settlement was deemed "satisfactory" to cover Preston's expenses and his needs. No matter what the amount (which is certainly none of our business), through what we learned from the public record and as the case progressed, was that the pain and suffering was intense and continuous. We felt that and wish to convey that fact first and foremost to our readers. Not only was there physical pain and suffering but also the aggravation of dealing with a large corporation that aggressively delayed making a reasonable settlement. As a result, a considerable portion of Tidewater's settlement was a direct result of their own failure to come to grips with its corporate responsibility to care for their injured mariner and to treat him fairly. Preston's attorney skillfully outlined the legal precedents in papers filed with the court and cited in our heading.

CASE #3: DECKHAND JOSEPH HULEN CRUSHED TO DEATH IN FALL FROM TOWBOAT

*[**Source:** This case was reported by Nelson G. Wolff, Esq., Schlicter, Bogard & Denton, 100 South 4th Street, Suite 900, St. Louis, MO 63102. Tel: 314.621.6115; Fax: 314.621.7151; e-mail: nwolff@uselaws.com]*

*[(1)**Ed Note:** We redacted the names of individuals directly involved in this terrible tragedy since responsibility for the death of deckhand Joseph Hulen was that of company management and not the crewmembers. The lessons the crewmembers learned from this tragedy were learned "first hand." If mistakes were made, their burden will be to live with them for the rest of their lives. However, we believe our mariners and others can learn from the attorneys and forensic experts who commented on this accident and to whom we are indebted. We are indebted as well as to Mr. and Mrs. William Hulen, parents of the deceased seaman, who contacted our Association and supported us as we brought this matter to the attention of the Towing Safety Advisory Committee (TSAC) in Washington in March 2006 – at which time an executive from the company accepted responsibility for the accident and the shortcomings it revealed.]*

At a recent Towing Safety Advisory Committee (TSAC) licensing Work Group meeting in Houston, there were suggestions that requiring new deckhands to "waste" a year and a half serving on deck before they became eligible to train for duty in the pilothouse was "excessive" and that some time period considerably shorter should be considered.

Captain David Whitehurst, representing our Association, firmly rejected any thought that time spent learning to be the best deckhand possible was a "waste of time." He rejected any thought of reducing time in service based on his more than 30-years experience on inland towing vessels.

Joe Hulen's Hopes and Dreams

The case under examination presents the needless and preventable death of a young man seeking a maritime career. The immediate and obvious cause of death was a fall overboard between two vessels during an equipment transfer. The Coast Guard investigated the accident and prepared its report, a copy of which we received under the Freedom of Information Act.

This case arises from the death of Joseph Hulen, who was working as a deckhand for American Commercial Barge Lines (ACBL) on its towboat the M/V WALLY ROLLER when he died in an accident on Nov. 2, 2002. Joe was only eighteen years old at the time of his death and is survived by his mother Lisa and father Bill. The same company, ACBL employed Bill for a number of years as a Chief Engineer on a different vessel. Joe, who had just graduated from High School, hoped to follow in his father's footsteps as an engineer. His Mom and Dad told our Association how much he loved working on the towboats and that after only a few trips he announced to them that towboating was a career he wanted to excel in. At the time of his death, Joe had worked for ACBL for only a few months as a deckhand trainee.

An Outline of the Accident

The incident occurred on the Ohio River, between the States of Illinois and Kentucky. The towboat and its crew had "touched up," but did not tie off to a fleet of 15 barges. Just before the accident, Joe was standing on the towboat as it approached a barge on which the other deckhand, ■■■ was standing. As Joe was attempting to pass a 150-foot coiled lock line from the starboard bow of the boat to the other deckhand on the barge, the towboat slowly drifted away from the barge at the stern allowing a gap to form between it and the barge.

After a failed initial attempt to transfer the line to the barge, it got tangled up between the crewmembers and Joe fell into the river. Joe struggled to escape the closing gap between the boat and barge but, due to his body weight and the weight of his equipment, he was unsuccessful. Attempts by the other deckhand to pull him onto the barge were also unsuccessful. In his attempt to help Joe out of the water, the other deckhand failed to alert the Master of the towboat of his plight by radio.

The Master apparently heard the "man overboard" cries and started to maneuver the boat back to the barge because he could not see the deck crew. In the meanwhile, other crewmembers were alerted to the emergency. At least one of them saw the scene and went back inside the towboat to alert the operator to the situation and also ordered the cook to awake the sleeping crewmembers for assistance. Before actual additional rescue assistance was rendered, the operator allowed the boat to swing back toward the barge, slowly pinning and crushing Joe against the barge while the other deckhand was holding him.

Joe did not sink or drown; rather, he struggled to escape before and after the boat trapped his body against the

barge. Eventually, the operator swung the boat away and Joe was pulled aboard the vessel and first aid started. He was transferred across the river to the Illinois shore where he was given further aid by EMT and transported to the hospital, but was pronounced dead upon arrival. At Joe's funeral, the company tried to cover up its responsibility by suggesting to the family that Joe's death was "just an accident."

The Coast Guard Investigation and Report

The Coast Guard reached three conclusions:

- That a briefing and discussion should have been held between the deckhand and the Captain so they could possibly discuss dangerous situations and ways to avoid tragedy.
- That ACBL failed to provide adequate communication between deck crew and the boat operator. The operator did not have visual contact with the crew and the hand-held radios were "useless" since the crew's work did not allow them a free hand to physically key the microphone.
- That ACBL failed to have a safety policy requiring that its boat be secured to barges before attempting line transfers If the boat and barge had been tied off instead of freefloating, there would not have been a gap in between for Joe Hulen to fall into.

Bill Hulen sadly pointed to these three sensible conclusions. He pointed out that they were advisory in nature and that the Coast Guard showed no further interest in taking steps to require ACBL to change existing practices. Despite these obvious safety violations, the Coast Guard did not fine ACBL.

Our Association often requests Coast Guard accident reports under the Freedom of Information Act. While these reports may be useful for a number of reasons, our mariners must understand that 46 U.S. Code §6308 states in part that "…no part of a report of a marine casualty investigation … including findings of fact, opinions, recommendations, deliberations, or conclusions, shall be admissible as evidence or subject to discovery in any civil…proceedings. In other words, the Coast Guard can investigate the accident for its own purposes – but mariners or other parties at interest will have to conduct their own investigations and hire attorneys and take the case to court if they want to learn facts and causes of injuries and deaths. It is easy to understand why many mariners view the accident investigation process as a sham – especially the required accident report form CG-2692 that mocks the reporting process.

Our Association often points to a report commissioned by the Coast Guard Research and Development Center in 1994 titled U.S. Coast Guard Marine Casualty Investigation and Reporting: Analysis and Recommendations for Improvement that really gets to the heart of the problem about accident investigations.[1] However, these problems remained unresolved for over fourteen years. The matter finally came to a head on May 20, 2008 in a hearing before the House Transportation and Infrastructure Committee as a result of a report by the Department of Homeland Security's Office of the Inspector General (#OIG 08-51).[2] *[[1]CG-D-13-95, posted on our Internet website as Report #R-429. [2]Posted on our website as our Report #R-429-M.]*

Legal Challenges to Proving the Case

Numerous complex legal hurdles faced the Hulens in their quest for the truth. Shortly after telling the Hulens their son's death was "just an accident" and then suggesting it was not at fault, ACBL and its lawyers actually filed the first legal suit under an ancient maritime doctrine. It sought to exonerate or excuse the corporation from any liability for compensatory damages it had to the Hulens whatsoever or, alternatively, to limit any liability it had to the mere value of its towboat.

The Hulens were served with notice of ACBL's lawsuit just days after the funeral and were told that if they did not file a legal claim within a short time period, they would be barred.

The Hulens were referred to St. Louis Maritime Attorney Nelson G. Wolff who had successfully represented the family of another ACBL employee who suffered a work-related death.[1] *[[1]Refer to our Report #R-412, Towboat Engineer's Death Points to Need for Changes in the Law.]*

Wolff successfully argued that ACBL should not be allowed to be free of liability or to limit the value of human life to the value of the vessel and that the Hulens were entitled to a trial by jury. The court eventually dismissed ACBL's case.

While this case was being contested, ACBL filed bankruptcy and again attempted to have the Hulens' case dismissed. Only after months of intense legal battles were the Hulens allowed to pursue their claim against ACBL to prove its responsibilities for his death.

Under the Jones Act, an employer is liable for compensatory damages caused in whole or in part by its negligence. A single claim inures to the surviving parents of an employee and the employee's estate, if the

employee has no spouse or children. In this case, Joe was survived by both parents, Bill and Lisa Hulen, with whom; he was living at the time of his death.

Under the law, they are entitled to compensation for lost economic support that they reasonably expected to receive, loss of counsel, support, guidance and for the conscious pain, suffering, and emotional distress experienced by Joe before he died. No compensation is allowed for grief and bereavement.

Joe had, in the past, and was expected in the future to have, provided some amount of economic support, emotional counseling and guidance to his parents. The most significant component of damages available under the law in this case, however, was the conscious pain, suffering, and distress he experienced until the time of his death.

Unimaginable Crushing Pain

Our Report #R-351, Rev. 1, How Safe Is The Towing Industry? is a reprint of a Coast Guard document that provides useful statistics on the dangers inherent in the towing industry as measured by industry fatalities. This document contains statistics that should jolt many "green" deckhands who consider a career in the towing industry. So, too, should the AWO/USCG Joint Quality Action Team report on deck crew safety in the inland towing industry released on Dec 30, 1996[1] But, these reports are just statistics. Here is a sample of the pain resulting from the most minor misstep. *[[1]NMA Report #R-428, Rev. 1.]*

The incident occurred at 10:30 a.m. and Joe was pronounced dead at 12:13. The autopsy report confirms that Joe's chest and abdomen were crushed with hemorrhages of the forehead, eyes and face, bilateral multiple rib fractures and fracture dislocation of his pelvis, lacerations of the liver, small intestine and transverse colon. His scrotum was distended and accumulated fluid consistent with acute trauma was noted. He had swelling and congestion in his lungs, consistent with a lost struggle to breathe and damage to the lungs. The cause of death was held to be asphyxiation due to thoraco-abdominal compression due to blunt trauma to the chest, abdomen and pelvis. In layman's terms, his body was crushed such that he was unable to inhale/exhale while pinned between the vessels. The Coroner concluded that Joe did not suffer any direct trauma to the head or face and that he was conscious during the crushing process.

According to the various accounts of the incident, the period of Joe's conscious pain and suffering ranged from a few seconds to a few minutes. Undoubtedly, the fatal injuries were exquisitely painful and Joe experienced psychological distress from the moment he was knocked from his feet until his death, with a conscious awareness, over what must have seemed like an eternity to him, that he was in grave danger and that severe injury or death was likely. An expert in pre-death terror opined that Joe would have experienced pre-death terror over a period as short as three seconds, including a "life review process," where, literally, his life and family would flash before his eyes. This distress and pain/suffering represented the most significant element of damages in this case.

Anguish of Joe's Family

Lisa Hulen first heard of our Association almost two years after the accident. In her call, that best can be described as distraught, she and her husband simply could not understand why nobody appeared interested or concerned about what happened to their oldest son. It was obvious that she and her husband Bill needed the services of a good admiralty lawyer.

At that point, I determined that they had hired an attorney, Nelson G. Wolff, Esq. of Schlicter, Bogard & Denton of St. Louis, whose success in handling difficult cases has been chronicled by our Association on several previous occasions. The concern both Lisa and Bill spoke about was ***NOT*** about collecting any money for their son's death. Their concern from day one was to discover the cause of their son's death in order to raise awareness of how both the industry and the Coast Guard were treating Joe's death as if it were "business as usual." Bill had a unique view from his inside position as an Engineer for the same company that their attitude was "deckhands are expendable commodities."

How long do you grieve for a lost son? The company answered that question rather bluntly by calling him a few weeks later suggesting that it was time he thought about going to work again – they needed his services. Instead, Bill quit both the job and the industry and now works ashore at a construction job!

Grieving for Joe Was Only Half of Bill's Burden

A significant precursor to Joe Hulen's death occurred on August 28, 2002, just two months before Joe was killed aboard ACBL's M/V WALLY ROLLER. At the time, Engineer Bill Hulen, then serving on ACBL's M/V CHARLES DITMAR, Jr., when deckhand Charles Hamby drowned after falling from the towboat's skiff while making crew change near Terrene Landing, Lower Mississippi River Mile 592.1.[1] Chad Hamby was only 26

years old and had worked on the river just over a year. *[[1]NMA accident file #M-550-A.]*

Bill was very upset about the accident and caustic about the length to which the company went to deny any responsibility for the accident. Bill believed that Chad Hamby never was trained properly to operate the towboat's skiff. After watching the way that the company lawyers handled the investigation following the accident, he seriously began to question whether his son, Joe, was wise to stick to his plans of making a career in the towing industry. It is this nagging doubt and the thought that he might have been able to change future events that haunts him to this day. This accident, that was so up-close and personal, coupled with the loss of their own son is what motivates Bill and Lisa Hulen to work to improve working conditions on towing vessels. Husband and wife attended the U.S. Coast Guard's preliminary public meeting on towing vessel inspection held in 2005 and spoke briefly about the accident and to point out that ACBL had, in a short period of time, lost three "green" deckhands to fatal accidents and had not taken responsibility for any of these deaths! This, and not the desire to reap a huge posthumous cash award, motivated the Hulens to press forward in a lawsuit against ACBL and set the tone for ACBL finally to accept responsibility for their actions.

As a direct result of our Association's discussion of the Chad Hamby accident with Bill Hulen, Captain Larry P. Gwin and Captain David C. Whitehurst on our Board of Directors helped to prepare Recommendation #77 in our Report #R-276. This is a detailed proposal that seeks to require "Rescue Boat & Training" for all crewmembers who serve on inland towing vessels because knowledge of small boats has been taken for granted for many years. In fact, this is the second fatality we reviewed in detail in the past year.[1] We furnished this significant recommendation to the Coast Guard for consideration in the Towing Vessel Inspection rulemaking package. Unfortunately, to date, the TSAC Working Group composed mostly of AWO member companies appears to have ignored both the problem and our Association's proposed solution. The Notice of Proposed Rulemaking (NPRM) issued in Aug. 2011 shows that most of our Association's recommendations were simply ignored. Consequently, we updated and re-submitted our report as NMA Report #R-276, Revision 10. *[[1]Refer to NMA file #M-547, USCG MISLE Activity #1732894 and to NMA Newsletter #30, May 2005, pages 9-13.]*

Company Blames Joe for His Own Death

Facing a possible lawsuit, the ACBL lawyers closed ranks and asserted that Joe Hulen had negligently caused his own death. Interestingly, they apparently failed to inform their own Director of Safety and Training of this who, stated in a Deposition: "No, I wasn't aware of that part of it, no."[1] "Given the facts as – that I have reviewed them, I don't know if young Joe really did do anything wrong." *[[1]Andrew Cannava, Deposition, Oct. 27, 2004, p.49, 50.*]

Understanding there are different viewpoints, here is an account of the accident as presented by Mr. Cannava, ACBL's Director of Training, in his deposition:[1] *[[1] Transcript, pgs. 54-58.]*

"Given what I've read, and given what our investigation has shown, we were building a 15-barge coal tow on the Ohio River on the Kentucky shore across the river from a loading facility on the Illinois shore, at approximate location of Shawneetown, Illinois.

"It was approximately 10:00 o'clock in the morning and on Eastern Time, and the WALLY ROLLER was just finishing up the tow, putting the last barges in tow shifting their lines around, preparing to face up to depart the area.

"We were moving a lock line from one end of a barge in mid tow up to the break coupling in the tow, by the boat, because we – the Captain felt, and the way we train is that if we can move the equipment in the easiest way possible, that is the route we are to take. That is the decision making process that the crew undertakes, and this time they chose, instead of carrying a line, the one single lock line they were going to move it on the head of the boat up from one end of the barge to the other.

"Once they had loaded it onto the boat, the head of the WALLY ROLLER on the starboard head, one deckhand walked up the tow and…Joe Hulen, the Probationary Deckhand, stayed on the boat and up to the next coupling.

"By the time the boat got up to the next coupling, the other deckhand that was on the tow, ■■■ had met the boat right there at the coupling, and they were in the process of offloading a line, one line, a break-coupling line, onto the tow.

"Mr. Hulen had picked up the line, and I think it's a little unclear as to whether it was the whole line or part of the head of the WALLY ROLLER gapped out away from the tow, and that was done just at the same time that Joe was giving it a second try to pass the line over to (the other deckhand), and when ■■■ saw that the boat was gapping out away from the tow, he had reached over to push Joe back, because he saw his motion – he was in motion to give the line over to him. ■■■ tried to push him back. At the same time Joe was trying to drop the line, but as he twisted and tried to drop the line, he tripped on something. The report says he tripped on something, what, we don't know, and the line went on the deck, and he went down between the boat and the tow…

"…as the boat gapped out, just a little bit more, ■■■ had jumped back a little bit and got down onto the deck, stepping over a deck fitting, and laid down on the deck and reached over the side of the tow just a few feet back just from where Joe had fallen in; and he reached into the water and grabbed Joe by the collar, by his shirt, or by the life jacket strap on his life jacket, and pulled him back up and tried to swing him up. And all the while he had one hand on Joe, and the other hand on the coaming of the barge behind him as he was lying down, or on something behind him to try to stabilize him, so he wouldn't go in the river, too.

"Joe tried, along with ■■■, he knew ■■■ had hold of him, and he was trying to swing his leg up onto the deck of the barge, and from what I understand, he tried it a couple of times, and he couldn't get … between ■■■ and Joe they couldn't get him out of the water, pull him up over the side of the barge, and at the same time ■■■ was hollering that we had a man overboard. The engineer had heard him. He came out, and he ran back inside, he being the engineer, ran back inside to call up to the pilothouse to say that they had a man in the river, and to try to get him to bring the boat back out, because he saw the boat was coming in on the bow.

"And they didn't have him far enough out of the water, or far enough, and the boat came in and landed on Joe, crushing him between the head of the boat and the tow. ■■■ still had hold of him, and by that time [the mate] had arrived at the spot at the break coupling, and [the mate] helped ■■■ get Joe out of the water and back up onto the tow. They put Joe in a Stokes basket, a litter, put him on the (WALLY) ROLLER and, at the same time, they had called over to the paramedics over in Illinois, and they had tried to go across the river as fast as they could to get him to some medical help.

The Other Side of the Story

ACBL was the defendant in the lawsuit titled Estate of Joseph Hulen vs American Commercial Barge Line.

Although Mr. Andrew Cannava, the company Director of Safety and Training, had full access to company records he had not been at the accident scene. Only the boat crew was there and only (the deckhand, the mate), and the Engineer saw the event occur. The Captain from his position in the pilothouse could not see the events taking place on the deck beneath him and had no posted lookout in place to inform him of the events that were unfolding.

Bill and Lisa Hulen's attorney had to reconstruct the evidence after the fact through "discovery" and, to do so, had to rely on the same evidence the company used, although with an eye toward identifying company fault. In preparing his case for trial, their attorney, Nelson G. Wolff, Esq., sought help from an extremely thorough and well-qualified forensic team affiliated with the American Admiralty Bureau operating in strict conformance with the Code of Professional and Ethical Conduct of the National Forensic Center.

The forensic team made a number of significant points that we believe are significant for our mariners. Faced with these significant points, which provided substantial evidence of ACBL's unsafe practices and policies, it had to admit liability and settle out of court on the eve of the trial for a substantial cash settlement. As a part of the settlement, there are no limitations on disclosure. We believe that each of these points made by the forensic experts, above and beyond the conclusions reached in the Coast Guard accident report, have merit and present them below: *[**Ed. Note:** Our edited, abbreviated, and annotated excerpts appears below.]*

- **Safe workplace.** Section (654) of the OSHA Act states in part that "Each employer…shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or likely to cause death or serious physical harm to his employees…"

  The company allowed certain "recognized hazards" (cited below) to exist on their workboats. Control and reduction of these recognized hazards was the duty of the owners and ship's officers rather than an apprentice deckhand just learning the trade.
- **Trainee or "probationary" deckhand.** Joe Hulen (who was only on his third trip) was considered (and paid) as a trainee. He was paired with a "more experienced" deckhand ■■■ (who was only on his fifth trip).
- **No USCG certification.** Since the Coast Guard does not require certificated and tested "Able Seamen" on western rivers towboats, there is no "third-party" competency certification of "deckhands." The company alone determines and assumes responsibility for rating an "experienced" or "supervisory capable" deckhand.
- **Placement of barge in tow.** The Captain allowed the box barge (i.e., the barge involved in the accident) to be returned to and inserted in the tow "backwards" with its lock line on the wrong end of the tow. As a result, this bulky line, weighing 100 lbs., had to be moved 200 feet to the other end of the barge. It was during this move that the fatal accident occurred.
- **Failed to secure towboat to barge before passing the line.** This simple action would have taken less than a minute. This allowed the towboat to drift away from the barge as Joe attempted to pass 100 lbs. of line across the gap. The load

was too heavy and the gap shouldn't have been there. This was an unsafe and unnecessary hazard.

- **Alternate methods of line-handling were available** but were not used. The entire evolution was not adequately supervised by the mate, ■■, who was in the general area at the time of the accident.
- **Deckhands' errors.** Deckhand ■■■ did not keep a careful lookout for dangerous conditions and failed to notify the Captain by radio that the towboat was slowly drifting away from the barge. Although there was a delay while Joe made a second attempt to pass a smaller length of line across the gap, ■■■ did not keep a lookout for the gap or tell the captain of this delay.
- **Supervisory error.** Although ■■■ testified that Joe may have turned his back to the water while preparing to pass the line across the gap, he did not testify that he ever admonished Joe (his trainee) that this was an "unsafe practice."
- **Violated company "man overboard" procedure.** Page 60 of ACBL's deckhand training guide called for ■■■ to contact the pilothouse immediately by radio twice to alert the Captain of the situation. Only then should he have attempted rescuing Joe Hulen. As soon as he dropped to the deck with one hand holding the barge coaming and one hand outstretched to Joe, he deprived himself of the ability to use the "push-to-talk" button on his hand-held radio. Given his deposition testimony under oath, there would have been ample time for the Captain to control the boat to protect Joe in the water.
- **Shouting and yelling was futile.** ■■■'s attempts to alert the Captain or others by yelling were inadequate. This may have been a result of inadequate and ineffective training by ACBL and panic that resulted from the situation and training inadequacy. Common sense and minimal experience on a towboat this size should demonstrate that the pilothouse can be a noisy place with all sounds from radios and other sources competing for attention.
- **Inadequate supervision by the mate**. ■■ failed to conduct any job safety briefing as set forth in ACBL's "Job Briefing" guide.
- **Mate was not present as a lookout for the line transfer task.** The line transfer was taking place in a blind spot relative to the pilothouse. Since ■■■ and Joe Hulen were both fully engaged in passing this bulky line from boat to barge, the mate should have been on the spot to coordinate with the Captain.
- **The Captain failed to maintain control of the boat.** He did not keep the boat against the barge until the line transfer was safely completed.
- **The Captain allowed the transfer to take place in a blind spot where he could not observe the activity.** He did not call for the mate to serve as his lookout during the transfer. He failed to question the delay in making a transfer that he later testified should only have taken 1 to 2 seconds.
- **The Captain's response to finally being alerted to an unusual situation was unsafe and improper.** He testified in his deposition that one-minute or so before he received an intercom alert from his Chief Engineer, he heard ■■■ yelling that indicated something was wrong. At that point, he should have communicated with the crew to assess the situation before bringing the boat back against the barge. Instead, he reacted by closing the gap, which is an illogical and inexplicable reaction for an experienced operator to make. *[**Ed. Note:** This evaluation is tempered by subsequent comments recited below.]*
- **ACBL improperly allowed ■■■ to supervise and train Joe Hulen.** ■■■ only had served as a deckhand for 5 to six trips according to the Safety and Training Director's testimony. His training should have been left to a more experienced deckhand.
- **ACBL is responsible for work practices that likely allowed fatigue to contribute to the incident.** The Captain had been allowed to work on the boat for almost 60 consecutive days while ■■■ had worked over 30 consecutive days. Although licensed officers are limited by law to 12-hour workdays, no such limitations apply to either deckhands like ■■■ or non-navigating mates like ■■. In fact, the AWO's Responsible Carrier Program has institutionalized the industry's use of a 15-hour day in spite of years of protest from our Association and other mariner organizations. In fact, in 2000 we published the book Mariners Speak Out on Violation of the 12-Hour Work Day containing over 50 letters from mariners exposing abuses of work hours. We distributed several hundred copies to the Coast Guard, Congress, and to national and international labor organizations.
- **Joe Hulen was assigned to the "call watch" at the time of the accident.** This meant that his workday was subject to irregular breaks instead of the standard routine of 6 hours on duty followed by 6 hours off duty around the clock. The call watch, in addition to the 15-hour workday in this industry is a real travesty whose scope was revealed to the public in our Report #R-375, Crew Endurance: The Call-Watch Cover-up and in our Report # R-401, Crew Endurance and the Towing Vessel Engineer – A Direct Appeal to Congress. We hope that Congress will respond to these appeals to remedy abuses as pervasive in the 21st century as those revealed by Richard Henry Dana in Two Years Before the Mast in the 19th century.
- **The "call watch" abuse is a result of improper manning.** If there is a "two-watch" system, there should be a full

crew to stand each watch. It is clear that this simple maneuver that turned deadly required three men on deck under all the circumstances of that maneuver. However, the company allowed one man, Deckhand Trainee Joe Hulen to be used on both watches – the real meaning of the "call watch." The company thereby saved the wages of one deckhand by using their most junior, most low-paid, and most vulnerable "green" deckhand on both the "front watch" and the "back watch." While this provides more training for a new man, it also expects more in the way of alertness and stamina. Deckhand trainees, by whatever name they are known, should be supernumeraries and not treated as "cannon fodder" to be awarded a small pay raise if they survive the experience.

- **Clearer heads might prevail if everybody involved had not been obviously fatigued**. Fatigue appeared to be a contributing factor in this accident and a growing menace to the public as reduced crew size is imposed on an already-stressed two-watch system. Any employer is free to grant crews on towing vessels an 8-hour three-watch system. Yet, there is only permissive authority in the regulations to impose the two-watch system. This is done to maximize profits by reducing overhead by eliminating about four jobs aboard a typical line-haul towboat. The major savings extracted from the system today are the elimination of a second Pilot, one of the highest-paid crewmembers. Today, there has been an overall reduction in crew size so that, on average, boats carry about one to four less crewmen than vessels under the two-watch system in the past. Yet, there has been no real change in the technology of this type of towing that would eliminate the tasking previously performed by the missing crewmembers. To the extent that fatigue contributed to this accident, company management practices imposed it, Joe Hulen died for it, and Bill Hulen had the guts to stand up and oppose it.

The Expert's Summary

Maritime expert, the late Captain Jay Disler (1941-2006), an NMA member, developed the following professional opinions:

The case under examination presents the needless and preventable death of a young man seeking a maritime career. The immediate and obvious cause of death was a fall overboard between two moving vessels. But, as demonstrated in the body of this report this fall was not a simple act of carelessness or inattention.

Joe Hulen died because he was overburdened by an awkward load, his superiors were inattentive to the evolving hazard forming next to him as a gap between the vessels widened.

His superiors deviated from standard procedure and it is highly likely that these deviations and inattentions were at least in part the result of fatigue. Fatigue in this case was induced by work practices imposed by management. The work method chosen that failed to wait for a secured closure of the two vessels responded to economic pressures on operational tempo that was described in the body of this report and an admitted absence of relevant management policy.

On its face, this is a simple fall overboard, one man dead with little relationship to other cases or impact on society. However as demonstrated within the body of this report, this case is a tragic example of a larger safety problem; rampant in the inland towing industry. This problem manifests itself in crew injuries, collisions, and bridge allisions, often with large numbers of deaths

Without the introduction of new technologies, it is unsafe to attempt serious reductions in deadhead time while simultaneously reducing crew size, increasing crew working hours, and increasing tow size. All of these cost-saving and profit enhancement measures taken without consideration of this effect on each other have, and continue, to drastically diminish safety margins on the inland navigational system.

The new technologies that have been introduced have not decreased the need for labor. Automatic plotting radar, GPS, and bridge-to-bridge radios have only increased the tasking in the pilothouse, yet the pilothouse is still manned by only one licensed officer at a time.

We still build tows with the same tools and rigging as 50 years ago, but now we do it with half the workers while the barges are growing larger. Labor unions in this field are virtually extinct. The major regulator, the U.S. Coast Guard is distracted by a growing list of high priority homeland security missions.

The courts are the only place where this trend can now be documented, described, and brought to the attention of the industry, the last power with any real ability to level the playing field in favor of increased safety that means a retreat from some of the more onerous crew reductions, and operational practices.

Fortunately, as a result of the hard-fought litigation against ACBL, Bill Hulen's attorney and the maritime expert, the complete picture of responsibility could be revealed and corporate accountability be compelled. The death of Joseph Hulen was not an isolated event, but an exemplary event that warrants serious attention, analysis, and publication of the results.

A Message to Mariners from Nelson G. Wolff, Esq.

As Capt. Disler mentioned in his report, "the courts are the only place where this trend [against safety in the industry] can be brought to the attention of the industry, the last power with any real ability to level the playing field…."

Unfortunately, meaningful access to the courts and the opportunity to achieve the potential for reform depends on injured workers finding legal counsel who is experienced with the nuances and challenges of the complex law that governs mariners. The only thing more unfortunate than the injury or death of a maritime worker is the failure to obtain compensation and lost opportunity to send a message to the industry in a language that it can understand – money.

I appreciate the opportunity you have afforded me through your media to communicate these results in hopes that other workers will not be deprived of their right to compensation and that industry safety can be improved through lessons learned through hard ball litigation and court judgments. Hopefully, it will result in fewer such deaths/injuries, whether be by increased, effective regulation or through cost management at the company level.

CASE #4: TOWING COMPANY REFUSES CAPT. JOHN LOCICERO PROPER MEDICAL CARE
*[**Source:** As reported by Captain John Locicero in several interviews.]*

He Made His Own Splint with a Rolled Newspaper and Duct Tape; Years After His Injury, He Cannot Use His Right Hand

Captain John LoCicero is an active member of our Association. He told us that ten years ago, he never would have considered joining a mariner's association like ours, or a labor union. Back then, he believed that his employer cared about him as a person and would take care of him if he was hurt on the job. He now admits that his trust was misplaced and wants to tell his story to other mariners so they may avoid the same bitter experience.

[NMA Comment: Mariners need to understand that there are two sides to many important health, safety, and welfare issues. Employers interests and concerns do not always coincide with those of their employees.]

John was serving as relief captain on an uninspected towing vessel working on the Gulf Intracoastal Waterway pushing tank barges between Louisiana and Texas in 1993. He was employed by the Frazier Towing Company, a small mom-and-pop towing operation based in southeast Louisiana. On the voyage when he was injured, he was working as Pilot under the direction of the son of the company's owner who was serving as the vessel's captain.

The tow consisted of one tank barge owned by Hollywood Marine – a customer of Frazier Towing Company.

While underway during a voyage in 1994, John tripped on the deck and injured his right wrist and arm and was in severe pain. The boat's Captain called on Hollywood Marine for assistance. A Hollywood employee drove John to a local Houston-area hospital where John's injured arm was examined. He was told his wrist was broken but that the hospital's orthopedic specialist was not there to set it. Consequently, John was brought back to the towboat even though he asked to be taken to another hospital for immediate emergency treatment. He was told that medical treatment was the responsibility of his employer, the Frazier Towing Company, and not up to Hollywood Marine, owner of the barge.

On returning to the boat, John was in severe pain and told the Captain that he thought he was going into shock. Since the towboat was now tied to the dock at the refinery, the Captain called the refinery's emergency medical technician (EMT) who arrived in an ambulance but did not even have a splint to immobilize the fracture. John finally immobilized it himself by wrapping a newspaper around it and using duct tape to secure it. Since he could not work because of the pain, he asked to be relieved.

Left to Suffer

Twenty-four hours later, John arrived by company carryall at Frazier Towing Company's parking lot on the bayou in southeast Louisiana where he was dropped off at his parked car and left to fend for himself. He had received no additional medical treatment and was still in severe pain. John put it this way: "I have hurt myself in the past, but I never had pain like that in my life. I hurt so damn bad I can't even begin to tell anyone the pain I felt."

John was left with no alternative but to drive his car with one arm immobilized about 25 miles up the bayou to Raceland and then on to his home in Metairie. He immediately called the company office and, being a Saturday, left a message for the Port Captain to call him with further instructions for medical care.

No Immediate Company Concern

On Sunday, the port captain never bothered to return his call. So, bright and early on Monday, John called the office and spoke to the secretary. The secretary asked him why he was still walking around-with a broken arm. John replied that the hospitals asked embarrassing questions about his medical coverage he could not answer and, specifically, who was responsible for paying the bill. Eventually, the office appeared to settle the matter and sent him to a doctor later in the day. The doctor gave him pain medicine, properly immobilized the arm, and because the doctor was busy, gave him an appointment to come back in a week to get it set.

When John returned, he learned that his arm had suffered severe nerve damage and that it would require a major operation using a nerve taken from his leg. The doctor scheduled the operation for the next day. However, when John arrived for the operation, he was told that the company did not have the funds to pay for it and that it could not be performed. Shortly thereafter, the company stopped paying maintenance and cure. Four-and-a-half months later, they were still talking about surgery but had not yet performed it.

No Surgery and Inadequate Settlement

John then hired an attorney who was only able to extract a small and unsatisfactory settlement from the company. John can no longer work as a mariner. Seven years later, John has no use of his right hand whatsoever and lives on small government disability payments.

Some Thoughts for Other Mariners

John's advice to his fellow mariners is this: "Watch your step. Be careful whom you work for. Be sure these people can and will take care of you if you are hurt. Don't blindly accept what these companies tell you, because they are all born liars. They'll tell you what you want to hear."

John asks our mariners consider these points:

- Are you working for a reputable employer that provides you and your family with medical coverage?
- Has your employer ever cheated mariners that you know out of legitimate "maintenance and cure" payments?
- What type of medical coverage do you have today and how would it cover you under the same circumstances that he faced in a distant city or even at home?
- Have you read the fine-print of your medical policy or do you need it explained to you?
- Do you carry the necessary credentials that will give you entry to an emergency room?
- Does your health coverage include transportation by ambulance if it is medically necessary?
- How soon will you be covered if you go to work for a new employer? If you have a 60 or 90 day waiting period, how do you plan to protect yourself against possible medical bills that could bankrupt you?
- If you must sue your employer, does he carry enough insurance to pay you for your medical care, your time lost from work, or for a disabling injury that lasts for the rest of your life? Would your employer fire you if you asked these questions? If so, your relationship with your employer is fragile indeed.

In 1994, the Coast Guard determined that working on a towing vessel was nine times more dangerous than working at an "average" job – even more dangerous than on a commercial fishing vessel.[(1)] With that in mind, do you have a lawyer in mind that can represent your interests in the maritime environment? *[[(1)]Refer to our Report #R-351, Rev.1 How Safe Is The Towing Industry? This is a reprint of an internal Coast Guard document that was never widely publicized within the towing industry for obvious reasons.]*

As a post-script, John left this thought: "I wish I could make our guys understand that it's not the same world anymore. Small companies are being swallowed up by big companies. Soon, only two or three big companies will be left, and the little guy will not have much of a choice anymore. One mistake and you just won't work on boats again – plain and simple. We are looking at a sweat-shop situation if we don't stand up, pitch in, and get noticed."

[NMA Comment: "…You just won't work on boats again" refers to the practice of "blacklisting" or "blackballing" – a unfair labor practice that ended many seagoing careers. Our Association attempted to end this practice, which has become pervasive in the marine industry.]

ISSUE: INDUSTRY BLACK LISTING PRACTICES AND THE FAIR CREDIT REPORTING ACT

*[**Background:** On Sept. 1, 2003 our Association wrote the following letter to Representative Billy Tauzin (R-La), then Chairman of the House Committee on Energy and Commerce, as well as to each member of the Committee presenting our views on the provisions of the Fair Credit Reporting Act (FCRA). We believe these practices continue to adversely affect our mariners. We followed up our correspondence with a second letter to the Chairman on December 17th. Unfortunately, thanks to former Representative Tauzin, we have absolutely nothing to show for our efforts.]*

Our Letter to Former U.S. Representative Tauzin

"I am writing to you as a member of the House **Subcommittee on Commerce, Trade and Consumer Protection** to earnestly ask you to amend a provision in the Fair Credit Reporting Act (FCRA). I am writing on behalf of the Gulf Coast Mariners Association, an independent Association representing the interests and concerns of approximately 50,000 lower-level merchant mariners who serve on the nation's tugs, towboats, small passenger vessels and offshore supply vessels.

"Employment purposes. 15 USC §1681b indicates that one of the permissible purposes of a consumer report is for "employment purposes." The Federal Trade Commission further defines these "permissible purposes" relating to employment to include reports used for evaluating a consumer "for employment, promotion,

reassignment or retention as an employee." Our request concerns abuse of this provision in a significant, non-unionized portion of the maritime industry for employment purposes.

"We believe that a good employee will try to maintain a good work record. The fact that such a record really exists and may follow him in the workplace provides a positive and sobering influence upon his or her conduct and stability.

"Unfortunately, there is one feature that stands out and detracts from the value of this type of "consumer report." That point deals with the answer to the question, "Would you rehire this employee?" or, restated, "Is this former employee eligible for rehire by your company?"

"We receive widespread reports from our mariners that this single point is used to evaluate and subsequently to "**blacklist**" many of our mariners. It is a "quick and dirty" test of suitability for employment. Our complaint lies with the law and not with the Consumer Reporting Agency that only appears to be doing what the law and/or the Federal Trade Commission allow. We make the following arguments for change. **[Enclosure #1]** is a Work Report with the "would rehire" blank circled. An employer may elect a "Yes", "No" or simply to make no comment.

- "Would not rehire" is not based upon any uniform set of employment guidelines. It is a subjective opinion of some person working for a former employer who is under no obligation to reveal his/her identity or even position within the company. It could represent the opinion of a President, a Personnel Director, or even a clerk-typist with access to the company's computer. In the case covered in **[Enclosure #1]** the employee was never "fired" or even given a "pink slip."
- A mariner does not know which person "blacklisted" him or when it was done. However, "would not rehire" now can appear on a computer screen at a job seeker's next job interview. Or, it may appear as part of the "reinvestigation" the present law allows. In this case, **[Enclosure #1]** the job applicant found out about it three years later – much of that time spent unemployed but constantly seeking work. Although he made written inquiry to both his former employer and to the Credit Reporting Agency, he was never told why his former employer would not rehire him. The information the mariner chose to add to his consumer report to counteract the "blacklisting" was nothing more than a shot in the dark since he had no access to solid facts he could refute. Even worse, his statement now stands out like a sore thumb on his work report.
- Most job applications require job seekers to list their previous employers. In the transportation industry, 49 CFR §40.25 even requires prospective employers to verify a job seeker's drug records for the past two years. If the prospective employer made such a call he would have a greater opportunity to speak with a responsible person in authority and ask legally permissible questions about the job seeker. A "would not rehire" computer entry short circuits the entire process and is manifestly unfair to job seeker.
- Accepting "would not rehire" notations without identifying them by name coupled with the limitation of liability in 15 USC 1681h make it very extremely difficult for an injured employee to prove in court that he was disqualified from employment by "...false information furnished with malice or willful intent to injure such (a) consumer" if this is the case. Our experience shows that most mariners, especially those who are unemployed, do not have the means, the ability, and the knowledge to deal with the administrative procedures of the Credit Reporting Agencies – even when those agencies scrupulously follow the law.

"It is for these reasons and in the interest of fairness to our mariners that I ask you on behalf of our Association to amend the Fair Credit Reporting Act to exclude the solicitation of the information by Credit Reporting Agencies that allows notations such as "would not rehire" or "not eligible for rehire" to appear on a work report furnished by such an agency." s/ Secretary, National Mariners Association

Our Association never received the courtesy of a reply from Congressman Tauzin or from any member of his committee.

[NMA Comment: Former Congressman Tauzin is now a paid lobbyist for a pharmaceutical trade association in Washington. His son was defeated in an election to take over his seat in the U.S. House of Representatives. Sadly, stonewalling this issue only showed that he was never an advocate for our mariners, only for management.]

CASE #5: IN A LIFE OR DEATH DECISION AN EMPLOYER EVADES RESPONSIBILITY

*[**Source:** By Jan Clifford, The Houma Courier, Apr.19, 2006. Emphasis is ours. Our Newsletter #40, June 2006.]*

A Honduran seaman hospitalized in Terrebonne General Medical Center since early February is at the center of what could be a landmark case in maritime law, according to an attorney representing him. While lawyers for the 20-year-old and the tugboat company he worked for argue about who is responsible for the costly life-saving procedure, Dilbert Calix remains in the hospital's intensive-care unit, his condition rapidly worsening.

Calix went to work for Global International Marine of Houma about a year ago. Global International operates ocean-class tugs and barges in domestic and foreign waters. Calix's father Daniel Chacon has worked for the same company for seven years, though he and his son were assigned to different vessels. Neither man speaks English.

Calix got sick in early February while working on a tugboat docked in Houma, said Dora Delancey, Hispanic community coordinator for Annunziata Catholic Church and translator for the father and son.

He underwent emergency gallbladder surgery but didn't get better, she said. That's when doctors made a second, more serious, diagnosis – Calix has congestive heart failure and won't survive without a heart transplant.

But it's doubtful he'll get the surgery unless a judge intervenes.

The problem? Calix could be forced to return to Honduras. His advocates say he's unlikely to get the necessary surgery in that country.

Global International CEO Tony Authement declined comment, citing the ongoing legal dispute. The company's attorney says the company is simply trying to do what Calix, and his father, agreed to when they signed on with the company. The men signed a contract, which states that each agrees to be sent home in the event of any illness, death, or employment dispute, said Randolph Waits, a New Orleans attorney representing Global International.

The contracts are written in English, but they include a measure that says the signers "have read or have had read to them" the contents.

"They agreed by international contract to bring their case before a Honduran court of law," Waits said. He said Global International has the right to send Calix back to Honduras for medical care. Asked if hospitals in that country had facilities necessary for heart-transplant surgery, Waits said he didn't know.

Calix and Chacon say they did not understand the particulars of the contract they signed in order to obtain work. They want Calix to get the operation here, and they want Global International to pay for it. Calix's family and friends say sending him to Honduras without a heart transplant amounts to a death sentence.

While lawyers debate his fate, Calix spends his days in a hospital bed hoping that his condition improves enough for him to be allowed to return to work.

He said he has "never run from work" and dreams of becoming a boat captain one day.

Calix is in constant pain, Myers said, and tries to stay as still as possible for fear of triggering a fatal heart attack. His father keeps a constant vigil at Calix's bedside and worries about the future. Chacon says a company representative told him to stay with his son and promised both men would continue to receive their paychecks.

They haven't gotten the money as promised, he said, and the cash they had is running out.

The men said they had hoped that Marta Chacon, Chacon's wife, could come to Houma and stay by Calix's side so Chacon, who is the family's sole source of income, could return to work. But Marta Chacon hasn't been able to secure the travel visa she needs to come to this country.

Dilbert Calix, a Honduras native who was working for a Houma company, waits in a Terrebonne General Medical

Center hospital room with his father, Daniel Chacon, to find out if he will get the heart transplant he needs to survive. (Sabree Hill/The Courier)

Global International hired Calix through the Harvey-based Pontchartrain Marine, Inc., according to the signed employment contract the family showed a Courier reporter. According to Pontchartrain Marine's Web site, the company provides foreign crewmembers to work on vessels worldwide. Particia Martinez, a human-resources manager for the company, refused to speak with The Courier.

According to Calix's father and uncle, Martinez is the woman who visited Calix's hospital room after his gallbladder surgery bearing a portable oxygen tank and plane tickets to Honduras. That's when the family contacted an attorney. Since Calix needed emergency-medical care while working on an American vessel docked in Houma, his case may fall under U.S. maritime law, said Matthew Slingbaum, a Florida attorney representing Calix.

Robert Myers, an attorney handling the Louisiana proceedings for Slingbaum, said offshore workers have been involved in similar incidents, but this is the first instance involving a resident of another country who has Louisiana ties.

Myers filed a motion late last month, asking a federal judge to determine whether the contract Calix signed is legally binding.

"A seaman is legally a ward of the court," Myers said, adding that the law, which is "hundreds of years old" requires the employer to pay for medical treatment when a seaman is injured or gets sick while working, whether his condition is pre-existing or not.

Authement, Global International's attorney, says the contract is valid, and Calix must seek treatment on his own in Honduras.

If U.S. District Court Judge Carl Barbier of New Orleans agrees, Calix will be sent back to Central America, and Global International will not be liable for his medical bills.

The heart surgery would cost an estimated $500,000; the hospital bills to date are upwards of $200,000, Myers said.

Once Barbier rules on the contract, Slingbaum said he'd file papers alleging that Calix's health problems stem from Global International's hazardous work conditions.

<u>Calix's job was to clean diesel and bilge tanks</u>, the family said, adding <u>he wasn't provided with the necessary protective gear</u>. They allege that's what caused his heart problem and say that a Honduras doctor gave Calix a clean bill of health during a pre-employment physical. The Courier's efforts to reach Dr. Oscar Luis Chavarria in Honduras were unsuccessful.

Waits disputes the men's claims, adding that other family members have suffered the same disease.

Attorneys for both sides say Barbier took an immediate interest in Calix's case, and is moving swiftly to reach a decision.

Waits' response to Myer's motion is due in the judge's office by May 1. A decision should come soon after that date.

As to what will happen if Calix does not recover, Myers said the litigation would escalate.

"We'll file a wrongful-death claim," he said.

ISSUE: WHO CARES FOR FOREIGN SEAMEN WORKING ON U.S.-FLAG VESSELS

We explored this issue in our Report #R-334, Rev. 2, in 2005 when the issue was reignited by the introduction of the Transportation Workers Identification Credential (TWIC) rulemaking reported in our newsletter.

Our Association consistently has opposed the exploitation of American "limited-tonnage" mariners serving on vessels of less than 1600 gross tons. The examples we cite are the abuse of the "12-Hour Rule" revealed in our Reports in the #R-370 series that the Coast Guard chooses to ignore. Cases like these and those reported in 2000 to the Marine Safety Directorate in Coast Guard Headquarters cautioned many mariners and potential mariners to the abuses encountered in working on commercial vessels. These reports were a precursor to the industry's current personnel shortages.

During the past twenty years, boat companies in the inland towing industry as well as the offshore oil industry cut crew size to the bone. Our mariners' wages failed to keep pace with inflation. Mariners were routinely overworked and overwhelmed in several attempts to organize to protect and advance their own interests.

The Pilots Agree movement on the western rivers and Gulf Intracoastal Waterway in 1998 was followed by an attempt to organize an independent union (Offshore Mariners United) to represent thousands of mariners in the offshore oil industry. These two movements were defeated by millions of dollars spent by boat companies and industry trade associations that even stooped to hiring professional "union busters" to distort the issues and even

mislead mariners. Our Association's Directors and members are veterans of these movements and continue to assist and inform our limited-tonnage mariners. While we witnessed these events happen, we do our best to maintain a record of these events and explain why they happened and see that they are not repeated.

Temporary Work Visas Are No Answer

Boat owners are becoming desperate to crew their boats. Many boat owners believe their key to "success" is to recruit "cheap" labor. "Cheap" inevitably leads to using individuals from foreign countries who may be desperate for a job or to immigrate to the United States for a "better life."

A letter in the May 2006 issue of WorkBoat magazine suggested that the maritime industry be granted an allotment of H-1B visas so they can bring in skilled workers from other countries as is allowed in other industries with a proven shortage of skilled labor.

We were not impressed with this argument. However, we were impressed, by a letter, by a Lawrence Crompton, a 1600 GT Master and Third Mate who wrote the following letter in WorkBoat's June issue.

"I strongly disagree with the letter…"Temporary Visas Could Ease Mariner Labor Woes." Not only would it not ease the woes, it would create even more problems.

"First, the officer pool in the "patch" (i.e., offshore oil industry) is made up almost entirely from those who came up the hawsepipe. When we open the entry-level jobs to H-1B (visa) labor, who are we training to run the boats in the future? It would only take a few years worth of layoffs and rehire cycles, and we would have to start hiring H-1B officers. How does that ease the woes?

"Second is the Jones Act. Shall we abolish it all at once to bring in "skilled workers" from other countries or just whittle it away piece by piece? The loss of the Jones Act would mean the death to U.S. maritime labor. We would also have to ask just how skilled these laborers are. Many of the H-1B workers I have seen are hired from their government-owned employment services. Will those governments also guarantee the skill and training levels of the workforce?

"The last thing I want to mention is the revolving door of H-1B labor. In other industries, H-1B labor has been used for short term (often on a six-month work visa) in jobs the employer can't find local labor to fill. Most are minimum wage positions. Once these jobs have been given to H-1B labor, there is no reason to improve working conditions and make wages more appealing to the local workforce. In six months (with a minimal amount of paperwork) they hire another group for the next six months.

"In the Oil Patch they are having a hard time with labor because of the working conditions and wages. When the less expensive H-1B labor comes in then wages will most likely drop, benefits lost, rotations will increase to six months on (same as the work visa) and conditions will not improve, except when legally required. That will surely push the mariner out of the workforce. I guess that would ease the woes of the U.S. mariner, because there wouldn't be any."

NMA Traditions

From the earliest days of our Association, the International Transport Workers Federation (ITF) always has been a source of support. We recall the day when one hundred fifty ITF delegates attending an international conference in New Orleans marched in support of our mariners and demonstrated in front of the Work Boat Show. They came from all corners of the world to protest the way that the offshore oil industry trampled the rights of our mariners.

Our concern over the employment of foreign workers follows most of the concerns mentioned in Lawrence Crompton's letter as well as the fact that the same people who exploit American workers can be trusted to do the same thing to foreign workers. This case serves as an example that we brought to the attention of both the Coast Guard and the International Transport Workers Federation.

CASE #6: "GREEN" DECKHAND LOST AT SEA – THE M/V GULF PRIDE CASE

*[**Source:** NMA File A-174]*

*[**Disclaimer:** What follows is not legal advice. Rather, it is a synopsis of information gleaned from reading this case. Each case must stand on its own merits. If you have a specific legal problem, you should contact a lawyer for legal advice.]*

If there is any "Gulf Pride" in the offshore oil industry in the Gulf of Mexico it is not symbolized by the now-defunct company of that name nor by the repossessed crewboat bearing the same name. In fact, the boat owner, the boat, its master and mate were just about as sorry as it gets out in the oil patch.

This is the largely untold and unpublicized story of what many "limited-tonnage" mariners knows that happens in a hundred different forms but never sees in print. When a whiff of scandal does reach the newspapers, it may as is this case, it may appear in a 3½-inch release from the court announcing a decision.

There are things that industry apologists who post yellow and red signs up and down the bayou don't want the general public to know about the marine industry. It is the truth about things that happen to many of our mariners both in the Gulf of Mexico as well as on inland waters.

The marine industry can be a very dangerous place for a newcomer, especially a young man with little or no experience around boats. It does not have to be a hostile environment, but it can still be a dangerous one because of the hazards of the oil industry. These hazards are coupled with the hazards of the sea and the carelessness of some people who work in the industry. The lack of standards of care and ethics of some (but not all) boat owners, whether individual or corporate, creates a workplace that leaves a great deal to be desired.

This is a true story brought to our attention by a brief news release of 3½ column inches in a local newspaper that never made front-page news. It announced a sizeable settlement made on behalf of two children of a mariner lost at sea. We extracted the story from the public record. The matter was brought to its conclusion by a team of persistent attorneys(1) who exposed a pattern of carelessness and neglect that left a several insurance companies holding the bill for insuring a very questionable commercial boat operation. *[(1)Hebert & Marceaux, 8026 Main St, Houma, LA 70360. (985) 876-4324]*

To secure "justice" in the marine industry, a mariner – and often his family or heirs – must be prepared to fight for it. To do this, you will have to call on the services of an experienced admiralty attorney who has studied the law, is conversant with all sorts of federal regulations and agency policies, and above all, is able to combine considerable legal research in case law with some good detective work and credible expert witnesses to forge the tools necessary to prevail.

The maritime industry in this part of the country brainwashes the public to look askance at trial lawyers much as they have been taught to look down on our "limited-tonnage" mariners as "boat trash." However, without conscientious trial lawyers, our mariners would never have their day in court.

Statement of the Case

*[**Editorial note:** Most of the following was extracted and edited directly from the public record with legal citations removed for ease of reading. Although some names are presented, others are not identified in the interest of privacy. Most of the events recited took place in Terrebonne Parish, LA, and in nearby offshore waters.]*

Names and Positions

- Jamie Ashford - Deckhand lost at sea.
- Robert Jones(1) - Boat owner of M/V Gulf Pride
- Captain Gerald Smith(1) - Captain M/V Gulf Pride
- Phil Taylor(1) - Unlicensed Relief Captain, Mate of M/V Gulf Pride

[(1)A pseudonym.]

["I guess the thing that is most shocking to my soul and heart is the fact that when they reached the Global Dock, the captain did not report Jamie missing, and in part his fault and part the fault of Mr. Jones because they were both aware that he was missing and to wait some 12 to 13 hours before reporting it to the Coast Guard or the Sheriff's Office is almost criminal in my mind. I think it could be considered a cause of Mr. Ashford's death." The Court.]

Trial court's decision.(1) The trial court held that Jamie Ashford died on the high seas, i.e., beyond territorial

waters. The court concluded that Jamie's survival time in the cold water was 5-6 hours. *[(1)The trial took place in the 32nd. Judicial District Court, Terrebonne Parish, LA. The decision was appealed to the First Circuit, Court of Appeal, in Baton Rouge, LA, that rendered its decision on Mar. 28, 2002.]*

The trial court found that the evidence proved that Gulf Pride was negligent for:

- failure to report a man overboard;
- failure to conduct a search and rescue for over twelve hours;
- failure to have a proper communication system between the captain and crew working at night;
- failure to obtain knowledge of Jamie's whereabouts;
- failure to properly man the vessel for the job;
- failure to provide proper training and rules on the proper use of safety vests; and
- the bulwarks on the vessel were low.

The court found that Jamie was a young, "green" hand and, thus, was not contributorily negligent. The court held that the vessel was unseaworthy, but was not the proximate cause leading to Jamie's death.

Jamie was 22 years old. He was a first-time deckhand assigned to the M/V Gulf Pride. He fell off the vessel on Jan. 27, 1997 while he was on night watch. Captain Gerald Smith testified that it was four hours after last seeing Jamie before he realized that he was no longer on the vessel. However, Jamie was conducting his night watch activities, as required by law. More egregious, however, was that once Captain Smith reached the dock in Houma, he did not call the Coast Guard. Rather, he called the vessel owner, Robert Jones. Nevertheless, neither man called the Coast Guard or law enforcement until the next day, well past any possible survival time. In fact, Captain Smith went to bed.

The defendants stipulated (i.e., agreed) that Jamie was a Jones Act seaman. They acknowledge their duty to keep watch and to rescue crewmembers that fell overboard. After Jamie's mother (i.e., the "plaintiff") presented her case, defense counsel admitted to the court that it was reasonable to infer from the evidence that Jamie fell off the M/V Gulf Pride.

Another unfortunate human being who previously had fallen off a vessel spent 10 hours in the Gulf of Mexico, and survived, stated, "I was not ready to die." He was lucky, but Jamie was not as lucky and is dead. The defendants' actions in this case are horrible by any standards of humanity.

Jamie's employment. Gulf Pride Marine Services, Inc. employed Jamie in Nov. 1996. He was 22 years old. He was assigned to the M/V Gulf Pride as a deckhand/seaman. On the date of the accident, a three-man crew manned the M/V Gulf Pride. The crew consisted of Captain Smith and Relief Captain/Mate Phil Taylor, and Jamie.

The Gulf Pride is a 95-foot, 92 gross ton aluminum hull crewboat. Other than working for several months as a roustabout/roughneck aboard a drilling rig, Jamie had little experience in the oilfield. Jamie's first experience working aboard vessels was with M/V Gulf Pride. He had only worked a couple of months on the vessel at the time of the accident and was a classic "green" hand. According to Captain Smith, it was his responsibility to train Jamie on the job. He admitted that a two to three month "first time" hitch was little experience.

The Gulf Pride (the boat and the company) were formerly owned by Robert Jones. Gulf Pride is no longer in business because of extreme financial trouble.[(1)] This led to its failure to maintain the two vessels which comprised its fleet. Subsequent to the incident at issue, Sea Craft Corporation seized the M/V Gulf Pride because Gulf Pride did not pay for necessary repairs done to the vessel. Jones is a convicted felon for theft. *[(1)For a colorful yet sordid history of Gulf Pride's "operations" see <u>Matter of Gulf Pride Marine Service, Inc.,</u> 1997 WL 118394 (E.D. La. 1997).]*

The M/V Gulf Pride was a vessel inspected by the United States Coast Guard. After inspecting the vessel, the Coast Guard issues a Certificate of Inspection with certain requirements for the vessel that must be followed along with vessel manning requirements. The certificate is then posted on the vessel in public view. The Coast Guard performs inspections and re-inspections annually. If events occur during the year that affects the vessel's seaworthiness, the captain is required to notify the Coast Guard.

<u>The M/V Gulf Pride was supposed to have a minimum of a four-man crew when operating more that twelve hours per day</u>. However, Jamie was part of only a three-man crew when he drowned. Captain Smith testified that <u>with a three-man crew, the vessel was considered undermanned</u>. He often complained to Jones about operating with only a three-man crew but Jones disregarded his complaints.

[NMA Comment: The Coast Guard has an absolutely dismal record of enforcing its vessel manning requirements in the Eighth Coast Guard District.]

Global Industries chartered the M/V Gulf Pride to provide crewboat services to its pipe laying barges working in the Gulf of Mexico. On Jan. 27, 1997, the M/V Gulf Pride made a trip to the Global pipe-laying barge GP-37,

which was working on the outer continental shelf (OCS). It was located in the Gulf of Mexico, approximately four to five hours from Global's dock in Houma, LA. The lay barge was located southwards from Cat Island Pass, the entrance to Terrebonne Bay. Captain Smith, along with mate Taylor and Jamie traveled past territorial waters to reach the GP-37.

Approximately thirty Global employees boarded the M/V Gulf Pride to ride home. Captain Smith began the return trip from the Global barge, heading to the Global dock in Houma where the passengers would disembark.

The only crewmembers transporting the passengers while underway were Captain Smith and Jamie, as his watchman. Jamie, as the deckhand on watch, would be "about" the vessel in order to perform his duties. For example, Captain Smith testified that when they were underway, he ordered Jamie to check the engineroom every twenty minutes – but apparently never checked to determine that this was being done.

After the Global passengers boarded the boat in the Gulf of Mexico, they went below deck to the cabin and there they went to sleep during the ride in.

The M/V Gulf Pride got underway between 6:30-7:00 p.m. in darkness. Captain Smith took a route that allowed them to travel through Cat Island Pass, up the Houma Navigational Canal, and ultimately to the Global dock in Houma. The seas that evening were estimated to have been between two and four feet, with occasional swells. The water temperature was 62 degrees.

[NMA Comment: Hypothermia is a serious issue facing mariners who fall overboard in cold water – and one the Coast Guard has neglected. See Our Report #R-354, Rev. 4, <u>An Appeal to the 111th. Congress on Lifesaving Issues that Affect Our Limited Tonnage Mariners</u>.]

Upon getting underway, the vessel ran without using either its inside or deck lights. Jamie was in the pilothouse with Captain Smith and a passenger. Captain Smith allowed Jamie to pilot the vessel for approximately 15 minutes. Thereafter, Jamie left the pilothouse. Captain Smith claims Jamie's destination was not known exactly, a claim that relies upon Captain Smith's veracity. Mate Taylor was sleeping since it was his time off duty.

The M/V Gulf Pride arrived at the Global dock at approximately 11:30 p.m. on Jan. 27, 1997. However, Jamie was not on deck to throw the lines to tie up the vessel. Unless Jamie could walk on water, it soon became clear that he was not on the vessel. Ironically, Captain Smith testified that he had not seen Jamie for the last three and one-half to four hours of the voyage. Captain Smith did not know Jamie's whereabouts for almost the entire trip. Modern seamanship practices and common sense dictate that the captain account for his crew on duty at regular intervals and use communication devices, such as walkie-talkies, to stay in contact with his deckhand on watch. All the vessel captains, including mate Taylor, testified that Captain Smith should have checked on Jamie's whereabouts every 15 to 30 minutes. Captain Smith was aware of his duty to care for and look out for the safety of his crew.

Captain Smith was the master of the vessel at the time that Jamie drowned. Captain Smith's license is currently under suspension because he failed a Coast Guard drug screen unrelated to this incident. Mate Taylor was not licensed because he pled guilty to negligent homicide in 1995 when he attempted to "perform surgery" on his girlfriend who overdosed. He has a 7th grade education. <u>Jones knew that he was required to have two licensed personnel on board the vessel</u>.

[NMA Comment: This "inspected" vessel should have operated with two licensed officers and two deckhands. Coast Guard inspectors should have checked its logbook to verify that it was operated consistently in this manner. Section 607 of the Coast Guard Authorization Act of 2010 mandated strict logbook standards requested by our Association. It will be up to the Coast Guard to enforce those standards.]

The boat. On Jan. 27, 1997, as well as several months before and seven months after, the M/V Gulf Pride had problems taking on unwanted water because of a cracked hull. Captain Smith knew this, but never reported the hull problem to the Coast Guard, as he was required to do. Captain Smith knew that once they got offshore, the boat had to be pumped out with the bilge pump. He knew this would be done at night, and would require the deckhand to check for oil discharge sheen by looking overboard because some oil commonly leaks into the bilge from the engines. Monitoring the bilge pump's flow was a continuous operation. Although a person inspecting the engineroom could tell if the bilge pump was pumping, he could not tell if it was pumping oil overboard except by visual inspection. To make this visual inspection, a person had to straddle the side of the vessel and lean over the side to view the discharge opening approximately 2 feet above water level. However, the top of the bulwark railing presented a hazard because it was below knee height.

Captain Smith knew the severe consequences of discharging oil in open water; and he knew that the "red hand" patch material was not stopping the leak in the vessel. In fact, the M/V Gulf Pride's Certificate of Inspection was temporarily suspended during a routine inspection in Aug. 1997, months after the accident, because of the cracks in the hull. Since Jones did not want his customers to know his boat leaked, he instructed Captain Smith to make no such notations in the billing logs. Although requested in court, Gulf Pride did not produce the official Captain's logs or the engineroom logs for Jan. 27, 1997 or surrounding dates.

[NMA Comment: Our Association prodded the Coast Guard to make needed reforms in the way that entries are made in a vessel's logbook – and did nothing. Therefore, we brought the matter to the attention of Congress.]

Part of Jamie's deckhand duties, although Gulf Pride never specifically trained him how to do it, was to check the bilge discharge while the pump was operating. Furthermore, no one ever told Jamie to wear a life vest or life jacket to perform this inspection or even while the vessel was underway.

The last time anyone saw Jamie alive was between 15 and 60 minutes after departing the GP-37 lay barge. Allegedly, Captain Smith did not know where Jamie was going when he left the wheelhouse. Of course, Captain Smith would never announce to his passengers that the vessel had problems taking on unwanted water! About thirty minutes after getting underway, a passenger saw Jamie down below looking for something in the storage compartment. At the time, Jamie had a life vest on. The item Jamie removed from the closet had a hose on it and appeared to be a pump. Another passenger saw Jamie on deck heading towards the side of the vessel.

Although Jones and the Coast Guard records dispute Smith's testimony, Smith claims to have no idea when Jamie was last seen. At no time did Captain Smith attempt to backtrack and perform what is known as a Williamson Turn maneuver to search for Jamie. This could easily have been done since Captain Smith had tracked his route on LORAN. Once he reached the Global dock in Houma, Jamie was not onboard. Captain Smith and mate Taylor did, however, search the vessel. They found Jamie's clothes and wallet, and Taylor claimed that the wallet was empty. The Terrebonne Parish Sheriff's Office later returned Jamie's clothes to his mother.

Knowing that Jamie obviously was not on the vessel, Captain Smith refused to notify the Coast Guard. Rather, he called Jones from the Global yard. This was after the vessel docked in between 11:00 p.m. and 12:00 a.m.

Jones instructed Captain Smith and mate Taylor to take no further action because allegedly he wanted them to wait until the morning to "see if Jamie would reappear." This was under the guise that Jones believed Jamie had left the vessel to go drinking in bars. Captain Smith and mate Taylor then went to bed. The next morning at approximately 8:00 a.m. Captain Smith again spoke with Jones. Finally, on Jan. 28, 1997, at approximately 10:14 a.m., fourteen hours after leaving barge GP-37, Jones notified the Coast Guard in Grand Isle. Around 11:00 a.m. he notified the Terrebonne Parish Sheriff's Office. He told these agencies that Jamie was missing and that "he was last seen at the dock." Jones never ordered his crew to use the vessel and attempt a search.

The Coast Guard dispatched a helicopter to cover the Gulf and notified the Terrebonne Parish Sheriff's Office. According to the Coast Guard's official record, Jones called the Coast Guard. The Coast Guard report states that Jones told them a person was in the water off the vessel M/V Gulf Pride and was last seen at "Cat Island Pass working on a light in a shop." The shop was the engineroom. Cat Island Pass is about ten miles offshore from the mainland at the entrance to Terrebonne Bay.

Captain Smith testified that he did not know who told Jones this information. On the other hand, Jones, by deposition impeachment testimony, testified that the crew thought Jamie had fallen overboard. Jones did not report the claim to his insurer until June 17, 1999 (almost 5 months after the accident), and falsified certain information about the incident.

The vessel had two logs: (1) The rough log that kept day-to-day events; and (2) a smooth log, sent to the customer, and called the billing log. Defendants never produced the rough logs and produced only portions of the billing logs. Captain Smith testified that the rough logs should contain information about the incident. Further, problems with the vessel were logged there as well.

Neither Captain Smith nor Jones ever filed a Coast Guard Form 2692 Incident Report to report the accident. The Coast Guard requires that this form be completed along with a 2692-A Substance Abuse Form. Also, the captain must take a substance abuse test within two hours after a serious incident such as loss of life occurs. This never happened.

A former Gulf Pride captain and close friend of mate Taylor's testified that during the early morning hours of Jan. 28, 1997, mate Taylor called him and was very excited and confused because he did not know what to do. Taylor told his friend that Jones wanted him and Captain Smith to lie by telling the authorities that they saw Jamie

leaving the vessel after it arrived in port. Mate Taylor admits that he called his friend to tell him about "a missing deckhand" and that he was upset. Mate Taylor could never be located, until shortly before trial when Gulf Pride found and produced him for a deposition. A "statement" was written by Gulf Pride's attorney at his office before the deposition and Taylor signed it.

The Global yard is a fenced-in yard with barbed wire and has a secured exit with a guard shack. It is well lighted with two or three security officers that checked out persons in and out of the yard. Security guards also patrolled the yard. A security guard noted in his logs that "word on the yard is that the deckhand was last seen near the sea buoy." No one at Global ever saw Jamie. No passenger who disembarked from the vessel saw Jamie at the dock. From the dock to the Global parking lot is about 829 feet, and means that everyone had to walk from the dock to the parking lot.

A Detective Lieutenant of the Terrebonne Parish Sheriff's Office investigated the case. He placed Jamie's name in the nationwide computer service used by law enforcement. On Mar. 10. 1997, a U.S. Customs Inspector from Galliano, Louisiana, called the detective. When the M/V Gulf Pride operates beyond territorial waters, a vessel officer, by federal law and under oath, must certify who comprises the vessel's crew. She informed the detective that Captain Smith and mate Taylor listed Jamie as a crewmember aboard the vessel on at least three separate occasions after Jan. 27, 1997. By signing the declaration forms indicating that Jamie was part of the crew on those occasions, the captain and mate certified that the information was true and correct.

After receiving this information, the detective immediately went to Jones' home in Chauvin, LA, which served as Gulf Pride's office. The detective was very puzzled that Jamie was still being listed as a crewmember aboard the vessel. Jones was aware that the captain and mate continued to use Jamie's name as a crewmember. Jones told the detective that he was required to have four (4) people on the vessel. Neither the Terrebonne Parish detective nor an independent detective have been able to find Jamie.

In 1996, David Morin prepared a safety audit, by written questionnaire, on Gulf Pride for insurance purposes. He wanted to see what safety procedures that Gulf Pride had implemented. Jones told Morin that the vessel maintained daily logs; after an accident they conducted drug testing; there was a formal written safety program; the crew on the vessel consisted of four members; and that they maintained two types of logs – master's rough log and Gulf Pride billing log. Morin then made recommendations to Jones on reporting and investigating incidents and provided him with Coast Guard forms.

Jones did not provide deckhand safety manuals to new employees, and Gulf Pride had no safety or training programs.

[NMA Comment: The Coast Guard has no requirements for training "green" deckhands or "deckineers" who are expected to work in the engineroom. We explain this sorry state of affairs in our Report #R-428, Rev.1.]

Captain Smith testified that it was only mandatory at a dock or when a barge was at the stern bitts for crewmembers to wear a life vest. Captain Smith and mate Taylor testified that they never wore work or life vests while aboard the M/V Gulf Pride.

Captain Smith quit Gulf Pride in May 1997 for fear of losing his license because of safety concerns aboard the M/V Gulf Pride. He testified that Gulf Pride's paychecks were bad. In May 1997, by impeachment, Captain Smith admitted that the hull leak still existed.

Dr. Alan M. Steinman, a former Coast Guard surgeon general who is board certified in occupational and environmental medical matters, specialized in sea survival in cold weather, cold water exposure, hypothermia, and drowning. He is the author of numerous publications on sea survival and hypothermia and was a flight surgeon. He is a graduate of M.I.T., Stanford, the Mayo Clinic, and the University of Washington and has performed experiments on sea survival and hypothermia. He was the Coast Guard's expert for twenty years in this field.

As an expert witness, Dr. Steinman offered the opinion that Jamie had a sea survival time of 5 to 10 hours in seawater of the temperature at the time of the accident. The Coast Guard records estimated Jamie had sea survival time of 8 hours. Dr. Steinman explained the events Jamie went through psychologically and physiology immediately upon falling into the water and up to his death.

Falling overboard is common on vessels. In its practice of search and rescue, the Coast Guard's purpose is to rescue people in the water. A timely rescue is relevant to survival. A lifejacket will not prevent death unless a person is rescued in a timely manner. It is not unusual that a body lost at sea cannot be located. Dr. Steinman testified that people do not become unconscious immediately upon entering the water. Also, it is unusual to be sucked under the boat after falling overboard. The defendants' expert said that Jamie would have survived if rescued within two hours and further testified that Jamie would not have become unconscious upon immediately

hitting the water. Both experts testified that Jamie would have suffered a horrifying death.

Finally, Gulf Pride did not do an investigation or take any statements concerning Jamie's drowning. Captain Smith and mate Taylor downplayed the leak on the vessel. They testified: "we patched it with red-hand." On Aug. 15, 1997, upon routine inspection, the Coast Guard pulled the M/V Gulf Pride's Certificate of Inspection when they found "a crack in the engineroom covered with red hand" and the life rings and life jackets were unsatisfactory.

Jamie's father testified that Jamie had little experience in the oilfield although he wanted to learn about it. In late Dec. 1996, Jamie was in good spirits. Jamie was working to buy a car and marry his fiancée. He was a fair swimmer.

The Building Blocks of This Case

For those mariners who believe the Coast Guard is out there on the water to protect your interests, think again. The Coast Guard does its best to police the waterways with its limited resources and does a good job in carrying out search and rescue work. The Coast Guard expects mariners to obey all laws and regulations, but does not always enforce all the laws uniformly. As you can see, they played a very minor role in this and many other cases that affect mariners that are finally resolved in court.

This case relied upon a number of laws and regulations. However, it also relied just as heavily on judgments reached in previous cases that were applied to the specific circumstances of this case (i.e., case law).

In this particular case, certain laws, regulations, policies, principles and precedents were skillfully blended together to identify the parties responsible for Jamie's death, to prove they were responsible, to arrive at a fair and just settlement for Jamie's mother and two children. Properly blending and presenting it at two trials and defending it against all challenges is up to the attorneys.

In this case, the "blend" involved each of the following items to some degree or another. Do not consider any of these to be absolute pronouncements that you can consider as your "rights" as a mariner. You may find some of them helpful, where some may be of no value. However, based on this particular case, these are at least "talking points" if nothing more:

1. If a trial court makes an error of law, the appellate court (i.e., court of appeal) reviews the evidence de novo.(1) *[(1)**Vocabulary: De novo** = a second time; from scratch.]*
2. The Jones Act states that the recovery of damages for death of seaman shall follow the laws for railway employees. *[Railway employees are covered by the Federal Employers Liability Act of 1908 (FELA) as amended.]*
3. Under FELA, a Jones Act seaman who dies has a negligence cause of action(1) for survival and wrongful death damages. *[(1)**Vocabulary: Cause of action** = a claim in law and fact sufficient to demand judicial attention to enforce a right.]*
4. If the death occurs on high seas, the Jones Act seaman has an additional claim for unseaworthiness for wrongful death under the Death on the High Seas Act (DOHSA).
5. The Outer Continental Shelf Lands Act (OCSLA) and its complimentary regulations may apply to vessels working on the water and regulates OCS activities in navigable waters. OCS activity includes any offshore activity associated with exploration or development of minerals.
6. Workplace safety is paramount on the outer continental shelf. Owners must conduct workplace activities free of hazards that can cause death or serious injury.
7. Adjacent state law may be adopted as Federal Law for damages and liability for breach of OCS violations.
8. The Code of Federal Regulations (CFR) may have the force and effect of law.
9. Coast Guard regulations may be used to establish a duty under Louisiana law and are adopted as federal OCS law.
10. Damages available under the Jones Act are survival and wrongful death. Survival damages under the Jones Act allow recovery for pre-death pain and suffering. These damages include compensation for the terror and fright a drowning victim experiences on the realization that he is about to lose his life.
11. Under the Jones Act, wrongful death damages allow recovery of only pecuniary damages. Pecuniary damages are generally defined as loss of support; loss of services; loss of nurture, guidance, care, and instruction; loss inheritance; loss of earning capacity; and expenses. The Jones Act does not allow recovery for loss of society, loss of consortium, or punitive damages because they are non-pecuniary.
12. DOHSA provides only a wrongful death remedy. DOHSA follows the Jones Act and only allows recovery for pecuniary damages for wrongful death unseaworthiness claims. The courts have allowed the following damages: loss of support; loss of services of deceased; loss of nurture, guidance, care, and instruction; Loss of inheritance; and funeral expenses.

13. DOHSA and the Jones Act may allow recovery for loss of inheritance, which is different from future loss earnings.
14. Under the General Maritime Law, there are survival and wrongful death remedies. Damages for a General Maritime death claim in territorial waters may be loss of support, loss of services, funeral expenses, loss of nurture, loss of inheritance, and loss of fringe benefits.
15. A seaman may be allowed to supplement the Jones Act with Louisiana law because the Outer Continental Shelf Lands Act (OCSLA) federalizes state law. The seaman's beneficiaries have the benefit of recovering Louisiana damages for mental anguish, and loss of society, love, and companionship by applying Louisiana law as an additional damages remedy.
16. The Jones Act requires a reasonable man standard. The negligence of the employer must be judged as a reasonable employer under like circumstances; and the seaman's negligence must be judged according to a reasonable seaman under like circumstances.
17. Negligence on the part of the employer may arise in many ways, including failure to provide the seaman a safe place to work, existence of a dangerous condition aboard the vessel, or any other breach of the standard of care. Since the duty to provide the employee with a safe place to work allocates substantial risk of maritime employment to the employer, identical conduct is not demanded of the employer and employee. Different risks are allocated to different parties. Central to the negligence inquiry is who had the duty to eliminate or minimize the risks.
18. Even under the ordinary standard of care required under the Jones Act, the <u>slightest</u> evidence meets the burden of proof.
19. The duty to provide a seaworthy vessel is a non-delegable duty on the vessel owner. Defective conditions on a ship or its appurtenances, and unqualified crews, all are situations that give rise to unseaworthiness. The test is one of reasonable fitness.
20. A vessel crew that is trained inadequately, not instructed properly, engages in unsafe work methods, or is furnished inadequate equipment can result in unseaworthiness.
21. Although a safer method may be proven, the causal chain is not broken if the evidence establishes that the seaman did not know of the safer method.
22. Failure to supply a vessel with a crew both adequate in number and competence in duties constitutes a classic case of unseaworthiness.
23. The rescue of a person in the water gives rise to an <u>exceptional duty and accountability</u>. The underlying character of the duty the employer owes a seaman overboard is such that, although it is less than a duty to rescue him, regardless of the cause for which he went overboard, it is a positive obligation to make a sincere attempt at rescue. "The duty is of such nature that ... once the evidence sustains the reasonable possibility of rescue, ample or narrow, according to the circumstances, total disregard of the duty, refusal to make even a try imposes liability."
24. The maritime rescue doctrine provides that where a seaman "has apparently fallen overboard, but his presence or location in the water is not readily discernable from the ship, the ship's officers are required to both effect a search of the area traversed by the ship and to rescue the seaman, so long as it is reasonably possible that the seaman remains alive in the water."
25. The absence of a crew member cannot be disregarded with impunity. Certain knowledge that a <u>seaman is missing is not a prerequisite to the duty of search and rescue</u>. The maritime rescue doctrine is based on the law of negligence, and like other aspects of this law, responsibility is tested by the standard of reasonable care.
26. If there is a reasonable possibility of rescue, the ship is under a duty to search and attempt a rescue when its officers know or, in the exercise of reasonable care, should have known a crewman is missing.
27. A Jones Act employer has a duty to supervise or instruct seamen as to safe methods by which they can carry out orders given to them.
28. A vessel captain has a duty to look out for the safety and care of his crew.
29. If a seaman is required to do his work in a dangerous manner where there are other and safer ways to do it, an officer may be negligent by having breached his duty to exercise reasonable care for the seaman's safety.
30. Whatever a ship owner might be permitted to do with respect to seasoned hands familiar with the peculiar hazards of the sea, it is plain that it may not be able to absolve itself of the obligation to furnish a seaworthy vessel and exercise prudent care for seamen by leaving this important decision (e.g., to wear or not to wear a life vest) up to an inexperienced person who had not yet begun to get his sea legs.
31. The mere issuance of a Certificate of Inspection by the U. S. Coast Guard does not mean that the vessel is seaworthy.

32. There may be no contributory negligence (on the part of the seaman) if the violation of a safety statute contributes to the seaman's injury.
33. If there is a violation of a statute, there may be a presumption of liability without regard to the seaman's negligence.
34. Unseaworthiness, like Jones Act negligence, can also be the per se result of a regulatory violation.
35. A vessel cannot begin to sail in an unseaworthy condition.
36. A captain must render assistance to seaman overboard.
37. A small passenger vessel may have to have a public address system. *[46 CFR 184.610.]*
38. The master and crew must be properly trained and trained for man overboard situations.
39. The failure to investigate a serious incident without substance abuse testing may violate federal statutes and regulations.
40. Adequate rails are needed on a vessel to prevent persons from falling overboard.
41. The standard in an unseaworthiness claim is "proximate cause in the traditional sense." Proximate cause means that:
    a. The unseaworthiness played a substantial part in bringing about or actually causing the injury; and
    b. The injury was either a direct result or a reasonably probable consequence of the unseaworthiness.
42. Courts have viewed the failure to make and keep appropriate entries in vessel logs with suspicion and disfavor. Failure to make, critical entries is proof, by itself, of the facts omitted.
43. Absence of a controversial fact in a logbook may be significant in evaluating testimony.
44. Suppression and loss of the vessel logs, such as spoliation of evidence, may create a legitimate inference that if the true facts were entered in the logs they would be unfavorable to the vessel.
45. A vessel's logs must be preserved after an incident.
46. A captain should log all vessel accidents.
47. When a seaman deserts a vessel, a vessel officer should promptly make an entry of this fact in the vessel's logbook. The entry must be signed by the master and witnessed by the mate or a crewmember.

There is a presumption of innocence from a charge of desertion in favor of the seaman if he leaves his clothes aboard the vessel when he left the ship. Leaving his clothes and possessions aboard his ship may be prima facie evidence that the seaman did not intend to desert his ship.

ISSUE: STACKED DECK: DEATH ON THE HIGH SEAS

***[Source:** Our Report #R-309, Mar. 20, 2002. From National Fisherman, Apr. 2002 issue with permission.]*

Rusty Smith was working as a first mate on a freighter in Alaska when a pallet jack ran over his foot, breaking his big toe. Smith, a 10-year veteran in the merchant marine who has also worked on crab boats, trawlers and tugs in Alaskan waters, toughed the injury out until arriving in Dutch Harbor on Jan. 5.

At the hospital, doctors discovered an infection and put the 46-year-old Ballard, Wash., resident on an intravenous drip of antibiotics and put his foot into a whirlpool filled with betadine solution. Smith wanted the physician treating him to allow him to go on light duty, so that he could earn a living. But the doctor declared him unfit, gave him a pair of crutches and told him to return home to Ballard for further observation and treatment.

"The doctor said, "You could lose your toe or the lower part of your foot," Smith recalls.

It was then Smith found out just how tough life can get for injured, out-of-work seamen. Although the company he was working for is on the hook for Smith's medical bills, it will only have to pay a fraction of his living expenses while he's unable to work.

A shore-based employee could expect to get up to two-thirds of his income while out on workers' compensation, But under the Jones Act – a law governing maritime injuries – Smith will be lucky to get $35, a day. The act says he is entitled to maintenance (the cost of room and board for the time he would have been out at sea) and cure (the cost of his medical bills).

It may sound good, in theory, but the reality is that boat owners and insurance companies typically end up spending very little for maintenance and may even cut corners when it comes time to pay for the cure.

Smith says that the company he worked for is trying to get him to accept $20 a day for maintenance, although under its typical contract, an officer would get $35. Smith, who was working without a contract, has hired a lawyer. As parsimonious as the $20 may seem, it's typical for the industry. Payouts for maintenance in the United States generally range from $8 to $20 a day.

Over the long term, lawyers explain, Smith may be entitled to more than just the maintenance and cure if he is

able to prove the pallet jack was poorly maintained. In instances where a seaman can prove unseaworthiness or negligence on the part of the boat owner, he can sue for emotional pain and suffering and for all of the lost wages he suffered while out of work – in the latter case, a right not typically accorded to shore-based employees under state-run workmen's compensation programs.

Additionally, if the injury is permanent, a seaman is entitled to recover the difference between his income as a seaman and his income in his next line of disabled, the seaman is entitled to full wages. But recovering these payments can take months or years, which makes the dependence on maintenance payments from insurance companies so important to injured seamen.

"A seaman cannot have a roof over his head or survive on $20 a day anywhere in the U.S.," says Smith's lawyer, Seattle-based Anthony Urie. "Maybe in Mexico, but not in the U.S."

But if it seems harsh that an injured seaman is expected to make-do on $20 a day, God forbid he or she should get killed at sea. If he is unmarried or has no children, his parents and siblings get nothing.

Indeed, while under U.S. maritime law a vessel's owner or insurer may be forced to compensate a seaman who survives an accident, either may get away scot-free if he dies. The reality is this: The death of a fisherman with no wife or children costs a vessel less than an amputated pinky. "There's a saying among marine insurers," says David Anderson, a partner in the Boston-based maritime law firm, Latti and Anderson. "If you're going to hurt him bad, make sure he dies."

The law largely responsible for this state of affairs is called the Death on the High Seas Act. The 1920 law stipulates that the survivors of seamen (a legal category that includes fishermen) who die offshore as a result of an accident are entitled to sue for monetary damages and for the conscious pain and suffering of the seaman before he died. If the survivors prove that the death was the result of negligence or unseaworthiness, they are entitled to compensation for the terror of dying at sea and the financial support the seaman would have provided to them if he hadn't died.

"The damages to the wife are pre-death conscious pain and suffering and loss of income," says Carolyn Latti, of Latti and Anderson. "If he has kids they get what we call `loss of nurture and guidance' to age 18."

Siblings and parents who suffer the loss of a loved one at sea get nothing unless they can prove the victim gave them financial support. Although relatives can get millions in the loss of a loved one in an accident ashore, U.S. maritime law recognizes no emotional component in the loss of a husband, father, or brother.

Insurance companies and boat owners have been known to go to great lengths to undermine the claim of financial support, lawyers familiar with such cases say. If the victim was a smoker, a heavy eater or wore expensive clothes, the insurance company will argue that the cost of these should be deducted from his income, says Steve Ouellette, a Gloucester-based maritime lawyer whose practice is for the most part devoted to fishermen's issues.

Urie agrees that insurers play hardball. "I represented a fellow who died on the Aleutian Enterprise," he says, referring to a catcher-processor that capsized in the Bering Sea in 1990. "He hadn't been paying child support regularly, so, the insurance company told his family, “You can't make the argument you lost anything.”

Urie was able to obtain a settlement for the seaman's survivors by demonstrating that in cases of non-payment of child support the state steps in, makes payments and then goes after non-payers, but the strategy demonstrated just how aggressive insurance companies are. "They try to knock down damages," Urie says.

The Death on the High Seas Act was amended in 2000 following a series of aviation disasters in the 1990s that took place over the water. When families discovered the law deprived them of the right to be compensated for their grief at the loss of their loved ones, they pressured Congress to amend it, giving them the right to sue for non-pecuniary damages—"the loss of care, comfort and companionship."

The straw that broke the camel's act, legislatively, with respect to aviation disasters and the high seas act, was the crash, in 1996, of TWA Flight 800 in the waters off Long Island. Sixteen children from Pennsylvania, on a school trip, were among the 230 victims. The children were held as having died instantaneously, and as minors were seen as having contributed nothing to family income. Nonetheless, the notion their relatives were not entitled to compensation seemed indefensible, if not shocking.

"There is something wrong when a shipping law dating back to 1920 keeps these families from having their day in court and, by limiting compensation to pecuniary losses, tells them that their loved ones had no value to them other than the salaries they brought home," said U.S. Sen. Arlen Specter (R-Penn.).

However, when the act was amended, the survivors of fishermen and other seamen lost at sea were excluded from the modified provisions.

Paul Hoffman, a maritime lawyer from New York, testified before Congress in 1998 in an effort to convince lawmakers that the survivors of seamen deserve the same legal rights they were proposing to give air travelers.

To not do so, he said, would create a "steerage class" of victims whose loved ones died in accidents afloat, Hoffman said. "It is discriminatory to create yet another class of wrongful-death victims, by allowing certain remedies to airplane accident victims dying on the high seas, while excluding from those rights the families of persons who die on ships and boats on the same waters."

Later in his testimony, he added: "Merely singling out airplane accident victims for special treatment is an affront to those whose family loved ones died at sea in vessel accidents."

Hoffman told the story of Joseph Waterhouse, a 37-year-old fisherman who died on board the Terri Lei, a fishing boat that sank in 1993 without explanation. Waterhouse's family recovered approximately $30,000, in pecuniary damages. As far as emotional damages, his survivors, who included a 10-year-old son got nothing.

"As to Joe's family, his son will never again be able to walk on the beach with his dad," Hoffman told Congress. "He'll never be able to speak to him on the phone to pass the time, ask his advice or tell a joke. Joe's mother will never again be able to sit down across the table and chat with him over Sunday dinner, or see all of her sons together again. But none of these intangible losses can be compensated under [the act]."

Hoffman said there was no way commercial fishermen could match the political clout enjoyed by the victims of aviation disasters and that his efforts to include seamen in the high seas act amendments failed because of opposition from the shipping industry. In order to get any changes passed, those who wanted the act amended had to content themselves with helping aviation accident victims, Hoffman says.

"The deal was `Let's do it for aviation, but when it comes to maritime interests let's ignore the seamen,'" he says.

Like the Death on the High Seas Act, the Vessel Liability Act limits the compensation given families of seamen who die at sea. The 1850 law, which was passed to promote the U.S. maritime industry, affords vessel owners the chance to limit their liability to the value of the vessel at the end of the trip that has triggered wrongful-death suit.

Thus, if the vessel is unsalvageable and lies at the bottom of the ocean, an owner's liability may be nothing. Only plaintiffs, who can prove that a boat was unseaworthy, and that its owner was aware of it, can surmount this provision of the law.

When the Vessel Liability Act is successfully invoked by boat owners and insurance companies – and it often is – victim's families get nothing.

For instance, Anderson says, if a boat goes down without a trace and no one knows why, families can't prove unseaworthiness.

Anderson says this could prove to be the case with the Arctic Rose, a trawler that sank last year in the Bering Sea for reasons as yet uncertain. All 15 aboard her perished. "There you have a lot of people dying," Anderson says, "but you don't know what happened, making it more difficult to prove the owner knew what caused the sinking."

Vessel owners and maritime insurance companies love the Vessel Liability Act, Latti says, because it often prevents claimants from getting any money. Insurance companies may pay a nominal sum to families to make them go away, but otherwise, the real cost of a sinking is the claim for the hull.

"Even though they are collecting premiums, if they prove limitation they don't have to pay a thing for a death," she says. "It's a great thing for them."

Moreover, with the lives of fishermen and other seamen seemingly so cheap, insurance companies don't do everything they should to make sure the boats they insure are safe, Anderson says. "If the law valued the life of seamen, the insurance companies would not let a lot of these boats leave the dock."

Taken together, the consequences of federal law – the Jones Act, the Death on the High Seas Act, and the Vessel Liability Act – is more than unfair treatment of families, Anderson says.

"When you undervalue life," Anderson says, "you make it expendable."

CASE #7: MASTER FIRED FOR MAKING A PROFESSIONAL JUDGMENT IN A SAFETY CALL
[Source: *NMA Newsletter #9, Sept./Oct. 2001, p. 24.]*

If you are an "employee at will," as are most mariners working for non-union companies, you can be fired at any time for any reason. Termination can be particularly painful when you are a long-term employee, are told reassuringly that you are a part of company "management," and are encouraged and expected to exercise your "professional judgment" on the job. This is the story of Captain Kevin Kelly of Alton, Illinois.

Let Captain Kelly's letter serve as a warning for long-term employees who hold their jobs without the protection of a written contract. This could be what happens when you exercise your professional judgment! Here is Captain Kelly's story:

To Whom it May Concern:

On June 3, 2001, while Master of American Commercial Barge Lines (ACBL) towing vessel M/V Tom Frazier, I refused to accept a 12 barge-loaded tow that was destined southbound out of the Upper Mississippi River. On June 4th, I was relieved of my duties by Thomas L. More, ACBL's Marine Superintendent at Burlington, Iowa, while I was still northbound. Subsequently, on June 7th, I received a letter stating that I was terminated immediately for "serious misconduct" for refusing to push this tow.

I have been an employee at ACBL for 26 years, 21 of which was in the capacity of Pilot or Captain. I have 15 years of experience on the Upper Mississippi River In over 21 years I operated vessels for ACBL, I have never before refused to take a tow. Why did I refuse this one?

ACBL claims its Company Policy is for every employee to abide by the company's four operating priorities, which are:

- Safety of life and limb;
- Safety of marine environment;
- Safety of property and equipment; and
- Cost and efficiency.

As individual employees, we are not only required to abide by these priorities but to report any employees we feel are not doing so. That the M/V Tom Frazier was in disrepair is indisputable. That its state of disrepair was bad enough to affect its performance is also indisputable. Whether or not it was unsafe is an opinion. Frankly, at the time, I was the only person qualified to make that decision.

Neither of the Marine Superintendents that kept insisting that the vessel was safe ever boarded it prior to my being relieved. The one that relieved me spent 24 hours aboard and then got off. During this time the vessel never navigated a lock or a narrow swing bridge traveling southbound with the current. In fact, the vessel traveled less than 30 miles southbound for the entire time he was aboard.

The Marine Superintendent that relieved me also has very little experience on the section of river in question. In fact, he brought another Pilot with him to operate the vessel. The second Marine Superintendent hasn't spent a 30-day trip operating a vessel in over 20 years. He, too, hasn't the experience on the river in question that I do. Furthermore, the Pilot that was aboard the vessel when I refused the tow had been aboard for only four days and had yet to operate the vessel south bound. I was the only one who had the experience to make an informed decision. Before I refused the tow, I took into consideration my experience with this vessel, my experience on the river in question, and the comments, and opinions of the Pilots who had worked aboard the vessel with me. I even called the Relief Captain at home to get his opinion. It was my decision, but it was an informed decision.

To call these towboats "uninspected vessels" is misleading. They are inspected every day by the men and women who work on them. By Coast Guard regulations at 33 CFR §164.80, we are required to document an inspection within 24 hours of boarding the vessel. The question now becomes who is responsible for determining the seaworthiness of this "uninspected vessel?"

The Coast Guard tends to be reactive instead of proactive. I notified St. Louis Marine Safety Office about my concerns. Yet, to the best of my knowledge and belief the vessel was never boarded. So that leaves the men and women who operate them and the company as being responsible for safe vessel operation.

The industry has long argued before the NLRB that the Captains and Pilots are management. Yet when I, as Captain in charge of this vessel made a management decision that only I was fully qualified to make, I was terminated for "serious misconduct."

If the Captain cannot be trusted with making such a decision, that just leaves the company men and women behind

the desks. Our industry operates on the rivers by the grace of public trust. With the environmental issues we face today, that public trust is shaky at best, especially on the environmentally-sensitive Upper Mississippi River.

After the Bayou Canot incident; the industry assured everyone that it was capable of policing itself. Out of that disaster emerged the "Responsible Carriers Program." While painting yellow stripes around all the equipment and posting colorful warning signs all over the vessel is fine, anyone in any type of transportation business will tell you safety starts with the maintenance and repair of the equipment.

It is no secret that the maintenance and repair at ACBL has been a long-standing joke with all of their vessel employees. So why should the Coast Guard and the general public be concerned with what is happening at ACBL? This concern should arise because ACBL is not only the largest carrier on the inland waterways but also the second largest carrier of hazardous cargoes. This company needs to be reminded that using the inland waterways is an exercise in protecting the public trust not putting it at risk.

I certify that this information is true and correct to the best of my knowledge and belief.
s/Capt. Kevin D. Kelly

[NMA Comment: The lack of proper maintenance of their equipment is discussed in our Report #R-401. Rev. 1 Crew Endurance and the Towing Vessel Engineer – A Direct Appeal to Congress. This report shows how a towboat engineer succumbed to overwork, fatigue, and unbearable physical and psychological pressure and presents the story of his widow's struggle for justice and compensation for her loss against ACBL.]

CASE #8: "PREMEDITATED MURDER"

*[**Source:** Waterways Journal, May 26, 2008, Letter to the Editor.]*

I've heard talk for years now of how the companies are constantly improving safety on our inland rivers. While some companies are actually making an effort to make sure that their crews are operating as safely and efficiently as possible, others are severely lagging behind. I am not going to bash the companies that are actually making the effort to improve working conditions on their vessels, but I am going to complain about those lackluster companies that do nothing more than give lip service to their personnel.

We all know that there are some companies out there that are running their boats at far below a safe level, meaning that they should have been drydocked a long time ago to get all the necessary repairs. However, how many times have you considered whether the safety of the crew is compromised on these boats? Do the boats have adequate medical devices and supplies on them to save a life in an emergency? Do the companies really care whether their employees are trained in giving CPR and other basic first aid techniques? Sadly, the answer is no, they do not care enough about their crews to give them the emergency tools they need to operate safely. It should be mandated that every person on the boat be trained in basic first aid before they ever set foot on the boat.

Why should they have to learn this now? Truth be told, they should have learned it years ago and not right this moment. They should be trained, as you never know when someone is going to have a heart attack, stroke, or other medical problem when you are miles from the nearest hospital. If these shady companies truly cared for their employees they would have already implemented this into their "safety" departments.

While I personally do not work on the river, I do care about the men and women who choose this as their profession. My father worked out there for years and most people knew him well. His name was Glyn Sharp and on Aug. 7, 2007, he died on a towboat tripping for a company that did not have any people trained in basic first aid. This is not the industry's fault, but rather one company's. No, strike that, one port captain's very poor judgment. I say that because the day before he died, he was so sick that a port captain ordered him to bed rather than stand his watch. If he was sick enough to be in bed rather than standing watch, then he was sick enough to be transferred to a hospital where he could have been saved, or at least had a chance of being saved. To make things worse, the boat was not going anywhere as it had barges aground. The company could have ordered him to the hospital, but they chose to save themselves the money instead. They also graciously let me pay to get my father's body back to us.

To say I am upset at this company would be an understatement as I pray every day that all companies operating like this one does will go out of business and leave the industry to the true professional companies. Wives, ask your husbands if their company has trained them in basic first aid. If not, then they just might want to take that course, just in case something like this happens to you. s/***Terry Sharp,*** **Smithland,** Ky.

CASE #9: ABANDONING MARINERS WITHOUT TRANSPORTATION HOME
[Source: *NMA Newsletter #54]*

Our Association received a number of calls from distressed mariners who, for various reasons, were abandoned by their employers and told to furnish their own transportation home.

Since the Coast Guard "superintends" our merchant mariners, we informed them of a "typical" case in a letter dated Dec. 18, 2007 to the attention of the Eighth District Commander through our Coast Guard Liaison Officer, Commander Jim Stewart.

The Situation

Captain ■ related to me that his former employer told to get out of his truck miles away from home as a result of a disagreement. Captain ■ reportedly notified the boat's charterer (Kirby Inland Marine) and they sent a vehicle to pick him up and charged the vessel's operating company $185.00 for doing so. The charterer reportedly then billed the boat owner for the $185.00 transportation charge.

The boat owner, in turn, deducted $185.00 from Captain ■'s wages.

Unfortunately, other towing companies simply ditch unwanted crewmembers "in the middle of nowhere." In fact, this practice has become quite common. In two recent cases, Versatility Marine (now out of business) put two seriously ill mariners off their towboat in Texas and told to find their own way home to Mississippi and Florida respectively – as reported in the next case (below).

We asked the Coast Guard to comment on this story (and Case #9, below) and to provide guidance for our mariners. We asked that the Coast Guard give us their "position" on grievances involving abandonment without travel funds remembering that the mariners we represent are, for the most part, ***not*** members of a labor union that have grievance procedures established under a collective bargaining agreement.

Coast Guard Response

Dear Mr. Block:

I am writing in response to your letter dated Dec. 18, 2007 in which you described several instances where mariners were reportedly discharged in remote locations by their employers and left to make their way home at their own expense.

Since this is inherently a **labor issue**, and thus outside the purview of our authority, the Coast Guard does not have an opinion about the practice of discharging mariners in remote locations without arranged transportation or travel reimbursement. As you are aware, there are many factors that influence how and where a mariner is discharged from a vessel. Company policy, contractual agreements, and the circumstances surrounding the mariner's discharge (i.e. completed their hitch, quit, terminated, illness, etc.) may all factor into whether the mariner is provided transportation or travel reimbursement.

[NMA Comment: We find the Coast Guard often cites the "labor issue" to avoid any responsibility for looking out for the legitimate interests of working mariners. From our experience, the Coast Guard shows little real interest in our mariners safety, health and welfare. If in doubt, we suggest that our mariners ask a lawyer for legal advice.]

Although it would be inappropriate for the Coast Guard to take a position or directly assist a mariner with a grievance relating to a labor issue, I can offer the following suggestions.

- Mariners are encouraged to know the rights and protections afforded them under Federal and State labor laws. Individuals interested in researching labor related issues may consult the U.S. Department of Labor's employment law assistance (ELAWS) website at http://www.dol.gov/elaws/.
- Additionally, mariners should have a thorough knowledge of all company policy and contractual agreements relating to transportation or travel reimbursement following their discharge from the vessel.
- In those instances where pre-existing policy or contractual agreements do not exist, mariners are encouraged to consult with their employers and establish a clear understanding regarding whether they will be provided transportation or travel reimbursement prior to joining the vessel.

If you have any additional questions regarding this issue, please contact Commander Jim Stewart at (504) 671-2164. Sincerely, s/T.D. Hooper, Captain, U.S. Coast Guard – Chief, Prevention Division, By Direction of the

Commander, Eighth Coast Guard District

[NMA Comment: We urge mariners to join a labor union in order to establish a contractual relationship to effectively address this and other related issues. Until you do this, plan to carry enough cash and a working cell phone so you can get home or summon help. You are on your own! Don’t expect the Coast Guard to help you!]

CASE #10: TOWING COMPANY MUST PAY FOR ENDANGERING ITS MARINERS' HEALTH THE NEWTON CASE

[Editorial note: NMA followed this remarkable case from the outset through the court's rendering the summary judgment requested by plaintiff Herman Newton. This article is an edited version of the motion for summary judgment, Civil Action #36199, filed in Division A of the 18th. Judicial District of Louisiana subsequently granted on "maintenance and cure" and "unseaworthiness" issues. The motion was filed by NMA Attorney Mark L. Ross, Esq. NMA edited out (for readability) cites of case law and use of depositions obtained in this case. For further information, contact Attorney Mark L. Ross, 600 Jefferson St., Suite 501, Lafayette, La. 70501. Tel. (337) 266-2345; Fax (337) 266-2346.]

Herman Newton vs. Versatility Marine, LLC

The plaintiff, Herman Newton, brought the Motion for Summary Judgment under La C.C.P, 966, the Jones Act, 46 U.S.C. 688, et seq. and the general maritime law.

The Plaintiff moves the Court to find as an uncontested matter of fact or law that the defendant, Versatility Marine, LLC, owes the plaintiff, a former member of defendant's crew aboard defendant's towboat EAST WIND, maintenance and cure following his development of an MRSA staph infection on or about Mar. 2, 2007.

The evidence shows that plaintiff became ill while in the service of his vessel. The evidence also shows that despite actual, repeated notice of plaintiff's staph infection and eleven day hospitalization, Versatility Marine, LLC arbitrarily and capriciously denied plaintiff maintenance and cure.

The Plaintiff further moves the Court to find as an uncontested matter of fact and law that defendant, Versatility Marine, LLC, is liable to plaintiff since plaintiff's staph infection resulted from the unseaworthiness of the M/V EAST WIND.

Towboat EAST WIND Judged to be "Unseaworthy"

The M/V EAST WIND's crew was rendered unseaworthy in that a fellow deckhand, Adam Hanshew, carried the MRSA staph and infected the plaintiff, Herman Newton. The vessel was further rendered unseaworthy by Versatility's failure to properly decontaminate the vessel after notification of the staph contagion, as well as provide plaintiff with medical care under Versatility's maintenance and cure obligations.

Herman Newton is a former crewmember of the M/V EAST WIND, a vessel chartered and/or operated by defendant, Versatility Marine, a towboat company doing business within the State of Louisiana from its office in Port Allen, Louisiana.

Another Crewmember Infected Herman Newton

In mid-February 2007, Herman Newton, was a crewmember of the M/V EAST WIND and working out of Galveston, Texas. On or about Feb. 11, 2007, Versatility brought aboard a new deckhand, Adam Hanshew. Unbeknownst to Newton, Adam Hanshew previously contracted and continued to suffer from a staph infection known as Methecillin-Resistant Staphylococcus Aureus (hereinafter "MRSA"). MRSA is infectious, resistant to antibiotics and can lead to toxic shock syndrome, pneumonia, blood poisoning, organ failure, the loss of limbs and death. Once contracted, MRSA remains in the victim's blood system for life and can manifest again at any time.

One eyewitness to the events at issue was former Versatility captain Gary Hensley, a towboat pilot with 20 years experience who began working with Versatility on Sept. 7, 2006 and who provided a deposition in this case.

Versatility appointed Captain Hensley to pilot their towboat M/V EAST WIND and gave him the option to choose his own crew. Captain Hensley chose as deckhand plaintiff Herman Newton with whom he had worked previously and considered an "outstanding deckhand".

Captain Hensley recalled that the carrier of the staph infection, Adam Hanshew, came aboard the M/V EAST WIND as a new deckhand in early Feb. 2007. After a day or day and a half, Captain Hensley noticed that Hanshew's nose was swollen and was "real red". Hanshew's nose continued to get "really big and really sore and it started draining". At that point, Hanshew told Captain Hensley and Herman Newton that the swelling stemmed from a staph infection from which he had suffered three previous outbreaks and showed them surgical scars to his stomach, chest and arm required to cut out the infected tissue. As deckhand Hanshew's infection continued to worsen it began to drain a "pussy mucus type drain."

Captain Hensley arranged for Hanshew to receive medical treatment in Port Arthur, Texas, because Hanshew

told him he could not sleep due to the "pussy mucus type" draining. Furthermore, Captain Hensley and his crew feared being infected since Hanshew cooked the crew's meals.

Captain Hensley felt compelled to get Hanshew medical attention less than a week after Hanshew came on board the M/V EAST WIND. The examining physician found that Hanshew suffered from a staph infection and refused to release him to return to work and further directed that Hanshew receive immediate medical attention at his home in Mississippi.

From the time Adam Hanshew came on board the M/V EAST WIND until he had to leave due to his staph infection, he bunked with the plaintiff, fellow deckhand Herman Newton, in a 8' by 10' bunkroom. Hanshew and Newton used the same shower and toilet. Captain Hensley recalled that Hanshew was "draining" and bunking with Herman Newton for three or four days.

Versatility Marine's management recognized the highly contagious nature of Hanshew's staph infection from the outset. When Versatility refused to provide transportation for Adam Hanshew to return home to Mississippi from Port Arthur, Texas, Versatility Marine general manager Rhonda Watson and port captain Doug Faust told Captain Hensley they were concerned about the contagious nature of Hanshew's staph infection and Versatility's potential liability if some else became infected.

Captain Hensley and his relief pilot, Captain David Whitehurst, concerned about their own exposure to Hanshew's staph infection, went on the internet to learn about staph infections, "and the more we read, the more scared we got about it..."

Captains Hensley and Whitehurst thereupon contacted the Center for Disease Control (CDC) in Atlanta, Georgia, among other agencies, and were advised to have a professional cleaning crew fumigate and clean the boat. The CDC also advised Captain Hensley to throw away the mattresses on which Adam Henshaw and his roommate, Herman Newton, had slept. Captain Hensley told Versatility's port captain, Doug Faust, its general manager, Rhonda Watson and the company's owner, Bud Watson, about the CDC's recommendations that Versatility shut down the M/V EAST WIND so a professional service could fumigate the vessel and that Hanshew's and Newton's mattresses be thrown away, "… to kill whatever viruses may be on that boat to protect us."

Versatility Refused to Take CDC-Recommended Steps to Remove Staph Infection From Their Towboat

Doug Faust was the marine superintendent for Versatility and was in charge of regulatory compliance and safety for Versatility's vessels. Faust admitted he learned of staph infections aboard the M/V EAST WIND when the vessel's captain, Gary Hensley, called and told him of deckhand Hanshew's infection. When the subject of maintenance and cure for deckhand Hanshew was discussed, however, Versatility refused to provide Hanshew medical treatment on the pretext that Hanshew's affliction was a so-called "pre-existing condition."

Incredibly, about two months after ejecting Hanshew from the M/V EAST WIND in Port Arthur, Texas and refusing to provide him medical treatment, Versatility rehired Adam Hanshew. Versatility rehired Hanshew despite its knowledge that he could expose yet other Versatility employees to the highly infectious and dangerous MRSA staph. Hanshew did not finish his 28 day hitch after Versatility hired him a second time since Hanshew had yet another outbreak and had to leave the vessel again.

Captain Hensley subsequently discovered in speaking with the captain of Hanshew's second Versatility boat that Hanshew came down with an outbreak of "something" and that Versatility never advised that vessel's crew that Hanshew had recently suffered an MRSA staph outbreak.

After deckhand Hanshew left the M/V EAST WIND to obtain medical treatment on his own, Versatility refused to hire a professional decontamination service to clean the M/V EAST WIND. Versatility told Captain Hensley, "they could not afford to shut the boat down for a professional cleaning crew...." Instead, Versatility's port captain Faust told Captain Hensley to have the crew clean the boat with Lysol and bleach.

Versatility also refused to throw away the mattresses on which Hanshew and Newton slept despite the CDC's strong recommendation that the mattresses be discarded since once the staph, "gets into the mattress, there is no killing that virus in the mattress." Versatility's Doug Faust responded that Versatility would not discard the mattresses as they were supposedly brand new and Versatility did not want to buy new ones.

Herman Newton Contracts MRSA Staph Infection

Captain Hensley recalled that Newton came to him a few days after Hanshew left the boat complaining of painful red spot on his right leg above his knee with a black spot in the middle. Captain Hensley told Doug Faust, Versatility's port captain, about Newton's staph infection, which was the second infection aboard his vessel in the space of a week.

Herman Newton went to San Jacinto Methodist Hospital in Baytown, Texas where he had his right leg aspirated, was prescribed antibiotics, given a "do not return for work" slip and directed to seek medical attention.

Captain Gary Hensley e-mailed both Versatility port captain Doug Faust and general manager Rhoda Watson a "First Report of Injury or Illness" dated Mar. 2, 2007, which reported that Newton suffered, "Possible spider bite or outbreak of Staph infection." Captain Hensley recalled that Versatility's port captain Doug Faust, general manager Rhonda Watson and owner Bud Watson seemed "very nonchalant" about a second case of staph infection aboard the M/V EAST WIND. Doug Faust and Versatility refused even after a second staph infection within a week to retain a professional cleaning crew to fumigate and decontaminate the vessel.

Captain Hensley recalled that Versatility would not arrange transportation for Herman Newton to return home to Florida because Versatility was concerned, "about the contagious level of it" and, "that they could be held liable and responsible for Mr. Joe Blow or Mr. Julio Inglesias coming down with this stuff...." Plaintiff Herman Newton, like Hanshew, therefore had to find his own way home.

Versatility's Doug Faust spoke to plaintiff Herman Newton after Newton left the M/V EAST WIND in Texas and returned home to Crestview, Florida to seek medical care. Newton informed Faust that a Florida doctor sent him straight to a hospital emergency room, "Because he was in urgent need", due to the infection in his right leg. Newton informed Faust in a series of telephone calls that he had been placed in isolation, diagnosed with a staph infection and repeated asked if Versatility would cover plaintiff's medical expenses. Faust filed an, "Incident Investigation Report" dated Mar. 12, 2007 with Versatility, reporting that Herman Newton had suffered an, "Infection of right leg", and that, "At his home in Florida he was diagnosed with CAMRSA." In short, Versatility received a constant stream of information concerning the source of Newton's infection, its diagnosis and pleas from Newton for maintenance and cure, all of which Versatility ignored.

Herman Newton entered North Okaloosa Medical Center on March 6 and was discharged from hospital on March 16, 2007. A treating physician diagnosed that Newton suffered from MRSA staph infection. Newton's physician stated that: "(he was)…a previously healthy 28-year-old gentlemen whom I have seen in the postoperative period after he had had an incision and drainage of his right knee. I agree with Dr. Herf's antibiotic choices in the form of Vancomycin and Zosyn, as the patient is a perfect setup for community acquired methicillin-resistant staphylococcus aureus**.** I question whether or not he ever actually had a spider bite. He denies any trauma to the right knee. He states that it popped up spontaneously, but given the history that there are other folks on the boat that he was working on in close quarters with this infection, I feel that this may be methicillin-resistant staphylococcus aureus..."

Newton presented a full set of the voluminous North Okaloosa Medical Center records for to Versatility Marine, LLC, but received no response to his request for payment of maintenance and cure.

Versatility's port captain, Doug Faust, "felt quite sure" that Versatility would cover plaintiff's maintenance and cure expenses "because of the situation at hand. He was aboard our vessel, had an infection, and sought medical treatment, and I felt it was our responsibility." Faust could not think of any reason why Herman Newton should not receive maintenance and cure. Captain Hensley agreed that he could not think of any reason why Newton should not receive maintenance and cure. Captain Hensley concurs that by all rights, "he should have been paid maintenance and cure and transportation home by the law."

Versatility "Stiffs" its Mariners

Versatility has neither paid, offered to pay nor been willing to discuss whether it will pay Herman Newton maintenance and cure despite repeated requests from Newton and his attorney.

The amount of maintenance and cure owed by Versatility to Herman Newton is considerable. Herman Newton is indebted to the North Okaloosa Medical Center for his eleven-day stay in isolation and surgery in the amount of $42,739.75. Mr. Newton is also indebted to a treating physician for post-discharge outpatient care, Dr. David Herf, in the amount of $630.00.

Herman Newton was out of work due to his staph infection from Mar. 2, 2007 until May 2007. Versatility's former port captain, Doug Faust, testified that Versatility's general manager, Rhonda Watson, had agreed to pay Newton maintenance of $15.00 per day, although no payment has ever actually been made.

The leading maintenance and cure case of *Hall v. Noble Drilling,* 242 F.3d 582, 591-2 (5th Cir. 2001), contains an excellent discussion how the marine industry's selection of $15.00 a day maintenance in the 1970's now translates into $38.35 per day in current dollars. Plaintiff notes that even $38.35 per day is a small fraction of the two-thirds payment of worker's compensation assured injured land based workers. Mr. Newton is entitled to unpaid maintenance in the amount of $1,342.25, representing the period between Mar. 2, 2007 and his release from

this particular bout of MRSA staph infection on Apri.16, 2007 at a rate of $38.35 a day. Newton also is entitled to an award of attorney's fees incurred in the prosecution of plaintiff's maintenance and cure claim.

Maintenance and Cure

The law required Versatility, as Herman Newton's Jones Act employer, to provide Newton medical care for any injury or illness incurred in the service of his vessel. Jones Act employers specifically owe maintenance and cure to seamen who suffer illnesses while in the service of their vessels. The Plaintiff need not show his illness is job-related. Similarly, a "seaman's entitlement to maintenance and cure is entirely unrelated to any fault or negligence on the part of the shipowner." A seaman need not "absolutely" prove his entitlement to maintenance and cure: "Any doubts or ambiguities in the application of the law of maintenance and cure are resolved in favor of the seaman." The employer's duty to pay maintenance and cure "is of ancient vintage...". *[**Editorial note:** Attorney Mark Ross fully documents each of these statements in case law in his motion.]*

Doug Faust, Versatility's ***former*** port captain and Captain Gary Hensley, ***former*** captain of the M/V EAST WIND, have both testified no issue existed in their minds that Versatility owed Herman Newton maintenance and cure. Given Versatility's denial of maintenance and cure to Herman Newton constitutes by any measure the "egregious fault," the plaintiff is also entitled to an award of attorney's fees. Therefore, Attorney Mark L. Ross moved the Court to award attorney's fees on a contingency fee basis based on the amount the Court may chose to award in maintenance and cure citing a Supreme Court case that observed that a lower court had assessed attorney's fees at 50% of the maintenance and cure award.

The Vessel Was Unseaworthy as a Matter of Law – A Substantial Cause of Newton's Infection.

"The case law holds that an owner is responsible to the captain or any seaman thereof for injuries received because of the unseaworthiness of the vessel." A vessel is unseaworthy when its crew is inadequate or incompetent. The duty of a vessel owner to provide a seaworthy vessel, including a competent crew, is absolute and non-delegable. Liability is imposed for unseaworthiness regardless of the vessel owner's negligence or failure to exercise reasonable care.

Versatility was obligated under its duty to provide plaintiff with a seaworthy vessel and an adequate crew. It is an uncontested matter of fact and law that burdening the M/V EAST WIND with an MRSA staph infected crewman such as Adam Hanshew rendered the vessel unseaworthy. Newton, in order to prevail on its unseaworthiness claim against Versatility, need not show that Versatility knew or should have known of Adam Hanshew's MRSA staph infection when it hired him since, "Liability is imposed for unseaworthiness regardless of fault, negligence or the failure to exercise reasonable care on the part of the vessel owner." However, given that Versatility rehired Hanshew after the outbreak of his Feb. 2007 staph infection and despite the infection of fellow crewman Herman Newton, ***the Court concluded that Versatility was indifferent to the health risks that an MRSA staph carrier presented to its employees***.

Refusal to Professionally Decontaminate the Vessel Also Rendered M/V EAST WIND Unseaworthy.

Versatility's refusal to have a professional cleaning service decontaminate the M/V EAST WIND and at a bare minimum dispose of the mattress on which Adam Hanshew had been draining a "pussy mucus type drain" rendered the vessel unseaworthy and led to plaintiff's MRSA staph infection. Professional cleaning services with special expertise in addressing MRSA staph infections exist and are readily available. Attorney Mark Ross attached a brochure of one such service with special expertise in addressing MRSA staph infections.

Versatility's refusal to dispose of Hanshew's obviously staph infected mattress, which may still be in use to this day, likewise renders the vessel unseaworthy.

Versatility's Failure to Provide Medical Care Rendered the Vessel Unseaworthy

Versatility's uncontradicted refusal to provide Herman Newton with medical care rendered the M/V EASTWIND unseaworthy. Failure to evaluate and provide proper medical care rendered vessel unseaworthy. The vessel was "rendered unseaworthy by the failure of the ship owner to render prompt and adequate medical treatment."

Unseaworthiness was the Proximate Cause of Newton's MRSA Staph Infection

For Herman Newton to prevail on a claim of unseaworthiness, he had to show that the unseaworthy condition, the presence of MRSA staph infected Adam Hanshew and Versatility's refusal to provide him with prompt medical

care, was a proximate cause of his staph infection, i.e. that Newton's staph infection was, "a reasonably probable consequence of the unseaworthy condition. The evidence on causation exceed that of being "reasonably probable" and was more in the realm of beyond a reasonable doubt.

Conclusion

On Nov. 26, 2007 Judge James Best, Division A, 18th Judicial District, New Roads, Louisiana granted Herman Newton's motion for summary judgment for the reasons stated in the plaintiff's motion (above) that were adopted by the court as its own.

The Plaintiff, Herman Newton, moved the Court to find as an uncontested matter of fact or law that the defendant, Versatility Marine, LLC, owes plaintiff maintenance and cure following his development of an MRSA staph infection while working in the course and scope of his employment as deckhand aboard defendant's towboat, the M/V EAST WIND. Newton showed that despite Versatility Marine having actual and repeated notice of plaintiff's staph infection, they arbitrarily and capriciously refused to pay plaintiff maintenance and cure.

Plaintiff further moved the Court to find as an uncontested matter of fact and law that Versatility Marine was liable to the plaintiff since the plaintiff's MRSA staph infection resulted from the unseaworthiness of the towboat M/V EAST WIND. The crew was rendered unseaworthy in that a fellow deckhand, Adam Hanshew, carried the MRSA staph and infected Herman Newton. The vessel was further rendered unseaworthy by Versatility's failure to properly decontaminate the vessel after discovery of the staph contagion, as well as Versatility's refusal to provide plaintiff with medical care under Versatility's maintenance and cure obligations.

[NMA Comment: Versatility Marine is no longer in business. Sic semper tyrannus.]

CASE #11: MARINER LOSES FOOT IN GRUESOME TOWING ACCIDENT.
12-HOUR RULE VIOLATION PROVEN IN COURT

*[**Source:** Letter by Nelson G. Wolff, Esq., Schlichter, Bogard & Denton, LLP, 100 South Fourth Street, Suite 900 St. Louis, Missouri 63102. nwolff@uselaws.com (314) 621-6115 FAX (314) 621-7151. **Emphasis is ours!**]*

August 23, 2011

Re: Kenneth Mercer v. Chem Carriers Towing, LLC

Dear Richard:

I am providing you with some information concerning this significant maritime injury/safety case and its recent settlement.

This case arose under the Jones Act for injuries suffered by Chem Carriers' deckhand/mate, Kenneth Mercer. Mercer was injured on April 15, 2009, while performing fleet work in Chem Carriers' Mile 207 fleet on the Mississippi River, near Baton Rouge, Louisiana. Mercer was the sole on-watch deck crewmember for the M/V Laura Banta (photo attached), which was also crewed with a single licensed captain and another, off-watch, sleeping deckhand. While Mercer was securing a barge under tow to a fleet barge with a line, the M/V Laura Banta, operated by the captain, collided with the barge on which Mercer was standing, causing him to lose his balance. His left foot became tangled in the line as the barge began drifting down river and was crushed against a barge fitting, ripping his foot in half. Because his foot could not be salvaged, Mercer's left leg was surgically amputated just above the knee, leaving him with a stump. Mercer has required five surgeries to his stump, and will likely require additional surgery to his low back. *See* Medical Illustration attached. He is now permanently forced to use a prosthetic leg. A vocational counselor, Dr. David Strauser, determined that Mercer is permanently disabled from returning to work in the maritime industry where worked for 20 years.

We filed this case in U.S. Federal Court, Eastern District of Louisiana, in New Orleans, seeking compensation for Mercer as a result of Chem Carriers' failure to provide him with safe working conditions. Our investigation into the facts, aided by the expertise of Captain Gary Hensley, revealed that at the time of Mercer's traumatic injury, Chem Carriers had required its captain to work over 13½ hours in the preceding 24-hour period, in violation of the federal regulation 46 U.S.C. § 8104 (12-hour Rule), which prohibits any licensed operator from working more than 12 hours in a 24-hour period. *See* Cpt. Hensley's Report attached. Coast Guard policy statements specifically state that boat operators are prohibited from working more than 12 hours in a 24-hour period in order to protect crewmembers from fatigue-related errors. *See* USCG G-MOC Policy Letter 4-00, Rev-1 attached. Yet, despite the risks of fatigue, Chem Carriers had required the sole licensed operator on the M/V Laura Banta to work excessive hours with only one on-watch deck crewmember.

[NMA Comment: Refer to NMA Report #R-370, Rev. 3 for a reprint of Coast Guard policy letter #G-MOC-04-00.]

Our extensive review with Captain Hensley of internal documents, log books, and company communications assisted in gaining ***admissions from Chem Carriers that the company required its vessel operator to work at any hour, day or night, and that it misinformed its operators about the amount work that could be performed under federal law.*** Despite these admissions, the company claimed that its vessel operators were not "working", and therefore not accumulating hours for purposes of the 12 hour rule, when its vessel's main engines were shut down. Chem Carriers suggested that because the M/V Laura Banta's engines were shut down for portions of the 24-hour period prior to Mercer's injury, its captain wasn't "working". ***We successfully responded, pointing to Coast Guard regulations, that "work" is made up of all tasks performed on watch, including administrative tasks***. The Court agreed and held that the Coast Guard's broad interpretation of "work" included tasks performed by Chem Carriers' operators even when its vessel's main engines are turned off.

Maritime expert Captain Hensley also aided in determining that Chem Carriers failed to operate its towboat in a reasonably safe manner and failed to adequately secure/maneuver the towboat and barges. Instead of securing the barges with steel cables at the bow of the boat (facing), Defendant dangerously attempted to move the barge along the side of the boat with a single nylon head line which failed to provide a secure coupling (hipping). The company

attempted to defend this shortcut industry practice, but we argued that headlining in high water conditions creates dangerous gaps and bumps. It was precisely this practice which allowed a gap to form at the time of Mercer's injury, which created the collision that knocked him into the line. ***In depositions, we were able to obtain admissions from Chem Carriers' that it should have faced the barge instead of hipping it and that, because the barge was hipped, the captain could not see Mercer at the time of his injury.***

Internal company documents also showed that Chem Carriers previously provided larger deck crews for the same fleet work. ***Yet, at the time of Mercer's injury, he had no assistance on the deck. Chem Carriers should have provided another deckhand, as required by its own company rules, to serve as a lookout for the captain as he operated the boat's controls and to call the bump.***

Chem Carriers retained its own maritime expert, Captain John Sutton, who opined that the company provided Mercer with safe working conditions and that Mercer was at fault for his own injuries. However, Mercer's attorneys were able to refute these opinions by establishing that Chem Carriers' captain had admittedly worked excessive hours, the practice of hipping barges in high water creates gaps and bumps, and Chem Carriers failed to provide Mercer with adequate assistance by reducing its on-watch deck crew to one person. Further, Mercer's attorneys were able to establish that Mercer was not at fault for his injuries because he was knocked into the line due to a gap that had formed through no fault of his own and he was not made aware of the dangerous situation because no one called the bump.

The Jones Act requires a negligent employer to compensate an injured seaman for lost earning capacity, pain/suffering, and disfigurement. We fought in Court to obtain this compensation for Mercer's profound injuries. Mercer's foot was crushed and many nerves were severed. His foot was literally ripped in half and flew through the air, landing an adjacent barge. The dismembered foot was given to him as he was airlifted to a local hospital, where he underwent immediate surgery to clean debris from his exposed foot. He was taken home in Tennessee by ambulance for two additional surgeries by an orthopedic foot surgeon, who amputated the leg after he was unable to save Mercer's foot.

During the ensuing months, Mercer struggled with physical pain and post-traumatic stress disorder and anxiety. Despite repeated prosthetic adjustments, ***he has continued to experience discomfort and phantom pain. His family doctor testified that Mercer's pain is permanent and his altered gait is causing low back problems. He will require narcotic pain, nerve, and anxiety medicine for the rest of his life.***

Prior to his injury, Mercer worked in the maritime industry for over 20 years and was earning approximately $50,000 in pay and benefits. In the years before working for Chem Carriers, Mercer had made much less. A vocational analysis showed that he has no transferable skills and is not gainfully employable. An economic expert calculated his financial damages alone to be approximately $600,000. Mercer, a father of two boys, has significant non-economic damages as well. The Carrier hired its own vocational and economic experts in an attempt to dispute these damages.

During the course of 2+ years of hard fought litigation and over a dozen depositions, the company maintained its denial of any responsibility. However, shortly before trial, Mercer's attorneys were able to secure a reasonable settlement of $2.25 million to fairly compensate him for his damages.

Please let me know if you have any questions, or need any further information.

Very truly yours,
Nelson G. Wolff

CASE #12: THE SEABULK GEORGIA CASE
[**Source:** *: USCG Case #MC 00009757*NMA Report #R-299, Rev. 1, Apr. 30, 2002

The "Official" Coast Guard Report

On Aug. 1, 2000, the M/V SEABULK GEORGIA, a 180-foot offshore supply vessel built in 1984 was underway en route to the offshore platform at Vermilion 267A on a course of 226 degrees at a speed of approximately 10 knots. The mate, Ronnie Chambers, was on watch. At approximately 0200, the SEABULK GEORGIA had an allision with the MODU DOLPHIN 105. The DOLPHIN 105 was jacked-up alongside the platform at Eugene Island 095-17 doing work to the well. Initial impact with the MODU was at the port quarter of the MODU and the starboard bow of the SEABULK GEORGIA.

After the initial impact, the SEABULK GEORGIA continued underneath the MODU, completely tearing off the entire pilothouse. Ronnie Chambers, at the helm, was dragged with the entire pilothouse to the deck below. Both Ronnie's legs were crushed and had to be amputated...

The SEABULK GEORGIA was on a course of 226 degrees and was being maintained by the vessel's autopilot. Visibility was at least 1 mile. Ronnie Chambers was on watch and had been on watch for about 6 hours. He had 6 hours of sleep prior to his watch. According to his statement and the QMED's[1] statement, Ronnie had gone down to the galley to make a sandwich and get a cola. The QMED stood by for Ronnie on the bridge. They both said Ronnie was gone for about 5-10 minutes. After he returned, the QMED stated that he stayed with Ronnie on the bridge for another 5 minutes and then went below to make a round. The QMED stated that he was gone about 10-15 minutes and was on the way back to the pilothouse when the allision happened. *[[1]**Vocabulary: QMED** = Qualified Member of the Engine Department; an unlicensed rating assisting the vessel's engineer perform his duties.]*

In talking with the mate after the incident, he stated the following: He was on watch. The autopilot was on. He didn't have any problems with the autopilot and had no alarms. He said visibility was at least 1 mile. He had gone down to the galley for a sandwich and a cola. When asked if night vision was a problem when coming back to the bridge from the galley, he stated he didn't think so. <u>The last thing he remembers was standing by the weather machine getting the updated weather.</u>[1] *[[1]Emphasis is ours.]*

After all the interviews and a visual inspection of the damaged vessel, the investigating officer concludes that mate Ronnie Chambers was in the pilothouse at the time of the allision and in charge of the safe navigation of the vessel. Ronnie's exact position in the pilothouse can't be proved, but he may have been at the helm at the time of the allision. His shoe and leg were found lodged between the overhead and the center window forward of the helm. The investigator's theory is that upon initial impact with the MODU, the pilot house's forward edge of the overhead and forward windows folded back against the inner pilot house overhead trapping Ronnie's foot; and as the vessel continued under the MODU, the entire pilot house overhead peeled back and fell onto the deck below. Once the vessel cleared the MODU, Ronnie fell to the 01 deck, tearing away from his leg, which had been torn while the pilothouse was peeling back.

The Coast Guard investigation concluded that Ronnie was negligent in the performance of his duties as mate while on watch by inattentiveness to the navigation of the vessel through a congested area.

There is More to This Story

Although the Coast Guard report established the principal events and provided a <u>theory</u> of what may have occurred, it just touched the surface. Many other <u>theories</u> abound.

We want to bring to our readers' attention that very few accidents involving "limited-tonnage" mariners are ever widely reported. Where the story is sensational or unusual or if there is some public impact, a brief local newspaper account immediately after the event is all you may ever see. Most mariners seldom see the results of a formal Coast Guard investigation of an accident because a long time often elapses before these reports are available to the public even under the Freedom of Information Act. For example, NMA has waited up to seven years for the results of some Coast Guard investigations that apply to our mariners. By that time, they are no longer news and lose much of their interest for mariners not directly affected.

At NMA, we have more than a passing concern for limited-tonnage mariners who are injured on the job and are dumped on the industry's scrap-heap. We join our friends and mentors in the labor movement to try to look after our own. In this case, in the words of Attorney Philip Cossich, "We were able to turn a bad situation into a positive one for a seriously-injured young man."

What follows is a story about a single father of a beautiful young daughter who was abandoned by the system to

navigate through life after he lost both his legs in a terrible workplace accident. It is a story of a mariner, his brave parents and other family members, and a team of lawyers willing to face down one of the largest boat companies in the offshore industry to reach a fair and just settlement.

Whatever our readers may choose to speculate, the trauma of the accident completely erased all Ronnie's memory of the immediate events leading up to the crash. But, why speculate? Even the company's Safety Manager determined that the cause of the accident remains "unknown."[(1)] Did Ronnie fall asleep on watch? Perhaps, but Ronnie does not accept any such assumption, and we see no need to speculate. *[(1)Safety Manager's deposition, p.116.]*

The Seabulk Georgia and Oilfield "Tradition"

I had the opportunity to review hundreds of pages of depositions that were taken from "expert" witnesses[(1)] as well as crew members, company shoreside personnel, and other concerned parties after this horrendous accident. *[(1)**Vocabulary: Expert witness** = A person not directly involved in an event but may have expertise in one or more pertinent areas.]*

In the depositions there was no "finger-pointing" by members of the crew who had lived through that gruesome night. It was clear that the Captain and other crewmembers interviewed had only respect and affection for Ronnie Chambers. Although he had only been assigned to the SEABULK GEORGIA for about 10 days, it was clear that Ronnie was readily accepted as part of the crew and was working among friends.

This was a hard-working crew whose Captain reported that he didn't sleep much and often put in 20-hour days. The QMED, who was on lookout duty with Ronnie, had already put in 17½ hours in the past 24 hour period. The QMED made it very clear in his deposition that nobody had forced him to work those long hours. He stated that he worked extra hours voluntarily and was not under duress. The picture emerges of a close-knit, hard-working crew that came together to do a job that lasted far beyond the number of hours legally available yet effectively mustered following the disaster to save Ronnie's life in the few moments available to them following impact. In the course of preparing this report, I plan to review the pertinent transcripts and make recommendations to commend the mariners involved for their heroic actions that saved the life of Ronnie Chambers.

A picture clearly emerges of a crew that simply had too many tasks to accomplish, too few hours to accomplish that work, and too little effective shoreside support. Of course, those who work in the offshore industry probably will yawn and say, "So what else is new!"

One of the most common problems that mariners on offshore supply vessels face is that their vessels are perpetually undermanned for the jobs they are expected to do. The boat owners, represented by their trade association, the Offshore Marine Services Association (OMSA), vehemently disagree in forums like the National Offshore Safety Advisory Committee (NOSAC) where we often meet. The boat owners have worked for many years to keep manning levels reflected on their vessels' Certificates of Inspection at the lowest possible level. Seamen manning these vessels have never had a voice in setting vessel manning levels – only the vessel owners have direct access to the Coast Guard when it comes to setting industry-wide manning policies. Between industry and the Coast Guard, they have "leveled the playing field" so that most vessels in the industry are insufficiently manned to engage in 24-hour service. The situation on uninspected towing vessels is even worse since they are not even issued a Certificate of Inspection and existing manning regulations are almost incomprehensible to the average mariner.

Yet, in many ways, the seamen are their own worst enemies. Although the Captain of SEABULK GEORGIA was assigned an extra man, he still believed the vessel was undermanned.[(1)] Yet, by working beyond the legal 12-hour limit and allowing his QMED to do so as well, the Captain virtually guaranteed that the company would never be under any pressure to assign the number of men necessary to operate the vessel safely and also to maintain it at the level the company apparently expected. *[(1)Captain's deposition, p.50.]*

What motivated the QMED to work these hours? In his own words: "...even though I've been up 10 or 12 hours, if I'm not tired and there's something going on, I'm going to help. I mean, that's part of the industry. And, if you do that, captains want you to come back. They call the office. You get good reports. And that helps you towards your license and progress and moving up and making ratings and stuff like that."[(1)] *[(1)QMED deposition, p. 126.]*

Although the Coast Guard overlooked these individuals' violations of the 12-Hour Rules, the company's Safety Manager became "concerned" after the accident that his QMED, who accepted the lookout assignment that night, worked 17½ hours in the 24 hours preceding the accident. He reportedly "discussed it with management" several days after the accident.[(1)] Although the QMED may deserve an "E" for effort, he is now earning it for another employer. *[(1)Safety Manager's deposition, p. 122.]*

Both the Safety Manager and Seabulk's unlimited Master expert witness with years of deep-sea shipping and managerial experience, considered the Captain at least partially at fault for not managing his crew members properly.

The company Safety Manager went even further and stated that this was why the Captain forfeited his safety bonus.[1] The expert witness stated: "...if he honestly believed that the vessel was undermanned...you should do something about it. You shouldn't take it away from the dock. You should report it to the Coast Guard. If the Coast Guard doesn't agree, you should report it to a federal judge, which you're required to do. And he didn't do so..."[2] Following the accident, the Captain decided to take a job with another major boat company. *[[1]Safety Manager, deposition, p.122. [2]Master expert witness, deposition, p.43.]*

Maintenance and Cure Versus Workmen's Compensation

A seaman injured while serving on his vessel is entitled to receive maintenance[1] benefits from his employer in addition to medical treatment called "cure."[2] Under most workers' compensation programs, which do not apply to seamen, a person who is not a seaman may continue to receive compensation benefits after he/she reaches a point of "maximum medical improvement." On the other hand, a seaman is owed maintenance and cure only until he reaches a point of "maximum cure." Maximum cure is the point of medical treatment where it appears that no improvement in the seaman's condition will result from further medical care. Seabulk saw this happening shortly after Ronnie left the hospital and was fitted with two artificial limbs. This might have been adequate in the days of Pegleg, but the world has changed since then. In reality, as evidenced by medical experts, care, refitting and replacing prostheses, and professional medical care will have to continue throughout his expected life span. Provision must be made for this care. *[[1]**Vocabulary: Maintenance** = normal shoreside living expenses. [2]**Cure** = adequate and complete medical treatment.]*

An employer's duty to pay maintenance and cure is not fault based. A non-negligent, fault-free employer owes benefits to its injured seamen. In most cases that do not involve seamen, an employer who pays workers' compensation benefits is immune from civil suits brought by its non-maritime employees. The worker's only recourse against his employer is to recover his worker compensation and medical benefits. In contrast, a seaman's employer does not enjoy tort immunity. The seaman can sue his employer and recover monetary damages if he can establish that his injury was caused by the legal fault of his employer, i.e., negligence, unseaworthiness or strict liability. In this case, undermanning a vessel or working its crew beyond legal limits (e.g., the 12-Hour Rules) are all very serious considerations.

The amount of benefits workmen's compensation offers a shoreside worker is different than what an injured seamen might receive from maintenance and cure. Typically, "worker's comp" is set by a wage-based formula according to state statute while a seaman's maintenance rate is unrelated to his earnings. Maintenance benefits are supposed to pay an injured seaman for food and lodging equivalent to those aboard the vessel...one often interpreted by employers as a rented room in a flophouse. Further, a vessel owner's maintenance and cure obligation is not set out in any statute. The duty to pay such benefits is a matter of uncodified general maritime law. This leaves it up to the employer to determine what is fair and reasonable for an employee who (for whatever reason) no longer contributes his labor to the company. Such payments tend to be small and of short duration since there is no universal maintenance formula.

Herculean Labor

Since undertaking Herculean tasks without great concern for their human costs is a tradition in this industry, let's reflect on the uneasy relationship between these traditions, workplace safety, and the law.

The SEABULK GEORGIA appears to have been run in a "***traditional***" manner reflecting the way things always have been done in the oil patch. Tradition in the offshore industry often involves cutting corners, especially at the expense inconvenient rules and regulations. Of these regulations, the 12-Hour Rules appear to be the most ignored and abused by both limited-tonnage mariners and their employers. When industry leaders or their trade association are unable to sidetrack a new regulation during the rulemaking process, they simply ignore or "interpret" unwelcome portions they believe the Coast Guard cannot easily enforce. Considering the Coast Guard's traditionally lax enforcement of maritime laws and regulations affecting our mariners, the chance of being caught is very limited; the chance of being punished is remote; and the opportunity to make a great deal of money is enhanced. NMA respectfully suggests that offshore supply vessel operations need to be scrutinized by an independent federal agency such as the National Transportation Safety Board. The Coast Guard needs to listen to and verify mariner complaints and then effectively enforce existing laws and regulations.

This is Dangerous Work

Limited-tonnage mariners who work on offshore supply vessels and uninspected towing vessels perform dangerous work. How dangerous it is may never be known because the Coast Guard has not been attentive to

deficiencies in accident reporting procedures over the years.[1] Although we reported this in our newsletters, the Coast Guard stonewalls us and shows no intention of cleaning up its act. This was reported as far back as 1994.[1] Several years ago, the Department of Homeland Security formally addressed the matter of casualty investigations that our Association contributed to.[2] accident reporting shortcomings with the Department of Transportation Inspector General's Office. *[(1)Refer to NMA Report #R-429-A, Rev. 1 (2) Refer to NMA Report #R-429-M]*

Every mariner needs to reflect on this question: If I am seriously injured on the job, who will take care of me? Care may be required for weeks, months, or in the case of Ronnie Chambers and in spite of his most courageous efforts, for the rest of his life.

Consider this: If I cannot go back to work, where will my next paycheck come from? Or my next meal? Or my family's? If I am not able to work and need medical care, prescriptions or treatment, who will provide them or how can I survive without them?

The truth in this case, as in cases with a number of other mariners we encounter, is simply this – when you are seriously injured and cannot return to work, your employment is terminated, your paycheck is no longer in the mail, and you must manage to make payments for your own health care and that of your dependents or you won't be cared for. If you are a mariner accustomed to bringing home a steady paycheck, you certainly have good reason to be alarmed with such treatment. If you are a union member, at least you and your co-workers will have an opportunity to bargain collectively with your employer to ensure that your needs are taken care of by your employment contract following a serious accident. But, as an employee "at-will"[1] you have no contract your employer must live up to, and you are left to find your own way. This means that you must hire an attorney and prepare to fight for your future in court. You must do this at a time when you are injured, often resentful, maybe depressed and without hope, and generally vulnerable to accepting a "quick settlement." As an Association of concerned mariners, NMA condemns this corporate practice of simply cutting loose an injured mariner. Unfortunately, this practice is widespread in this industry and is by no means limited to this particular employer. *[(1)An "at-will" employee has no employment contract that guarantees him/her any rights or benefits. Employment can be terminated at any time for any reason whatsoever – or for no reason at all.]*

Standing up to Corporate Giants

The prospect of standing up to a corporate giant that owns over 200 vessels around the world and with international interests is daunting. The prospect in this case appeared even more hopeless when the Coast Guard pronounced its collegial judgment in unforgiving terms like "negligence" and "inattentiveness." Making the blow a little less crushing, the Coast Guard mercifully allowed Ronnie to surrender his license for medical reasons without dragging him through a formal hearing process.

Meeting the high costs of rehabilitation, lifetime care, vocational counseling, retraining to provide future income, and assistance with day-to-day living were all matters that had to be examined and then somehow financed. By cutting Ronnie loose at the earliest possible date, the company was determined to divorce itself from responsibility for what happened. In effect, Seabulk assumed that they were blameless, distanced themselves from the accident, and went about their business. Any problems an injured, unemployed, and penniless seaman might generate could be easily dispatched by the company attorneys.

The "Real" Investigation

Proving that Seabulk shared the blame for the accident was a major problem considering the fact that the trauma of the accident totally erased Ronnie's memory of the accident. Following the Coast Guard's investigation released in March 2001, the "real" investigation was conducted by Ronnie's attorneys Les Martin and Phil Cossich.[1] *[(1)The law firm of Cossich, Martin, Sumich & Parsiola, L.L.C., 8056 Highway 23, Suite 200, P.O. Box 400, Belle Chasse Highway, LA 70037. (504) 394-9000]*

The attorneys' examination of how Seabulk Offshore, Ltd. operated the SEABULK GEORGIA was at the heart of the investigation. This investigation had many facets we will examine in some detail so our mariners may examine issues pertinent to their own future.

The investigation would consume the better part of a year and required hundreds of hours of legal preparation and produced over three-hundred pounds of documentation. Up until the day of the trial on Dec. 17, 2001, Seabulk was unwilling to make anything that could be considered a reasonable settlement considering his projected expenses to compensate Ronnie for the injuries he received as an employee on their vessel. Furthermore, no settlement would have resulted if Seabulk had not been in some way at fault for their practices. What they were willing to admit and the exact amount it cost the corporation was not made available. However, the settlement was

reported to be considerable. Fair and reasonable are terms that could be applied to the settlement whereas "charitable" could not!

During the time following the accident, Ronnie exhibited tremendous courage and perseverance in his attempt to put his life back together and arise above his pain and conquer his disabilities. After release from the hospital, he underwent rehabilitation and was examined by medical experts that advised him as to his medical prognosis. He received vocational counseling that centered on how he could retrain to make a living in a completely new occupation. Financial estimates for the cost of this care had to be carefully prepared and were subjected to close scrutiny. During this period, an exceptionally heavy burden for his care and maintenance fell upon his parents and upon other caregivers.

To gain their attention and to convince them they were serious in pursuing a settlement, Ronnie's attorneys sued Seabulk Offshore Ltd. in Federal District Court for $28,000,000. That amount and a recent jury verdict in Federal District Court in Lafayette in the case of an injured oilfield worker that also lost both legs, may have helped make the point that Seabulk's practices would be closely scrutinized.

To generate as full and complete a picture of the accident as possible, most of the vessel's crew was "deposed." A "deposition" is a method of pre-trial discovery, which consists of a statement of a witness under oath, taken in question, and answer form as it would be in court, with opportunity given to the adversary (in this case, Seabulk) to be present and to cross-examine. All depositions were reported and transcribed by a Court Reporter and became part of the official public record. In addition to crewmembers, a number of Seabulk shoreside employees were deposed at length as were several expert witnesses Seabulk hired to provide their opinions of what had happened.

Prologue to the Accident

On the day before the accident, the SEABULK GEORGIA spent the day alongside the dock in Berwick, LA. The vessel had six assigned crewmembers, one more than the minimal number its Certificate of Inspection called for. The crew included the Captain, one Mate, one licensed engineer, one QMED (qualified member of the engine department), one Able Seaman and one Ordinary Seaman.

The vessel's two seamen were set to work chipping and painting the colorful red, white, and blue vessel to keep it standing tall in the best oilfield ***tradition***. This would probably be the most expensive paint job the vessel ever received because these two seamen put in their full day's work in the hot summer sun and were not available for duty later that night. Every mariner knows how a poorly maintained boat reflects poorly on its Captain, its crew, and its company...one of those unsinkable ***traditions***.

The Captain and the Mate

The Captain is 25-year veteran of the oil-patch. He was also a very handy person to have around any boat. He was concerned with vessel maintenance and knew enough about cutting and welding to help the engineer replace a pair of valves in the pipe tunnel during the day. In mid-summer, this was hot and tiring work.

It would stretch the truth to say that the company did not know all this activity was taking place. After all, they were called and even brought at least one of the new replacement valves to the boat. However, there is no evidence that a hot-work permit was ever sought or obtained for welding repairs on this inspected vessel – a fact that, more than likely, would dismay the local Coast Guard Marine Safety Office across the river had they encountered the work in progress. While this work was underway, the QMED, the "extra" man on the boat, was also busy at other tasks throughout the long, hot day taking only a brief nap during the late afternoon. The QMED was also one of those persons who "knew his stuff." In fact, the company lucked-out in having an excellent boat crew in the best oilfield ***tradition***. Why then, less than 24-hours later did following these same ***traditions*** contribute to a devastating accident that cost the company and its insurers many millions of dollars?

Knowing that the boat would have to make a long run that night, the Captain wisely let his mate, Ronnie Chambers, rest during the day. Ronnie did not participate in the strenuous work schedule with the rest of the crew because he would have to take the boat out on its night run to Vermilion 267A. When the time came, Ronnie was expected to prepare the boat to get underway, maneuver it away from the dock, and take it on a 40-mile run down the winding and congested Atchafalaya River, across the bay and out the dredged channel into the Gulf of Mexico – all tasks that Ronnie performed flawlessly and up to his Captain's expectations. Ronnie also knew his stuff.

The Captain, with his many years experience, had worked with Ronnie for the past ten days. He developed a favorable opinion of his mate who was also almost ready to sit for his Master's license. The Captain decided Ronnie was a good boat handler and could be trusted to make the night run. In this industry, trust must be earned. When offered by a veteran Captain, it is a compliment carrying an obligation a conscientious mariner does not take lightly.

It is ***traditional*** in this industry for the Captain to handle his vessel around the dock, take her out the channel to the sea buoy, and then turn her over to his mate. The mate runs to the destination and then hands the vessel back to the Captain to maneuver around the rig; the mate then goes out on deck to play the role of chief deckhand. Following this particular ***tradition*** makes it very difficult for a mate to obtain much practical boat-handling experience. This particular ***tradition*** also violates the "12-Hour Rules" that govern OSVs on voyages under 600 miles and all uninspected towing vessels.[1] *[(1)USCG Headquarters clarified the "12-Hour Rule" in G-MOC Policy Letter #04-00 available in NMA Report #R-370, Rev.3.]*

Ronnie is the sort of person that seeks responsibility and was rewarded by a Captain that trusted him and offered him real boat-handling experience. In return, he looked up to his Captain with respect for giving him the opportunity to prove his ability. Whatever happened in the hours that followed, the mutual respect remains between these two men. In interviewing Ronnie Chambers, terms like "negligent" and "inattentive" are strangely out of place and beg a definitive explanation for the events that changed his life forever. The record and the man provide no explanation – only theories.

Our Association believes any assignment of blame falls in large measure on some of the unsafe ***traditions*** that still exist within the industry. Clearly, some traditions must change and change quickly to meet changed requirements such as the International Safe Management (ISM) Code as well as STCW and ILO requirements.

Relinquishing Command of the Vessel

After the SEABULK GEORGIA passed the sea buoy and into the Gulf, Ronnie asked his assigned lookout, the QMED, to hold the wheel for a few minutes while he ducked below to get some sandwich fixings and a cola. With no cook assigned to the boat, the crew is left to raid the refrigerator at will to scrounge up a meal or a snack. Removing the cooks ***traditionally*** assigned to OSVs was an austerity measure dating back to the oilfield "bust" of the mid-1980s. While not paying a cook may cut expenses, the real cost is borne the expense of crew's comfort and nutritional well-being.[1] *[(1) Refer to NMA Report #R-395-A.]*

The simple act of a watch officer ducking out for a quick snack when all is clear ahead clashes with Coast Guard legal precedents[1] that a licensed officer must never turn the watch over to an unlicensed crew member, not even for a minute. The company Safety Manager[2] blasted Ronnie for this transgression although this is traditional oilfield practice. *[(1)Refer NMA Report #R-405. (2)Safety Manager deposition, p. 106.]*

Handing over control to go below for a call of nature is also a common practice. This ***tradition*** is so ingrained that OSVs are still built without plumbing in the pilothouse. How does ***tradition*** explain human necessities for those on watch to answer calls of nature? The thought of installing a flush-toilet on the bridge would be laughable if it were not a common fixture aboard some (but not all) line-haul river towboats.[1] *[(1)One mariner, who relieved himself in a metal can that he subsequently dumped into the Ohio River, was admonished for polluting the river by Coast Guard interviewers for this act. Also significant at the same time, was the fact his tow collided with a moored barge dumping 85,568 gallons of gasoline into the river. NMA File #M-113.]*

When Ronnie returned to the pilothouse, the QMED soon announced that he was going to make his rounds in the engineroom, which also, is ***traditional.*** Although most companies have "automated" enginerooms that allow them to operate the vessel with only one person assigned to the engine department, some person must be available to answer and investigate engine alarms 24 hours a day while the vessel is underway or standing by at an offshore rig or platform. A functional job analysis performed by the Coast Guard in 1980 shows the OSV engineer as the most overworked person on a supply boat since he is not only responsible for maintaining the engineroom but also for pumping all the vessel's bulk cargo. Aside from answering alarms, it is also sensible to check the engines periodically to see that all is running smoothly. Before leaving the pilothouse, the QMED glanced at the radars and saw that the SEABULK GEORGIA was on a course that would bring it safely midway between two obstructions ahead. The QMED had previous experience at sea in the U.S. Navy. He expressed no real concern in leaving the pilothouse for a few minutes (later estimated to be between 15 and 18 minutes) to check the engines...nor did Ronnie. While below, the QMED did his "rounds," closed several deck plates as the chief engineer had requested, picked up some tools, and then grabbed some milk and cookies in the galley. It was then, as he prepared to mount the stairs to the pilothouse that the SEABULK GEORGIA struck the rig and plowed underneath it as the pilothouse was crumpled and torn off the upper deck, dragged aft with Ronnie in it, and deposited on the cargo deck aft of the galley. It was the QMED and the Captain, who picked through the wreckage, found Ronnie, applied tourniquets, summoned help and saved his life.

Who Was on Watch?

Soon the question arose as to how the watch was established. Here the law[1] specifies that the watches be set by the vessel's master. In addition, according to law,[2] the watch schedule must be posted where it is easily accessible. *[[1]46 CFR 15.1109 states: "Each master of a vessel that operates beyond the Boundary Line shall ensure observance of the principles concerning watchkeeping set out in STCW Regulation VIII/2 and Section A-VIII/2 of the STCW Code." Section A-VII/2 contains 106 separate and specific guidelines that must be observed. [2]STCW Code, Section A-VIII/2.5.]*

Tradition, at least as practiced in the oil patch, discourages putting things that are routine or easily understood into writing – watch schedules included. Consequently, setting the watch that evening was done informally with the vessel's master pretty much leaving it up to the mate to arrange for his own lookout. Since the QMED "volunteered" to stay on duty at night, the Captain, the Chief Engineer and the two seamen rested from their hard day's work as the boat headed down river. Everything looked rosy: Ronnie describes himself as a night person, and the QMED volunteered for the duty. Such an ideal arrangement seemed to cover both the deck and the engineroom – or at least so they believed. However, the law and regulations simply are not written that way and clash with ***tradition***![1] *[[1]46 USC 8104(e), that applies to merchant vessels over 100 gross tons states that a seaman may not be engaged to work alternately in the deck and engine departments or be required to work in the deck department if engaged for engine department duty (or vice versa). The oiler should not have been used as a lookout.]*

Seabulk assigned an extra person to work on the vessel that was not required by the Certificate of Inspection, in this case a person hired as a QMED-Oiler. Our Association, in Report #R-279, Revision 8,[1] urged the Coast Guard to "Review and set safe manning standards for offshore supply vessels and uninspected towing vessels." The Merchant Marine Personnel Advisory Committee (MERPAC), a federal advisory committee, in 2002 dismissed our Association's work on a project that may have eventually reevaluated manning standards. Work in revising manning standards for vessels under 1,600 gross tons is a project that is long overdue. This is especially true in 2011 relative to the Inspection of Towing Vessels – whose Notice of Proposed Rulemaking (NPRM) again delayed consideration of that matter.[1] Reevaluating manning is not something that boat companies encourage because solving obvious manning shortcomings will cost them money. *[[1]Refer to NMA Reports #R-276, Rev. 10 and #R-276-H.]*

In each of these cases, ***tradition clashed with the law***. One of SEABULK's "expert" witnesses, an unlimited master, repeatedly invoked the word "***traditional***" to try to justify most aspects of Seabulk's flawed operation. He even pointed out that the Coast Guard's accident investigation did not cite any of these legal shortcomings as "violations."

Unfortunately, such omissions are characteristic of many Coast Guard casualty investigations that are often hurried and may often do little more than scratch the surface.[1] Aside from providing an outline of what happened and a preliminary tally of the damages, the Coast Guard report became irrelevant in the months following the accident and, in any event, cannot be used in court. *[[1]The Coast Guard investigation and report took a total of 30 hours to prepare.]*

We have taken great pains in the past to warn our readers about the Coast Guard investigative process. In 1994, the Coast Guard contracted with the Human Factors and Systems Analysis Unit, Idaho National Engineering Laboratory to produce a report titled U.S. Coast Guard Marine Casualty Investigation and Reporting: Analysis and Recommendations for Improvement.[1] This report, coupled with the heavy investigations workload[2] that many Marine Safety Offices face, explains why mariners are not always protected with balanced enforcement of laws and regulations designed to protect them. *[[1]Report #R-429, Rev. 1. [2]The investigations workload at the Morgan City Marine Safety Office at the time of the accident was reported to number over 300 "open" cases.]*

The "Fast Rudder" Steering Problem

The SEABULK GEORGIA had a steering problem that the Captain called a "fast rudder." This describes a condition where the rudders suddenly and unexpectedly go hard over without warning and without any steering command. The problem was reported to the company's Port Engineer on June 28, 2000, a month before the accident. From repair reports, there were indications that hydraulic cylinder failures in January and June did require corrective action and were repaired. Still, the Captain recalled this condition occurred again just a few days before the accident. The main question seems to be whether or not a hard-over rudder command may have occurred on the night of the accident.

The Captain testified that this same condition occurred even after repairs were made just a few days before the accident. Unfortunately, Seabulk could offer no records of this service call for the repair work. Ronnie independently experienced a similar "fast rudder" problem while tied stern-to a rig with the engines working slow ahead within the short time he served on SEABULK GEORGIA.

The Captain reported twice in June that the "repeater needs to be relocated due to magnetic flux." Although Seabulk's expert witness on steering claims to be baffled by this report, it is clear that the Captain knew something

was wrong with the steering system and thought the problem was electrical rather than hydraulic. However, technicians did repair some obvious hydraulic problems, while possible electrical problems were not looked into.

A NMA steering consultant with years of commercial hydraulics experience who discussed pertinent parts of the case with us at our request stated that the rudders would not go hard-over without an electrical command to do so. Such a command might be random and generated by two contacts coming together on their own. The difficulty was that such a problem, whatever its cause was intermittent. It is both expensive and problematic to hire a technician to stay aboard the vessel to wait for such a random problem to recur. Nevertheless, whatever caused the problem was likely electrical rather than hydraulic.

The Gyrocompass

The SEABULK GEORGIA was fitted with a Sperry gyrocompass, autopilot, and magnetic compass. Sperry builds fine top-of-the-line equipment that usually serves for many years of trouble-free service. The fact that it had been installed on the vessel for 17 years was not as important as the fact that the gyrocompass reportedly did not function. The law[1] does not require that a gyrocompass be installed on a vessel of less than 1,600 gross tons.[2] However, Coast Guard inspectors require that inoperable equipment either be repaired or removed from the vessel.[3] At the time of the accident, the vessel was operating on autopilot using direction input from the Sperry magnetic compass because the gyrocompass did not work and apparently had not worked for a long time. *[(1)33 CFR 164.35(d). (2)The SEABULK GEORGIA is 290 gross tons. (3)As per discussion at USCG MSU Houma.]*

Expert testimony provided by Seabulk followed the vessel's "trajectory" from the sea buoy to the site of the accident only a few miles away. The scenarios presented in the depositions provided theories in which course changes of fractional parts of a degree were argued over. However, the accuracy of the magnetic compass never appears to have been questioned even after it was picked from the wreckage set on 226 degrees. However, Ronnie pointed out that the compass course was rarely within 15 degrees of the true course and that using the GPS with its off-track error as he had done was more reliable than relying solely on the magnetic compass. The deviation table, if it existed for SEABULK GEORGIA, was never mentioned in any testimony and never appears to have been presented as evidence of the compass calibration or accuracy.

What haunts the discussion is the Captain's statement of a month earlier: "(the) repeater needs to be relocated due to magnetic flux." Repeater, of course, refers to the gyrocompass' display unit. The Captain suspected that something was wrong with it and that the repeater or its wiring might have caused the "fast rudder" problems that plagued the vessel. Of course, this was only a theory and, as such, was based on an incomplete knowledge of the electrical end of the complex Sperry steering system. But, it was based on many years of oilfield know-how that often tends to be easily dismissed. Was the vessel's autopilot set on a magnetic collision course with the rig? Did the vessel suddenly swerve off course because of its recurring and unsolved "fast rudder" problem? Or, did the vessel gradually drift off a course that had been set to skirt the rig safely? There is no answer to these questions, only theories.

Questionable Shoreside Support

If you have a good crew that is interested in performing maintenance on a boat, some companies take advantage of the situation by stretching their shoreside support by hiring fewer supervisory personnel. An intelligent Port Engineer is key to getting major problems fixed in a timely and complete manner. Lacking that, any Port Engineer standing on the dock when an OSV arrives from offshore is a welcome sight. Previously, and for approximately six months, the SEABULK GEORGIA was not assigned a regular Port Engineer.[1] That, coupled with constant crew changes, makes it difficult to have any continuity in major repair work. Caring for six or seven large supply boats presents a major juggling act that is a challenge to any supervisor's "span of control." It is also clear from testimony that the Port Engineer who took the Captain's report about the "fast rudder" in late June didn't understand the nature of the problem even though he signed the report that recorded the complaint. The Port Engineer even stated that the autopilot is "the Captain's thing" displaying his ignorance of this equipment for all to see.[2] The Port Engineer stated in his deposition that he did not know in which direction the vessel would turn if hit with a hard starboard rudder command.[3] With such responses, it is not hard to see why equipment such as the vessel's complex steering system and gyrocompass never were successfully repaired. *[(1)Port Engineer deposition, p.16. (2)Ibid., p.59. (3)Ibid., pgs. 59, 60.]*

Rebuild The Wreck

Although the steering system was operational but, in questionable condition before the accident, its performance has now probably improved. Without knowing the details, the old SEABULK GEORGIA was not sent to the scrap

heap but was resurrected to run another day. If there were any electrical problems with the steering, there was no damage to the boat's two steering motors. All wiring problems that may have existed in the pilothouse were solved instantly by the accident that smashed most of the navigation equipment and controls and tore out all the wiring. Pictures of the reconstructed pilothouse show a shiny new (or reconditioned) gyro display unit. It is clear that the company (or its insurer) spared no expense repairing their boat and returning it to service and to Coast Guard standards. Yet, they sought to avoid their most important responsibility to care for their injured former employee.

In the long run, failing to address Ronnie's future cost them much more than repairing the boat. It is time both industry and the Coast Guard consider that restoring damaged human beings is at least as important as repairing damaged equipment. This is one of the "human factors" both the Coast Guard and the industry need to consider and not ignore. If Seabulk's management believed it could simply wave a magic wand and absolve themselves from blame, they now know otherwise.

The Seabulk Georgia was Undermanned

"Administrations[(1)] must establish and enforce rest periods for watchkeeping personnel and require watches onboard seagoing ships to be so arranged as to avoid any impairment of the efficiency of watchkeeping personnel because of fatigue. They must also require their watch systems to be so organized that, on proceeding to sea, the first and all subsequent watches are sufficiently rested and fit for duty." These requirements contained in the regulation itself[(2)] apply to all watchkeeping personnel. Administrations must also include in their legislation a requirement for watch schedules to be posted where they may easily be seen and read by all watchkeeping personnel."[(3)] *[[(1)]"Administrations" includes the U.S. Coast Guard. In 2000,our Association pushed the Coast Guard to clarify certain existing work-hour regulations. The Coast Guard addressed this in policy letter G-MOC #04-00. This document serves to clarify existing regulations informally called the 12-Hour Rules. [(2)]STCW Regulation VIII/1. Although STCW and the International Labour Organization require 10 hours of rest in a 24-hour period, U.S. regulations limit mariners to working no more than 12 hours in any 24-hour period except in genuine emergencies. [(3)]Morrison, W.S.G., Competent Crews = Safer Ships: An Aid to Understanding STCW '95. 1997, Malmo, Sweden. World Maritime University, p.170, #6.]*

Several months after the accident, Seabulk "clarified" its watchstanding procedures so that they now required the vessel masters to post their watch schedules. This was called a "clarification" of previous procedures so that the company could claim it had always followed the law. At least by making this paper gesture, ***tradition*** began to show some hopeful signs of being altered to follow the law. However, the law was clearly violated at the time of the accident and, to quote an old saying, "ignorance of the law is no excuse." Although the Captain escaped Coast Guard scrutiny on this point, and only a few scraps of paper from the boat survived the accident and a brief rain shower, the matter of establishing and conducting the watch played an important role in the lawsuit that followed.

The Coast Guard believes that a vessel like the SEABULK GEORGIA can successfully operate on a 24-hour schedule on a voyage of less than 600 miles with a minimum complement of only 5 mariners. Consequently, this is the number the Coast Guard placed on SEABULK GEORGIA's (and hundreds of other OSV) Certificate of Inspection. The owner of the vessel may use additional crewmembers if it so desires, but may not operate with fewer than five. Where the "600-mile" figure came from is something the Coast Guard refused to divulge to us even under the Freedom of Information Act routed through a Member of Congress several years ago. This provision has been on the books for many years, probably placed there as one of many concessions given to the owners of oilfield vessels. Whereas oilfield vessels must carry extra crewmembers on voyages over 600 miles, even this small safeguard does not exist for mariners who toil on uninspected towing vessels.

In a deposition after the accident, the Captain was questioned about the manning on the SEABULK GEORGIA. He stated: "I always thought vessels were undermanned. Because you cannot hold your watches like you want, like a professional captain would want...With all the activities going on running to rigs you get to the rigs, and you need your men up to help you tie up. Then you need someone on the watch. Then you have your engineering crew on the watch. We're doing all our pumping, never enough men."[(1)] *[[(1)]Captain's deposition, p. 48]*

The QMED independently believed that the SEABULK GEORGIA was short handed when he said: "It wouldn't hurt to have more people on. I agree. I mean, that's every company out there is the same way. It ain't just – that's not just Seabulk. That's through the whole industry."[(1)] The Coast Guard has found it easy to ignore individual mariners. However, it will be more difficult for both the Coast Guard and Congress to continue to ignore the crisis of undermanning that continues to plague limited-tonnage mariners. Nevertheless, ten years after the accident, nothing has changed nor does change appear likely. *[[(1)]QMED deposition, p.113.]*

In his deposition, the Captain and Seabulk's expert witness, both with years' of experience, demonstrated a basic

lack of understanding the statutes separating engine department from deck department duties. The Captain commented on his QMED as follows: "You take (name) – he shares duties, he's just an oiler right there. Officially he's a deck hand. He can work in the engine room or if I assign him to go chip and paint, or sweep, or mop he can do this. He's a "Q" mate, he's a qualified mate of the engineroom department, but he's still an oiler. They can divide (duties) among themselves, because when he's tired or the engineer's tired, either (of the two deckhands) is going to help him. They're going to do engineroom checks."[1] *[[1]Captain's Transcript, p. 54.]*

On undermanned oilfield vessels as well as uninspected towing vessels, the natural instinct of crewmembers helping one another has become a matter of survival. As a result of operating short-handed, these vessels become more vulnerable to being overwhelmed by either the sea or fatigue from overwork!

The Company's Lookout Policy

The fact that the existing company policy allowed the mate to stand watch alone in the pilothouse for about 18 minutes before the accident led to an abrupt revision in its safety policy after the accident.

Seabulk's new policy breaks with oilfield ***tradition*** and more closely follows STCW Section A-VIII/2.15 that states: "The duties of the look-out and helmsperson are separate and the helmsperson shall not be considered to be the look-out while steering, except in small ships[1] where an unobstructed all-round view is provided at the steering position and there is no impairment of night vision or other impediment to the keeping of a proper look-out. The officer in charge of the navigational watch may be the sole look-out in daylight..."[2] *[[1]Although Seabulk's "expert" witness justified the one-man bridge watch saying the SEABULK GEORGIA was a "small ship," nowhere in the rules does STCW define a "small ship." [2]The accident occurred just after two o'clock at night, not during daylight!]*

Yet, even the revised company policy still allows the lookout to leave his post for a reduced period of up to 10 minutes to perform engine checks. While it is to the company's benefit to periodically check an "automated" engineroom, such a policy still reflects ***tradition*** and leaves a gaping and insupportable gap in lookout coverage.

Even more telling than its policy "clarification" (attempting to show that no fault existed the traditional system), is the fact that the pilothouse of the rebuilt SEABULK GEORGIA contains two pilot chairs. I have always wondered how a person could stand lookout for endless hours on his feet at night in addition to working all day without resorting to sitting and eventually reclining on a ***traditional*** settee inconveniently set below the level of the windows in the pilothouse.

This accident illustrates why maintaining an effective watch has always been important. STCW's "Standards Regarding Watchkeeping" lays down definitive guidelines consisting of 106 steps. Maintaining a proper lookout is only one part of effective watchkeeping. In May 2001, our Association provided itsmariners with a "Special Report" titled 45 Musts for Effective Watchkeeping[1] based largely upon previous court decisions. We believe that a watchstander must be instructed in all these points before standing an effective watch. *[[1]Refer to Report #R-207, Rev. 1.]*

"Crew Endurance"

Both the industry and the Coast Guard have had their heads in the sand far too long. At Coast Guard Industry Day in New Orleans on May 15, 1996 the speaker, Mr. William Sirois of Circadian Technologies spoke on the topic Alertness Assurance: The Key to Reducing Fatigue and Human Error in the Marine Industry. He prepared an excellent and descriptive set of materials that and distributed them to the 500 registered attendees from the ranks of industry management. Much of what he covered in very dramatic fashion seems to have missed its mark since fatigue and violation of the 12-Hour Rules continue to plague both the offshore oil and towing sectors of the marine industry today.

On the SEABULK GEORGIA, the QMED worked over 17½ hours in the 24 hour period before the accident...and most likely put in many additional hours in the wake of the accident.

Our Association protested the unconscionably frequent violations of the 12-Hour Rules that are supposed to protect limited-tonnage mariners. We note that this problem does not exist with upper-level mariners protected by union contracts and provided overtime pay for their work and generally work a three-watch system. Our protests appear in our book titled Mariners Speak Out On Violation of the 12-Hour Work Day issued in June 2000.[1] Our protests are not limited to situations where mariners are forced to work over 12 hours in a 24 hour period. Our protests include those mariners who choose to work beyond 12 hours voluntarily and thereby make a mockery out of existing manning regulations. In his deposition, the QMED admits that there is at least a possibility that he could have prevented the accident if he had been acting as full-time lookout in the pilothouse for the mate.[2] Even the company Safety Manager believed the new policy of requiring a lookout during hours of darkness was safer than the old policy that left assigning a lookout up to the Captain.[3] After all, a lookout has a definite function to perform and must not be detailed to perform other duties. *[[1]NMA Report #R-201. [2]QMED deposition, p.102. [3]Safety Manager deposition, pgs. 65-68.]*

The Coast Guard also has its head firmly planted in the sand. On May 15, 2000, less than three months before this accident, Rear Admiral Pluta, then Eighth District Commander and later Assistant Commandant for Marine Safety wrote to Congressman Billy Tauzin, stating in part: "I am writing in response to your letter of Apr. 20, 2000 addressing the concerns raised by your constituent...regarding vessel operator fatigue and work hour limitations on commercial vessels...Although we receive very few complaints, either anonymous or attributed, of 12-hour rule violations, we strongly encourage...and his colleagues to report these incidents to the nearest Coast Guard Marine Safety Office...Recently my staff conducted an informal phone survey of a cross section of the Eighth Coast Guard District Marine Safety Offices to get a feel for the volume of 12-hour rule complaints we receive. This survey indicated...(we)...received very few complaints involving mariners being forced to work more than 12 hours."

Shortly after we received a copy of this letter, we provided Admiral Pluta a copy of our "Yellow Book" with letters from 57 mariners with 12-hour rule complaints. The Coast Guard never investigated any of those complaints!

It doesn't take a rocket scientist to explain why mariners working on an "at will" basis hesitate to report 12-hour rule violations to the Coast Guard. Unfortunately, the Coast Guard is inclined to ignore such complaints if they receive them from individual mariners just as they ignored the complaints our Association gathered and carefully placed in their hands. In fact, the Coast Guard has not taken any meaningful action to require limited-tonnage mariners to maintain accurate logbooks that would record their hours on duty.[1] Admiral Pluta, while in charge of the Marine Safety Directorate, took no action to solve a problem he was unwilling to admit or even confront. Furthermore, his letter to Congressman Tauzin did inestimable harm to all our overworked mariners. *[[1]However, Congress stepped in and addressed this problem in Section 607 of the Coast Guard Authorization Act of 2010.]*

NMA provided copies of our "Yellow Book" (Report #R-201) to three federal advisory committees, MERPAC, TSAC, and NOSAC that advise the Coast Guard on matters that concern lower-level mariners. Of the three committees, only NOSAC was willing to look into the problem by tasking the job to its "Prevention Through People" (PTP) subcommittee. The subcommittee chairman formed a working group including NMA President Penny Adams that read and reviewed a number of studies on fatigue. When the subcommittee met on Nov. 7, 2001, a recent Coast Guard report titled U.S. Coast Guard Guide for the Management of Crew Endurance Risk Factors[1] surfaced and became a key part of the discussion. The report goes a long way toward explaining why the Coast Guard itself has such a serious problem retaining its own personnel. The parallel between the Coast Guard's own experiences with overworking its own seagoing personnel and problems faced by our mariners is unmistakable. *[[1]GCMA Document #A771C.]*

Our Association believes that the Coast Guard clarification of the 12-Hour Rules has gone a long way to outlining the responsibilities of mariners, employers, and the Coast Guard. However, we want to make these points:

- If a vessel works over 12 hours a day and is allowed to operate under the two-watch system, it should be provided with two complete and trained crews. The only other acceptable alternative is a three-watch system for both the deck and engine department.
- Watchstanders, including lookouts, must be trained before standing watch.
- Each crew must be fully trained to operate the vessel without calling out the other crew except in a true emergency. Anchoring, mooring or cargo handling should not be justified as an "emergency" measure. This ensures that meaningful assistance will be available in a true emergency.
- Mates must be employed as watch officers not as deckhands or oilers. Employers should be certain they are adequate boat handlers before sending them to sea.
- Any boat contracted for 24-hour service should have a trained cook.
- All events including watch changes and actual working hours should be accurately logged.

CASE #13: $710,000 FEDERAL COURT VERDICT IN FAVOR OF ACL MATE INJURED WHILE JERKING WIRE

*[**Source:** Nelson G. Wolff, Esq., Schlichter, Bogard & Denton, LLP, 100 South Fourth Street, Suite 900, St. Louis, Missouri 63102. Phone: (314) 621-6115. Fax: FAX (314) 621-7151 e-mail: nwolff@uselaws.com.]*

On May 13, 2005, an Illinois Federal Court ordered **American Commercial Barge Line, LLC**. (ACBL now ACL) to pay almost $710,000 to Dennis Shreve for back injuries he suffered from a work related injury in November of 2002. Shreve, 43, of Hartford, Kentucky, was working as a mate crewed to the M/V TOM FRAZIER when he injured his back while attempting to "jerk" slack out of a steel wire at a "high-low coupling" after passing through a lock on the Mississippi River at Winfield, Missouri. The judgment is believed to be the largest ever against a barge company involving this work practice, which was described by ACBL at trial as "customary" and "ordinary" in the maritime industry.

At the time of the injury, Shreve had worked for ACBL for over 20 years, and his family had a history of 75+ years of service for the company. Shreve was used by ACBL as a safety trainer of other deckhands for years before the incident and was the boat's safety representative.

After coming through the lock, Shreve and two deckhands attempted to secure two of the fifteen barges in the tow together with a 35-foot fore/aft 3-part wire, extended an additional 10 ft. with chain links, cable strap, shackles, and pins. After the cable had been wrapped around several barge deck fittings, it was to be secured to a ratchet and tightened to another fitting on the barge.

Pursuant to ACBL work rules and procedures, the crew was required to "jerk" slack out of the wire before securing it to the ratchet. Shreve was required to stand on the upper barge, 2½-feet above the lower barge where the other two crewmembers were trying to synchronize their jerk. In the process, Shreve had to bend his back at waist level to reach down to grab and jerk the steel cable and felt immediate and excruciating pain that caused him to fall to his knees with a low back injury.

After **ACBL terminated maintenance and cure payments and health insurance**, Shreve filed suit under the Jones Act alleging <u>a failure to provide a safe workplace based on unsafe work methods and the failure of ACBL to provide winches to remove the wire slack</u>.

The evidence at trial showed that ACBL employees previously had suffered injuries jerking wire and had complained about this work method and had requested barge winches, but that ACBL had chosen to provide winches on new barges only. The evidence also proved that the stationary 45-foot wire with which the barge had been originally equipped had not been replaced and Shreve was required to work with a more cumbersome and heavy set of boat rigging.

Shreve's treating doctors diagnosed a herniated disc in his low back but declined to perform spinal surgery since that would not allow him to return to work. A functional capacity evaluation suggested that Shreve was capable of performing heavy work. <u>ACBL admitted that he was not capable of returning to work, yet did not offer him any other employment</u>. Shreve did not hire any experts to testify at trial.

ACBL denied the existence of any unsafe conditions, methods or inadequate equipment. Its maritime expert, Capt. Samuel Schropp, of Ingram Barge Co., contended that jerking slack from wires, instead of using a winch, remained a common maritime industry practice, which he believed to be safe. He claimed that Shreve was contributorily negligent for failing to ask the captain to rearrange the barges to avoid the high-low coupling, if Shreve thought there was a hazard.

However, every company official and employee who testified at trial admitted that <u>Shreve had done nothing wrong, had not violated any safety rules, and was simply using the company's methods</u>.

ACBL's medical expert claimed that Shreve had only suffered a back strain and that he had pre-existing degenerative disk disease exacerbated by multiple prior and unrelated motor vehicle collisions. ACBL's vocational expert claimed that Shreve was physically qualified to return to 92% of all jobs, including as a tow boat pilot or truck driver, despite the fact that Shreve had chronic pain and was taking Darvocet. At the end of the trial, <u>ACBL's lawyers asked the jury to deny Shreve any compensation for his injuries</u>.

The jury of eight men and women from throughout southern Illinois deliberated for only two hours before returning a unanimous verdict for Shreve in the gross amount of $874,332. The itemized verdict ordered ACBL to pay over $730,000 to Shreve for future medical expenses and past and future wage loss, with the remainder going for non-economic damages of loss of a normal life, pain and suffering, and emotional distress. The jury reduced

the gross verdict by 19% on account of what it determined to be Shreve's contributory negligence, resulting in a net verdict of $708,208.92, upon which judgment was entered.

Shreve filed a motion with the court asking it to reinstate the entire verdict, since the finding of contributory negligence was not supported by the evidence and constituted assumption of risks inherent in the employment, which is not allowed as a basis for offset under the Jones Act.

It is also noteworthy that following the date of injury, defendant (ACBL) filed for bankruptcy under Chapter 11 and sought to discharge this claim as unsecured. The plaintiff challenged same and successfully obtained secured status, such that the claim will not be subject to any discount. Prior to trial, ACBL had only offered a settlement of $275,000, which was rejected. Shreve was represented by Attorney Nelson G. Wolff of the St. Louis, Missouri firm Schlichter, Bogard & Denton.

According to Mr. Wolff: "The verdict vindicated Dennis, a worker with 20 years experience who had been blamed by the company for causing his own injury. The disabling injuries could have been prevented if ACBL had learned from previous similar incidents and just spent some of its profits on safety equipment."

The Honorable Michael J. Reagan presided over the trial in East St. Louis, Illinois.

The Significance of This Case

The common industry defense that this type of work is "customary" and not out of the ordinary demonstrates a clear need to satisfactorily regulate work on barges since they are often unsafe and dangerous workplaces.

In GCMA Report #R-276,*(1)* our mariners ask that Congress "inspect dry cargo barges for workplace safety." *[(1)Item #72]*

Each year a number of mariners fall overboard from or otherwise injure themselves in other ways while working at making and breaking tow and pumping and maintaining dry cargo and other barges that are <u>not subject to USCG inspection</u>. Our mariners report that the barge owners maintain <u>some</u> of these barges in deplorable condition. In this case, the failure to maintain the "standing rigging" (i.e., winches and cables) on the barge in this case led mariners to use the only available "portable rigging" that resulted in a serious back injury for the experienced Mate, Dennis Shreve.

Dry cargo barges, and even some manned barges, still remain as uninspected vessels and managed to escape <u>effective</u> government safety regulation. Even though barge accidents like this are not uncommon, few ever reach the public's attention even in industry trade journals.

Although workplace safety on these uninspected vessels falls to the Occupational Safety and Health Administration under DOL Directive CPL2-1.20, the Coast Guard rather than OSHA has the waterborne transportation (e.g., patrol boats) and presence on the waterway necessary to board these vessels and check for workplace safety issues before mariners are injured and killed. Consequently, our mariners maintain that workplace inspection, safety regulation, and proper maintenance of <u>all</u> barges must become a Coast Guard rather than an OSHA function – as long as the Coast Guard remains in control of marine safety.

We believe that Congress must assign the USCG authority to inspect and regulate all barges since OSHA has <u>not been effective</u> in protecting our mariners. In fact, Congress recently placed the inspection of previously "uninspected" towing vessels in the Coast Guard's hands in September 2004.

It is reasonable for Congress to bring <u>all</u> barges under USCG numbering, identification, and inspection to provide a safe workplace for the merchant mariners who must work on these barges in light of the many injuries and falls from uninspected barges, some of which are fatal.

GCMA reviewed several depositions taken in this case – one by ACBL's Safety Director and the other an experienced back surgeon and medical expert hired by ACBL's lawyers to testify on their behalf.

Essentially, ACBL's Safety Director admitted that his company failed to follow its own procedures that required it to assess the "root cause" of all injuries, since according to their policy statements, "All injuries are preventable." He admitted that <u>ACBL, knew that other employees previously were injured attempting to jerk slack from barge wires as a result of an "unsafe method</u>." He further acknowledged that only 10% of barges used by ACBL had winches, although barge winches were available for at least 40 to 50 years. He cited cost as the factor why not all barges were fitted with winches. He pointed out that all new barges had winches. He also pointed out that ACBL had a "program" to retrofit existing barges when they were dry docked for repair. Nevertheless, the fact that after a five-year period that only 10% of ACBL's barges had winches installed on them did not support their alleged safety concern for their employees.

Although the company's Safety Director denied any <u>increased</u> risk of injury from "jerking" as compared to "winching" the wires to tighten them, the medical expert admitted this fact and that the work method that involved

in “jerking” the slack out of the wire was unsafe.

The fact is that not only ACBL but also the rest of the towing industry has failed to adapt modern technology and safe work practices in building barge tows. “Steamboat ratchets” as an example indicate their historical roots from a bygone era. River steam towboats vanished about the same time as steam railroad locomotives about 50 years ago. The steamboat ratchets did the job in an age of cheap and plentiful labor – a situation that has clearly changed today.

Even the term “cheater pipe” as used to increase the force a person can apply to work these ratchets and tighten the slack in wire rope couplings indicates by its name that it subjects the equipment it is used on to a force beyond its manufacturer’s design limit. Double or triple even that “cheated” force by having two or three deckhands try to synchronize applying even more force. The risk of slipping, falling, losing your grip multiplies and makes it more likely that there will be some unexpected and undesirable outcome as there was in this case. If not the case, why aren’t these ratchets manufactured with longer levers? Is it a matter of product liability?

This case shows that the “portable rigging” that must be dragged around the deck and then assembled piece-by-piece to build a tow ought to be subjected to close OSHA examination and evaluation for workplace safety. Even ACBL’s own evaluation shows their preference for winches as a cost-effective method of coupling barges – even considering the savings from recycling used elevator cable rather than new wire rope as is a common practice.

Another safety hazard exposed in this in barge-coupling work results from ACBL's use of different size barges in the tow, including at the “break-coupling” where the 15 barge tow had to be separated to fit into the lock. There was a 2½ foot height differential at that coupling that required Dennis to bend at his waist to handle the wire, in "tug of war" fashion, synchronized with the other two crewmembers on the lower barge. The safety hazard could be eliminated with winches or by a requirement that barges of uniform size be used and loaded to the same or similar level. This type of regulation of freight container size is commonplace in the rail and highway transport industries and certainly is warranted in the barge transport industry.

An even more basic consideration involves the use of wire cable in making up tows. Even a brief review of a wire rope manufacturer’s safety manual shows that the use of wire rope as barge couplings violates just about every one of the manufacturer’s cautionary statements. The fact is that wire rope, especially used elevator cable, is relatively cheap and expendable. The same is NOT true of our mariners who work as deckhands. This case shows that abusing our mariners by not installing or maintaining safe, modern equipment is not cheap either.

The case brought up another point of interest. Although Dennis undisputedly followed company procedure in performing this hazardous work, the company at trial attempted to blame Dennis for not identifying the safety hazard and working differently. However, ACBL's law and maritime experts were unwilling to say Dennis did anything wrong.

The case also illustrates to every single one of its employees how a poorly this company that claims to be a leader in the industry treats a long-term valued employee. Unfortunately, ACBL does not stand alone in this regard.

There is no telling how many previously injured employees were denied compensation by ACBL and other towing industry barge lines using this logic. Accordingly, the under-utilized civil tort system, by itself, does not provide an adequate incentive for employers to be proactive in providing a safe work place. Most injured workers do not know when or how to obtain the legal advice they need and lack the resources to sustain themselves in pain and without pay for the legal system to decide their case.

CASE #14 – ANOTHER ACL TOWBOAT DECKHAND FALLS OVERBOARD AND IS CRUSHED TO DEATH

***[Source:** Letter from Nelson G. Wolff, Esq. Schlichter, Bogard & Denton, LLP, 100 South Fourth Street, Suite 900, St. Louis, Missouri 63102. Phone: (314) 621-6115. Fax: FAX (314) 621-7151 e-mail: nwolff@uselaws.com. **Emphasis is ours**.]*

March 16, 2010

Mr. Richard A. Block
National Mariners Association
124 North Van Avenue
Houma, LA 70363-5895

Re: Estate of Brian Edwin Messinger, Jr. v. ACL

Dear Richard:

I am writing to provide you and the Association with information regarding a recent Maritime/Jones Act case, which we handled involving another ***avoidable death*** of an ***American Commercial Lines (ACL)*** crew member. This case arises from the death of Brian Edwin Messinger, Jr., age 35, who was working as a lead deckhand for ACL on one of its barges when he was killed on November 29, 2007. He is survived by a young daughter. Brian was described by his crew mates as a friendly, competent deckhand who wanted to be captain of his own boat one day and, in fact, had recently taken his pilot's tests before his death. Brian had worked for ACL for a few years prior to his death.

The incident occurred around ***4:00 a.m.*** at Lock and Dam 14 on the upper Mississippi River near LeClaire, Iowa. Brian was standing on the head of a recently added barge. Conditions were ***dark and cold***. Ice had been reported on the head of the barges earlier in the evening. The crew was moving the first cut of barges through the lock. Brian was attempting to tie up the starboard corner of the lead barge in the first cut when ***he slipped on the barge deck and fell into the icy water between the lock wall and the barge***. Brian yelled for another deckhand to call on the radio to the stern man to cut away the stern lines because the barges were scissoring in on him. ***The deckhand panicked and failed to make the call and was unable to place a safety block between the barge and lock wall or pull Brian from the water.*** Brian struggled screaming in the waters as the barge drifted closer to him and eventually pinned him against the lock wall, crushing him and causing him to suffocate. The autopsy report confirmed that Brian died from blunt force trauma to the chest, head and pelvis. Brian's body was not retrieved from the water until it had floated downriver and was fished out of the river by first responders using a hook.

The Coast Guard concluded that the lack of adequate safety blocks and their spacing were a contributing factor in Brian's death. ***It found that inadequate crew training also contributed to his death***. We began our investigation in February of 2008. We conducted depositions of crew members, the captain, pilot and a Marine Superintendent for ACL. ***We also engaged a maritime expert to examine the barge even though ACL had attempted to destroy it for scrap in Pittsburgh***. The expert, **Captain William M. Beacom**, Sioux City, Iowa, also inspected Lock and Dam 14. We were successful in compelling ACL to turn over numerous documents allowing us to piece together the following facts:

1. Improper training by ACL was a major factor. ***The captain, pilot and other members of the crew admitted that they had only conducted 3 "man-overboard" drills in the 9 months preceding Brian's death***. ACL's Marine Superintendent admitted this was inadequate. Also, ***the crew members seemed confused as to the location of safety blocks on the lock and dam wall and how and when to use these blocks***. The crew also seemed confused as to how to use the pike pole, which was located within 10 feet of the deckhand on the lock wall where Brian went into the water. ***The crew admitted that the pike pole could have been used to push Brian to safety if they had known it was there and how to use it in that manner***. ***The crew admitted that they had never been trained to deal with a man-overboard situation in a lock and dam***.
2. The barge from which Brian fell had been added to the tow shortly before Brian's death. Despite the fact that slick conditions should have been expected, the ***barge deck had not been inspected for ice before Brian was called for duty***. Upon our inspection, we discovered that the ***barge deck also lacked necessary non-skid paint***. Thus, the deck was slippery in the best of conditions and absolutely hazardous when coated with ice.

3. ***A proper pre-work safety briefing had not been conducted*** to discuss which fittings to use when tying up the tow. The head end fittings should have been used according to the expert.

Legal Analysis

Under the Jones Act, a maritime employer is liable for damages caused in whole or in part by its negligence. A death claim inures to the surviving children of an employee. In this case, Brian was survived by his 8 year-old daughter. Under the law, she is entitled to ***compensation for the lost economic support she reasonably expected to receive, as well as compensatory damages for her loss of counsel, support, and guidance she would have received from her father; and for the conscious pain, suffering, and emotional distress experienced by Brian before he died***. We developed evidence to show that Brian had and would have continued to provide this economic support and guidance. ***ACL argued in the case that she was not entitled to economic support damages and that the value of the loss of his life was minimal.***

This is the third on duty death of an ACL crew member to have been investigated and successfully prosecuted by attorney Nelson G. Wolff, a partner in the maritime injury firm of Schlichter, Bogard & Denton. The cases of **Gary Duncan**(1) and **Joseph Hulen**(2) were previously reported in Newsletter #33 & #68 articles. Duncan suffered a fatal heart attack after years of being overworked and sleep deprived as a chief engineer for ACL. Hulen, a green deckhand, was crushed and killed, much like Messinger, in an incident a few years ago when he also fell between a barge and boat. **These three cases demonstrate the safety hazards that continue to be present at ACL and other companies**. **Management's failure to commit adequate resources to train and staff vessel crews was determined to be a significant factor in all three deaths**. Until the industry invests more of its profits into safety, workplace hazards will continue unabated. Sadly, governmental oversight has not adequately addressed these needs. While the success in these legal cases will not bring these crew members back, their families have received economic security and the satisfaction that the responsible companies have been held accountable. *[(1)In reference to the Gary Duncan case, see NMA Report #R-412, Towboat Engineer's Death Points to Need for Changes in the Law. (2)In reference to the Hulen case, see NMA Report #R-433, Towing Vessel Fatalities. GCMA Coverage of Two Accidents on TSAC Sept. 2006 Agenda.]*

Please let me know if you have any questions, or need any further information (1-800-873-5297).

Very Truly Yours,
s/Nelson G. Wolff

[NMA Comment: While the Coast Guard is unwilling to connect the dots, American Commercial Lines' poor business practices were involved in the bridge allision that took down the South Padre Island bridge in Texas in 2001 with 8 fatalities as well as in the huge Mississippi River Oil Spill at New Orleans in July 2007 that stopped traffic on the river below New Orleans for five days.]

[NMA Comment: Current Coast Guard regulations for towing vessels are deficient in that they do not mandate man overboard drills. 46 CFR §27.209 only calls for fire drills. Our Association notified the Coast Guard of this shortcoming in the past but were ignored. *Perhaps* this shortcoming will be remedied in the proposed towing vessel inspection rulemaking, but don't hold your breath in anticipation.]