Gulf Coast Mariners Association

P. O. Box 3589
Houma, LA 70361-3589
Phone: (985) 851-2134
Fax: (985) 879-3911
www.gulfcoastmariners.org

GCMA REPORT #R-426, Rev. 1
DATE: August 27, 2007

REPORT TO CONGRESS: CHALLENGES TO THE COAST GUARD'S MARINE SAFETY PROGRAM – *EFFECTIVELY* REGULATING THE TOWING INDUSTRY

Edited by Capt. Richard A. Block, Secretary, GCMA

Table of Contents

THE PLAYERS

- The **American Waterways Operators (AWO)** is **a**n effective industry lobby based in Arlington, VA that represents the nationôs tug and barge industry. In a letter of Aug. 25, 2005, the Coast Guard informed us: ñYou also assert that AWO claims to represent 80% of the "tug and barge industry," and you ask us to verify this claim. The Coast Guard is under no obligation to verify the claims of AWO, and we neither collect nor maintain the data necessary to fulfill your request in this regard. Nonetheless, Mr. Miante (G-MSO) spoke with AWO about the 80% figure. AWO advised us of the following: 1.) using Army Corps of Engineers' data, AWO estimates that there are approximately 1,287 towing vessel companies, including those that engage both in towing and in other endeavors (but excluding government agencies, oil field production, shipyard and other "tug

assist" work), 2.) AWO claims to represent about 200 of these companies (plus approximately 200 "affiliates" who not directly own/operate towing vessels, e.g. insurance companies and shipyards), 3.) AWO estimates that these 1,287 towing vessel companies own/operate approximately 3,932 towing vessels regularly engaged in the business of commercial towing, 4.) AWO estimates that these 1,287 towing vessel companies also own/operate approximately 27,568 barges, for a total of approximately 31,500 towing vessels and barges combined; and, 5.) AWO members own/operate approximately 25,200 of these 31,500 towing vessels and barges, which is 80%. The Coast Guard has not verified any of the data that AWO provided, and we cannot attest to the accuracy of any of these figures. Nor will we question the veracity of this data in this report.

- The **U.S. Coast Guard** Marine Safety Program regulates the nationôs inspected vessels. On Sept. 9, 2004 Congress added ñtowing vesselsò to the list of vessels that will come under Coast Guard inspection. This will occur on some future date when the Coast Guard promulgates necessary regulations. ñOperatorsò of towing vessels, now identified as Masters, Mates, or Pilots of towing vessels, were required to hold Coast Guard licenses since 1972.[(1)] *[[(1)]PL 92-339, July 7, 1972].*

- The **Occupational Safety & Health Administration (OSHA),** created within the U.S. Department of Labor pursuant to the OSH Act of 1970 that is supposed to firmly and fairly enforce safety and health rules. Congress declared ñé its purpose and policyé to assure so far as possible every working man and woman in the Nation safe and healthful working conditions and to preserve our human resources.ò[(1)] Two Memoranda of Understanding with the Coast Guard in 1983 and 1986 delineated OSHAôs responsibility for enforcing their rules on ***uninspected vessels***. This includes all barges that do not carry a Coast Guard Certificate of Inspection including, inter alia, deck barges, dry cargo barges, and many manned and unmanned ñwork barges.ò *[[(1)] OSH Act, §651]*

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

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

OSHA WAS *SUPPOSED TO* REGULATE UNINSPECTED DRY CARGO BARGE SAFETY BUT FAILED
*[**Source:** GCMA Newsletter #26, Nov. 2004.]*

Unsafe Working Conditions on Dry Cargo Barges

On Dec. 8, 2003, GCMA filed formal complaints with the Coast Guard, OSHA, and the U.S. Army Corps of Engineers about unsafe working conditions and unsatisfactory barge maintenance on unmanned dry cargo barges carrying pulpwood cargo on the inland waters, specifically the Tennessee-Tombigbee Waterway. This followed an accident in which a deckhand fell through an open manhole cover on the deck of a barge at night and was seriously injured.

This accident occurred in the same time period when the Brownwater Mariners Association reported that a barge worker was crushed between barges at 0511 on Dec. 6, 2003 in the Triangle Fleet, at Reserve, LA. The same mariner organization also reported on Dec. 9, 2003 that a tugboat crewman was crushed between a barge and the pier at Pinto Island, Mobile, AL. Accidents of this type and fatalities from falls overboard from towing vessels and barges are frequent and well documented occurrences. GCMA, as is customary, requested copies of all three accident reports and the reports of the Coast Guard investigation of the accident under the Freedom of Information Act.

The Coast Guard does not inspect most of the nationôs dry cargo barges estimated to number in excess of 17,000. These barges exist and will continue to exist as ñuninspectedò commercial vessels.

The NTSB Pinpoints the Problem

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

In its analysis of a recent accident[(1)] (p.40) the Safety Board stated: ñWhen the new regulations supporting the Coast Guard and Maritime Transportation Act of 2004 are promulgated, they ***should*** restate the masterôs responsibility for his vessel and for the safety of the vessels in tow. The new regulations will add a layer of oversight for vessels under tow that are not subject to inspection. Although towboats will be inspected under the new rules, ***monitoring of workplace safety aboard barges such as ATHENA 106 needs to be improved.*** The memorandum of understanding that the Coast Guard and OSHA signed in 1983 was ñintended to eliminate confusion among members of the public with regard to the relative authorities of the two agencies.ò The memorandum does not address uninspected vessels.[(2)] Although OSHA has exercised its jurisdiction over workplace safety on barges after accidents, ***responsibility has been divided between the two agencies***. With the advent of regulations for towing vessels, the gap will shrink between vessels subject to inspection and uninspected barges such as the ATHENA 106. The Safety Board concludes that ***workplace safety on uninspected vessels should be more closely observed before accidents occur,*** and that the agreement between the Coast Guard and OSHA should reflect the new regulatory scheme, address all specifics of workplace and navigational safety, and encourage communication between the two agencies and industry. *[(1)The Athena 106 accident, p.40, is described later in this report. (2)A subsequent MOU in 1996, reprinted in GCMA Report #R-347, discusses uninspected vessels in greater detail.]*

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

The OSHA Connection

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

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

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

[GCMA Comment: One of the "Challenges" facing Congress is to provide for the safety of mariners and barge workers on all types of "uninspected" barges. We want to point out that neither the Coast Guard nor OSHA brought this matter to the attention of Congress. Consequently, in light of this failure to either recognize or address the issue, we question whether the Coast Guard should continue to oversee the nation's commercial vessel inspection program.]

[GCMA Comment: We see this as part of a pattern by AWO to avoid the regulation of a large part of its assets in spite of the industry's poor safety record. Refer to GCMA Report #R-351, Rev. 1, How Safe Is The Towing Industry?]

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

OSHA Drops the Ball on Dry Cargo Barges

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

ñBecause your letter does not provide specific details as to employer identifications and when and where personnel were exposed to the hazards, we ask that .you have the trip pilot contact our office to provide needed information. The pilot should contact: U.S. Department of Labor ï OSHA. Atlanta Regional Office, Sam Nunn Atlanta Federal Center, 61 Forsyth Street, SW; Room 6T50, Atlanta, Georgia 30303. (404) 562-2300 phone (404) 562-2295 fax. Attn: Team Leader - Enforcement Programs[1] *[[1]The vessel's Master, Captain David C. Whitehurst, a GCMA Director, immediately contacted OSHA and provided all information required. He kept in touch with his injured crewmember, the Coast Guard, OSHA and USACE. The Atlanta office covers AL, FL, GA, KY, MS, NC, SC & TN.]*

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

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

1. A written, signed complaint by a current employee or employee representative with enough detail to enable OSHA to determine that a violation or danger likely exists that threatens physical harm or that an imminent danger exists;
2. An allegation that physical harm has occurred as a result of the hazard and that it still exists;
3. A report of an imminent danger;
4. A complaint about a company in an industry covered by one of OSHA's local or national emphasis programs or a hazard targeted by one of these programs;
5. Inadequate response from an employer who has received information on the hazard through a phone/fax investigation;.
6. A complaint against an employer with a past history of egregious, willful or failure-to-abate OSHA citations within the past three years;
7. Referral from a whistle blower investigator; or
8. Complaint at a facility scheduled for or already undergoing an OSHA inspection.

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

Low Towing Industry Standards

Our Association urged that towing vessels be inspected as early as May 15, 2001 when we published GCMA Report #R-276[1] and presented it to the Towing Safety Advisory Committee (TSAC), a Federal advisory committee. We included in that report is Item #72, ñInspect Dry Cargo Barges for Workplace Safety.ò The ninth

revision of this report currently appears on our internet website. As time passed, GCMA supplemented this report with a 204-page book containing extensive documentation as well as a comparison between existing small passenger vessel regulations and the Responsible Carrier Program (RCP) ï a proprietary Safety Management System of the American Waterways Operators. We recently prepared two additional reports[2] as TSAC worked with the Coast Guard to develop towing vessel regulations. We pleaded with Coast Guard project officers to pay sufficient attention to our marinersô constructive suggestions. Unfortunately, GCMA unlike AWO has no lobbyists in Washington to represent our mariners. *[[1]GCMA Report #R-276, Rev. 9, Towing Vessels Must Be Regulated Like Every Other Inspected Vessel. [2]GCMA Reports #R-276-A & 276-B.]*

One of GCMA Report #R-276ôs conclusions is that the Responsible Carrier Program does meet existing Coast Guard regulatory standards as far as they go. However, the standards the Coast Guard set for towing industry vessels are unacceptably lower than the standards it sets for other comparable commercial vessels. Over 30,000 mariners work in the towing industry and are at risk unless properly regulated. Three years after Congress ordered towing vessels to be inspected, the Coast Guard still has not issued a Notice of Proposed Rulemaking. Furthermore, TSAC ï which is dominated by industry lobbyists from AWO ï has commandeered the rulemaking process as we pointed out in GCMA Report #R-417, Rev. 1, Report to the 110th Congress: Request for Congressional Oversight on the Towing Safety Advisory Committee.

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

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

OSHA Finally Cites the Employer for Unsafe Conditions

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

Consequently, OSHA notified the employer, Marine Carriers, Inc. in Mobile, AL, that ñEmployees are exposed to fall hazards due to open manholes (flush manholes) missing manhole covers on the barges they are working on. The manholes are in the walkways the employees use.ò (Duh!)

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

ñM/V TOMBIGBEE ï a deckhand was carrying a gasoline pump when he fell into a manhole on the log deck or passageway around the barge coaming where a manhole cover(s) were not installed. OR IN THE ALTERNATIVEé

ñSection 5(a)(1) of the Occupational Safety and Health Act of 1970: The employer did not furnish employment and a place of employment which were free from recognized hazards that were causing or likely to cause death or serious physical harm to employees in that employees were exposed to slip, trip and fall-in hazards.ò

The employer also received another citation as follows: ñ29 CFR 1904.29(a): A log of all Work-Related Injuries and Illnesses (OSHA Form 300) and/or the Summary of Work Related Injuries and Illnesses (OSHA FORM 300-A) and/or the Injury and Illness Incident Report (OSHA Form 301) or equivalent forms were not kept

by the establishment.ò

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

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

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

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

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

NTSB REPORT ON ATHENA 106 CONSTRUCTION BARGE ACCIDENT

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

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

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

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

The Significance of the Problem

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

ñAccording to the American Waterways Operators, the national trade association for the U.S. tugboat, towboat, and barge industry, more than 4,000 deck barges operate across the country, using different types of winches and other equipment in a variety of different operations. ***Coast Guard data show that 305 people were fatally injured*** on barge/tow combinations between 1997 and 2006, and 379 explosions or fires occurred on barges or towboats during the same period killing 14 people.ò

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

The Accident

On Oct. 12, 2006, the ***uninspected*** towing vessel MISS MEGAN was pushing two ***uninspected*** deck barges in the West Cote Blanche Bay oil field in Louisiana, en route to a pile-driving location. Barge ATHENA 106 was tied along the port side of barge IBR 234 which carried creosote pilings and other supplies for the job. The MISS MEGAN was secured astern of IBR 234 pushing both barges.

While the vessels were under way, the aft spud (a vertical steel shaft extending through a well in the bottom of the barge and used for mooring) on the ATHENA 106 suddenly released from its fully raised position. The spud dropped into the water and struck a submerged, high- pressure natural gas pipeline. The resulting gas release ignited and created a fireball that engulfed the towing vessel and both barges. The master of the towing vessel and four barge workers were killed and another barge worker was missing and presumed dead. The MISS MEGAN deckhand and one barge worker, the winch operator, survived. ***A second point in common was that all the fatalities were Jones-Act seamen.***

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

The Board stated in its final report that Athena Construction's manual contained no procedures mandating the use of the safety devices on the spud winch except during electrical work. If the ATHENA 106 crew had used the available steel pin lying on the deck next to the spud to secure the retracted spuds during their transit, the pin would have prevented the aft spud from accidentally deploying. The spud would have remained locked in its lifted position regardless of whether the winch brake mechanism, the spud's supporting cable, or a piece of connecting hardware failed ï as it did.

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

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

GCMA Criticizes the Coast Guard for Not Requiring Equipment Training

Our Association criticizes the Coast Guardôs longstanding inattention to safety and vocational training for lower-level personnel, especially persons performing engineroom duties on towing vessels.[(1)] We extend our criticism to include the lack of training for operating equipment required to raise and lower spuds on barges that are equipped with them. While we believe the NTSB correctly places the burden of contributing to the accident upon both the towing vessel master and the deckhand for not checking to see that both spuds were ñpinned,ò it fails to mention that ***mariners need to be trained and checked out to operate all sorts of equipment*** before being expected to operate or even check it. In this case, the equipment was a diesel engine powered deck winch that did not even have an instruction manual. The Coast Guard consistently ignored the lack of training in the past and continues to do in regulating our lower-level mariners. Here are several notable examples:

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

Example #2: The Coast Guard assumes that all towing officers can figure out how to use fancy new Automatic Identification System (AIS) electronic equipment without formal training. They ordered expensive equipment installations on thousands of towing vessels without requiring adequate training in its use. *[(1)GCMA Report #R-428, Rev.1. Report to Congress: The Forgotten Mariners. Maritime Education & Training for Entry-Level Deck & Engine Personnel.]*

Pertinent NTSB Recommendations

Recommendations the NTSB made as a result of this accident investigation include:

To the Occupational Safety and Health Administration:

- Review and ***update your Memorandum of Understanding with the Coast Guard to specifically address your respective oversight roles on vessels that are NOT subject to Coast Guard inspection***. (Recommendation #M-07-4)
- Direct the Maritime Advisory Committee for Occupational Safety and Health (MACOSH) to issue the following documents to the maritime industry: (1) a fact sheet regarding the accident, and (2) a guidance document regarding the need to secure the gear on barges, including spud pins, before the barges are moved, and detailing any changes to your memorandum of understanding with the Coast Guard. (Recommendation #M-07-5)

To the U. S. Coast Guard:

- Finalize and implement the new towing vessel inspection regulations and ***require the establishment of safety management systems appropriate for the characteristics, methods of operation, and nature of service of towing vessels.*** (Recommendation #M-07-6).
- Review and ***update your Memorandum of Understanding with the Occupational Safety and Health Administration*** to specifically address your respective oversight roles on vessels that are not subject to Coast Guard inspection. (Recommendation #M-07-7)

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

Report's Importance to All Towing Vessel Personnel

The preceding summary does not do justice to the full report available on the NTSB website. These important long-term problems must be corrected:

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

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

- The Coast Guard inspects some barges under 46 CFR Subchapter I as ñMiscellaneous Vessels.ò They inspect floating drilling rigs under Subchapter I-A, ñMobile Offshore Drilling Units.ò They also inspect tank barges

under 46 CFR Subchapter D, ñTank Vesselsò or 33 CFR Subchapter O. Our concern in this report is ***not*** for these vessels because their mariners have an acceptable standard of regulatory protection.

- Death and injury on uninspected inland drilling barges was the subject of a famous case that reached the U.S. Supreme Court and was decided in early 2002.[(1)] This case explored the relationship between OSHA and the Coast Guard and ultimately left regulation of uninspected vessels up to Congress. ***Uninspected vessels continue to be an area in which the absence or conflicts of regulations must be addressed***

Athena's Short Term Significance

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

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

When the Coast Guard Refuses to Penalize Violators

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

GCMA also filed numerous complaints with our local Marine Safety Unit when another local employer placed its maritime workers at risk by taking advantage of the ñuninspectedò nature of their manned work barges. They undermanned their manned tug/barge combinations, sent inland push boats into exposed offshore waters in rough weather, violated the 12-hour rules, and failed to repair a broken sanitation system and pumped raw sewage overboard for months on end. Despairing of action by the Coast Guard either locally or from the Coast Guard Hearing Office in Arlington, VA, at the national level, we turned our file over to auditors from the Department of Homeland Security Office of the Inspector General on Mar. 5, 2007 along with our other information about investigations.[(1)] In addition, GCMA leveled other complaints against the way that the Coast Guard enforces hearing protection regulations[(2)] and regulations protecting mariners from the hazards of asbestos.[(3)] *[[(1)]GCMA Report #R-429, GCMA Report to Congress: How Coast Guard Investigations Adversely Affect Lower Level Mariners. [(2)]GCMA Report #R-349, Protecting Mariners' Hearing. [(3)]One of our GCMA Directors filed a case in Federal district court against his employer on this issue. Neither the Coast Guard nor OSHA protected him against egregious asbestos exposure in his workplace on board an oilfield liftboat.]*

Safety Management System Recommendations

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

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

We have had complaints from our mariners about AWOôs ***existing*** safety management system (i.e., the

ñResponsible Carrier Programò). One towing vessel Master, also a GCMA Director, finds that the Responsible Carrier Program already ***transfers*** new administrative duties directly to licensed personnel on towing vessels without providing adequate support by the office and field supervisory staff:

> ñé We like many things about the American Waterways Operatorsô Responsible Carrier Program (RCP). RCP has helped promote safety. However, as you can see, this has become more a safety maintenance system than a physical inspection system in design.
>
> ñAs Captain, I do not appreciate the shift of responsibility from management to crew. I do not think RCP should be used as a substitute or a model for a physical inspection of towing vessels for the following reason. The RCP does not take into account the time needed to conduct drills, hold meetings, and do all the required paperwork. The crew off-watch must participate on its own time in this additional work.
>
> ñAs Captain, I am not left in a position to make the RCP a priority over my boatôs performance. The real world comes first! If there is not enough time in a hitch to complete the REC requirements they simply remain unfinished.
>
> I have been pressured to complete documents with a ñsatisfactoryò report when weather or other factors; prevented us from actually conducting drills or holding meetings. It forced me to work over the 12-hour work rule many times.
>
> I say this in confidence. All the enclosed (24) documents would no doubt be considered sensitive proprietary materials to AWO and others including my employer. However, I need to show them to you in hopes they help you understand the paperwork required by the RCP and will bring to light some of the hidden problems it causes for working mariners.ò
>
> ñOh, yes not to mention five men, 24 hours per day, 365 day a year must operate and maintain a very active towing vessel. This includes engine and deck maintenance, shopping for food and boat supplies, carrying them back to the boat, traveling, and ï of course ï all the administrative workéò

Unfulfilled Promise of the OSH Act

ñThe Congress declares it to be its purpose and policyé to assure as far as possible every working man and woman in the nation safe and healthful working conditions and to preserve our human resourcesé ò[1] *[[1]Sec. 651, OSH Act, 1970]*

The Coast Guard ignored and failed to apply the Occupational Safety and Health Act effectively to maritime enterprises for far too long. Starting with a Memorandum of Understanding between the Coast Guard and OSHA signed on March 8, 1983, OSHA accepted the ñé standards and regulations é generally set forth at 46 CFR Chapter 1, and in the Coast Guardôs Marine Safety Manual and in its Navigation and Vessel Inspection Circulars.ò Of these cites, only the regulations contained in the Code of Federal Regulations are enforceable and contain sanctions and penalties. Furthermore, the Memorandum stated that ñBased on OSHAôs interpretation of section 4(b)(1), and as a result of the Coast Guardôs exercise of its authorityé OSHA has concluded that it may not enforce the OSH Act with respect to the working conditions of seamen aboard inspected vessels.ò ñNothing in this MOU pertains to uninspected vessels.ò Consequently, tugs, towboats, dry cargo barges, and various other work barges remained subject to OSHA. Consequently, most of these vessels effectively remained outside OSHAôs purview for over 30 years and still are essentially unregulated today.

In several areas such as hearing protection [1] and asbestos removal and abatement, the Coast Guard has issued ñguidelinesò such as NVICs rather than enforceable regulations as OSHA has done. This failure to use enforceable regulations instead of ñguidelinesò leaves our mariners at risk. In examples covering adequate protection of deck openings (such as leaving manhole covers open), we searched in vain for any Coast Guard regulation whatsoever ï even on inspected vessels. On the other hand, OSHA covers this area with prescriptive regulations in appropriate and enforceable regulations in as it should be covered to protect our mariners in regulations like 29 CFR 1910.23. However, as luck would have it, OSHA could not enforce this regulation on an inspected vessel. OSHAôs performance on protecting the mariner who fell through an open manhole cover on the ***un***inspected dry-cargo pulpwood barge cited above was less than stellar. *[[1]GCMA Report #R-349, Protecting Mariners' Hearing.]*

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

In addition, the desperate and primitive working conditions on many substandard uninspected dry cargo barges also need attention as the remainder of this report illustrates. We hope that the ATHENA 106 NTSB accident report will help draw a connection between the work barges and dry cargo barges as ñuninspected vesselsò and dangerous workplaces.

The repercussions of this accident may be long-lasting. We believe this is one advantage of having the National Transportation Safety Board conduct ALL maritime safety accident investigations using full-time professional accident investigation specialists instead of the Coast Guard current and flawed investigative system that suffers from constant rotation of personnel and the shortage of professional investigators. We reinforce the message we brought to the attention of Congress in our report on ñinvestigations.ò[1] *[[1]GCMA Report #R-429, GCMA Report to Congress: How Coast Guard Investigations Adversely Affect Lower Level Mariners.]*

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

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

Workplace deaths can devastate families, but OSHA fines are often modest – if employers pay at all.

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

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

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

The companyôs fine: $2,700.

When Jamesô mother learned of the amount, she wept. ñThatôs nothing for taking my sonôs life,ò said Donna Frailey of Warsaw, Mo.

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

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

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

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

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

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

ñAs far as weôre concerned, the amount of the penalty is incidental to the accomplishment that we get as the result of that inspection,ò Adkins said.

But even former OSHA administrators decried the low fines.

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

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

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

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

ñThe penalty we propose is not intended to pay for that life,ò he said, adding that itôs more important to remove

workplace hazards and provide safety training to prevent accidents.

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

Low fines 'appalling'

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

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

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

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

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

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

Baker is convinced, however, that higher OSHA fines would prompt many companies to correct serious safety hazards faster. Baker called The Starôs findings on low fines ñappalling.ò

ñUntil the fine for ignoring a hazard is bigger than the cost of fixing the hazard, a lot of employers wonôt do anything,ò she said.

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

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

ñA lot of employers é are never going to see an OSHA inspector, and that fear is never going to motivate them,ò said Marc Freedman. ñIôm not convinced employers look at the OSHA citation situation in deciding whether theyôre going to do the right thing in protecting their employees.ò

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

To be sure, the vast majority of businesses didnôt have a fatality, including some large employers such as the General Motors Fairfax assembly plant in Kansas City, Kan., or Hallmark Cardsô local production and distribution facilities.

Still, The Star found that more than 130 area workers have died on the job since 1994 and about half perished at construction sites. Roofing and utility construction were the deadliest industries.

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

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

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

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

OSHA proposed a $1,500 fine. When it didnôt receive payment, OSHA turned the debt over to the Treasury Department, but it couldnôt locate Allied and the government gave up trying to collect in 1999, records show.

The Star, however, found Alliedôs president in Florida after only one phone call.

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

When told Allied never paid the fine, Bellerôs daughter was upset.

ñThey should be made to pay,ò Misty St. Lawrence said.

Three fatalities

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

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

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

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

Records also show that the accident wasnôt the first time that OSHA had found the companyôs training deficient.

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

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

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

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

But the companyôs three deaths over a six-year period troubled OSHAôs regional director.

ñThree,ò Adkins said. ñThatôs terrible.ò

Meanwhile, a union official said that new window washers such as James should never have been on a roof. ñYou donôt send a guy up there without experience,ò said John Zarris of Local 1 of the Service Employees International Union in Chicago.

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

ñItôs been our position all along that Mr. Mannschreck did nothing wrong,ò said his attorney, Jeff Stigall.

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

'Unclassified' deaths

About 15 years ago, OSHA began changing some of its willful safety violations ï its most serious charge ï to ñunclassified.ò

The reclassification does not change OSHAôs findings, but it removes the words ñwillful,ò ñrepeatò or ñseriousò in describing the nature of the violations, OSHAôs Adkins said.

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

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

Adkins said the agency has a policy of collecting at least 80 percent of a proposed penalty in settlements that involve

unclassified violations, but he acknowledged, ñThat doesnôt always occur.ò

It certainly didnôt occur in a case involving Stephen Barber III, 26.

Barber worked at Kansas City Southern Railwayôs facility in Kansas City. One evening in February 1999, Barber was walking along the track when a large industrial truck crushed him.

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

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

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

The action infuriated union leadership.

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

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

Barberôs mother, Mary Ann Barber, likened the negotiations between OSHAôs lawyers and the company to ñplea bargaining.ò His father, Steve Barber, said the pain of his sonôs death has not faded.

ñItôll be seven years in February, and it doesnôt get any easier,ò he said as he dabbed tears from his eyes.

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

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

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

OSHAôs lawyers also changed willful citations to unclassified after a flash fire killed a worker at Hodgdon Powder Co. in Shawnee in 1994. OSHA proposed a $108,850 fine, but its lawyers settled the case for $30,650 ï a 72 percent reduction.

Records show Hodgdon Powder corrected the hazards. A company official declined to be interviewed. Worker safety advocates criticized OSHA for its use of unclassified citations.

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

- Samuel Mera died when trench collapsed. OSHA fine: $5,525
- Guy Beller Jr. died after falling, entangling in a rope. OSHA fine: $1,500, but it was not paid.
- Les James died in a window-washing accident. OSHA fine: $2,700