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

March 3, 2014

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[Department of Homeland Security (DHS)]

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Ladies and Gentlemen,

Our Association respectfully submits for your consideration NMA Report #R-350-Y, Revision 1 in response to the Federal Register Towing Safety Advisory Committee (TSAC) meeting announcement.⁽¹⁾ This submission relates directly to Agenda Item #8: "Recommendations for Improvement of Coast Guard Marine Casualty Reporting." [⁽¹⁾79 FR 11806-11808, March 3, 2014.]

Our Association submits this report on behalf of approximately 126,000 limited-tonnage credentialed mariners as well as many other mariners without credentials who work throughout the marine industry. This message pertains to an estimated 30,000 mariners working in the towing sector as well as to mariners in the offshore oil and small passenger vessel sectors as well.

Our concern is for the safety and health of mariners who sustain reportable personal injuries whether those injuries are actually reported to Coast Guard officials or not! In interpreting these injuries (including fatalities) we are in fundamental agreement with interpretations found in the draft NVIC that appears in Docket #USCG-2013-1047. We hereby respectfully request that TSAC recommend that the Coast Guard place a copy of that draft NVIC or the final NVIC upon completion in this docket for your convenience.

Our Association is distressed with the findings in the DHS Inspector General's Report #OIG-08-51 released in 2008 especially those cited in the attached NMA Report #R-350-Y, Rev. 1 as [Enclosure #7, "page 6 thru page 17"].⁽¹⁾ [⁽¹⁾This citation refers to the small page numbers in the original DHS report.]

With the active participation of our counsel, our Association specifically requested a follow-up audit of Coast Guard investigations. Subsequently, a DHS audit report was released in May 2013 and cites this "Result of Audit" found in [Enclosure #7A, page 3] that contains the following statement:

"The USCG does not have adequate processes or sufficient personnel to investigate, take corrective actions, and enforce regulations related to the reporting of marine accidents as required by Federal

regulations and USCG policy.....”.

Very simply, the existing system does not work. Neither the Coast Guard nor DHS has been able to make it work! For these reasons, our Association drafted and dispatched copies of NMA Report #R-350-Y, Rev. 1 to the appropriate Congressional oversight committees of the 113th Congress in July 2013.

By posting the lengthy NMA Report #R-350-Y, Rev. 1 in this Docket we want to bring this matter to the attention of members of the TSAC working group and make it available to members of the public on a government website. Our Association's work on this topic extends back to our founding in 1999.

This Inspector General revelation was a shock: ***“On November 9, 2006, Coast Guard Headquarters had a backlog of 4,240 investigations, of which 2,466 (58%) were open and had been awaiting review and closure for more than six months. However, one (member of) Coast Guard headquarters staff was responsible for reviewing and closing all of the investigations. This staff member estimated that, at best, she could devote 50% of her time to this function.”*** How the Coast Guard handled the overload was even more revealing, and you can read about it. How could this happen?

In a televised Congressional hearing on April 8, 2008 following the presentation by Ms. Anne Richards of the DHS OIG's audit, we were distressed to observe a brief “turf war” between a USCG Rear-Admiral and a NTSB representative. The Admiral fought tooth-and-nail to retain control of casualty investigations that DHS clearly reported they were not adequately staffed to manage effectively. The second OIG report in 2013 was even more devastating considering that five additional years had elapsed. *[⁽¹⁾ Refer to Enclosure #7, page 6 thru page 17.]*

It is also clear from members of our Association who attended presentations by Investigators at TSAC meetings and from a number of thorough reports of major casualties, that the Coast Guard has a number of serious, talented and hardworking investigators. The Agency is very fortunate to have them, and we recognize and praise their professional skills. Nevertheless, the **personal injuries** our mariners endure deserve much better treatment, processing, and evaluation. This starts with the prompt reporting of every action required by regulations. We assert that greater attention to the extent of their personal injuries and resultant disabilities (if any) needs adequate follow up in the field so that it is at least commensurate with that required for landside workers under OSHA.

Both DHS OIG reports provide an insight into what still needs to be done. The “big picture” of major casualties appears to focus on crumpled, burned, or sunken vessels and equipment failures. This is an area where Coast Guard “**inspectors**” have expertise as they have shown positive results in the recent “bridging” program for towing vessels in preparation for new inspection regulations. Many “inspectors” move up in a career path to become “investigators.” Where many Coast Guard officers have much less background and expertise is dealing with the “human element,” i.e., our limited tonnage mariners. Our injured mariners need closer attention. Our hope is that the TSAC working group managing this assignment can provide meaningful guidance and recommendations based upon their knowledge of the industry to the Coast Guard as well as to the Congressional Oversight Committees.

We also suggest for your attention our book titled “Blood on Brown Water” (NMA Report #R-213) that the Vice-President of our Association, a retired Coast Guard Master Chief, delivered to and discussed in detail with Congressional staffers in the summer of 2012. This report appears on our website.

Respectfully Submitted,



Richard A. Block
Secretary
National Mariners Association

REPORT TO THE 113th. CONGRESS: Coast Guard Careless Personal Injury Reporting & Enforcement Practices

NMA Report #R-350-Y, Rev. 1



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



NMA REPORT #R-350-Y, Revision 1

DATE: July 4, 2013

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REPORT TO THE 113th CONGRESS: Coast Guard Careless Personal Injury Reporting & Enforcement Practices

[**Publication History:** This report is based upon a portion of NMA Report #R-350, Revision 7 previously mailed on April 10, 2013 to members of the he 113th Congress' House Coast Guard and Maritime Subcommittee and the Senate Commerce, Science, and Transportation Committee. It *expands* upon the discussion of "Issue Y" of that report. The original of NMA Report #R-350-Y was issued on May 1, 2012. Revision 1 was issued on July 4, 2013 following the release of DHS OIG Audit Report #R-13-92 (new Enclosure #7A). All "NMA Reports" are listed in the Bibliography and are available to Members of Congress and investigators on request.]

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EXECUTIVE SUMMARY

Congress, in its introduction to the Occupational Safety and Health Act of 1970 (OSH Act) "...declared it to be its purpose and policy through the exercise of its powers to regulate its powers among the several states and with foreign nations and to provide for the general welfare, to assure so far as possible every working man and woman in the nation safe and healthful working conditions ... and to preserve our human resources by providing for appropriate reporting procedures with respect to occupational safety and health which procedures." *We assert, and DHS audits prove beyond a reasonable doubt, that Coast Guard personal injury reporting procedures are not and never have been "appropriate."* [⁽¹⁾29 U.S. Code §651]

Our Association speaks directly to the safety, health, and welfare of the entire population of 214,000 credentialed merchant mariners and for uncounted mariners working on commercial vessels that do not require credentials since existing Coast Guard personal injury reporting regulations apply to all commercial mariners.

The "limited-tonnage" segment of the U.S. Merchant Marine comprising 60% of all merchant mariners is unique in that most of our mariners are vulnerable to job termination since they do not work under a contract negotiated under collective bargaining agreements with their employers and are, therefore, "employees at will." Our Association is a volunteer membership organization and is not a labor union. As such, we cannot and do not engage in collective bargaining with employers.

Our Association asserts that for over 40 years, our mariners' interests and concerns in accurate personal injury reporting were poorly served by the Coast Guard (USCG) on inspected vessels as well as by the Occupational Safety and Health Administration (OSHA) on uninspected vessels. Consequently, neither agency carried out the reporting procedures envisioned by Congress in the OSH Act of 1970.

We brought this matter to the attention of the Office of Management and Budget⁽¹⁾ (OMB) that approves the collection of data for both agencies under the Paperwork Reduction Act. We brought it to the attention of the DHS Inspector General in 2012 in their preparation of DHS audit report #OIG-13-92 (Marine Accident Reporting, Investigations, and Enforcement in the U.S. Coast Guard) where the auditors reached the conclusion that: "*The USCG does not have adequate processes to investigate, take corrective actions, and enforce Federal regulations related to the reporting of marine accidents.*" [⁽²⁾Enclosure #14 in this report. ⁽²⁾Executive Summary, p.1. in Enclosure #7A in this report.]

This latest DHS audit reinforces a 2008 DHS Inspector General audit of the Coast Guard Office of Investigations and (Casualty) Analysis⁽¹⁾ that revealed in considerable detail the ineffective management of casualty reporting by the Coast Guard. The reporting of personal injuries appears as an unwanted step-child of vessel casualty reporting – where injuries to the human workforce are completely subordinated to the damage to merchant vessels. Neither of these DHS audits bring any hope of immediate relief to our mariners. [⁽¹⁾DHS Report #OIG-08-51, in Enclosure #7 in this report.]

Our limited-tonnage mariners, who serve on both inspected and uninspected vessels, are provided with two different and conflicting accident reporting regimes by two government agencies that provide only uncertain, conflicting and ineffective personal injury reporting coverage and enforcement. The problems inherent in the Coast Guard reporting system often result in serious medical, legal, and financial consequences for our mariners directly as a result of the Coast Guard's accident reporting form (i.e., CG-2692), the lax and inconsistent enforcement of its information collection requirements (ICR) as confirmed by the DHS audit report #OIG-13-92, and whose final statistical product provide only skewed and misleading personal injury reporting statistics. The problems associated with form CG-2692 are further confirmed by the four posted public comments in Coast Guard docket #USCG-2011-0710 in which our Association attempted to contribute Enclosure #14 in this report.⁽¹⁾

In addition, we assert that there may be an unintended duplication of the information collection requirements by the Coast Guard and OSHA that may require further interagency study under the supervision of the Office of Management and Budget (OMB) to evaluate a true and balanced need for the information required by Coast Guard investigators in performing their duties as well as clarifying the extent of those duties in creating valid and meaningful statistics. *We asked the visiting DHS auditors to look into this issue, but find no evidence in their audit report #OIG-13-92 that they attempted any such interagency investigation.*

Our Association alerted the Coast Guard to this issue as early as 2001 and Congressional oversight committees as early as 2003. We alerted the Department of Homeland Security, Office of the Inspector General Audit Branch in 2007 and again in 2012. We will present evidence and recommendations supporting our views below.

Who Should Our Mariners Report Personal Injuries and Illnesses To?

Every merchant mariner, like every other worker in the country, understands that it is part of his or her job to report to his or her employer every casualty that results in a **personal injury** (or an illness) that renders the individual unfit to perform his or her routine duties.⁽¹⁾ Most vessels carry some sort of Company accident report form to fill out and send to the office. This practice is so common that it is little more than common sense. It is especially true if a mariner's job-related injury or illness results in a trip to the doctor's office or to an emergency room. However, most mariners have no idea that medical care beyond first aid (e.g., a visit to a medical professional after first aid at the workplace, or a workplace injury-related trip to the emergency room) must be reported to the Coast Guard. [⁽¹⁾46 CFR §4.05-1(a)(6).]

Our Association's experience is that most mariners **do** report work-related injuries and illnesses in a timely manner using whatever forms or method of notification is specified by their employer. The problems our mariners encounter usually develop beyond this point.

A recent court case decided in Federal District Court and reviewed by the Fifth Circuit Court of Appeals dealt with a licensed engineer working on an offshore diving support vessel carrying and accommodating over 30 offshore workers including divers.⁽¹⁾ The mariner reported unsanitary, unhealthful, and unsafe working and living conditions on his vessel that sickened him to the point of his eventual and total disability. Shortly after his health forced him to come ashore, the vessel exploded and sank with numerous injuries and fatalities. This licensed engineer's illness exceeded his lifetime earnings by \$400,000, accumulated medical bills exceeded \$200,000, legal fees exceeded \$100,000 and after seeking resolution through the Federal court system failed to achieve sufficient recovery to make him whole again. His experience, in spite of the work of a dedicated attorney, left him permanently disabled, bankrupt, and hovering close to death. As in so many other cases, the employer never notified the Coast Guard, terminated his employment, and ended his health insurance coverage.⁽²⁾ [⁽¹⁾Refer to Enclosure #17 in this report). ⁽²⁾Refer to Appendix A in this report.]

We reiterate an important factor in this case was that that this mariner's illnesses were never reported to the Coast Guard on CG form 2692 as required by regulations.⁽¹⁾ Since there was no "paperwork," the Coast Guard was never informed as they should have been and, consequently, there was no attempt made at enforcement. The mariner's illness that eventually led to the complete removal of his colon and additional acute medical problems were successfully shunted aside by his employer. When he could no longer actively serve his employer, he was terminated in ill health and his health insurance was cancelled. He even was forced to file suit in Federal District court to obtain the "Maintenance and Cure" payments to which he was entitled. [⁽¹⁾46 CFR §4.05(a)(6) & §4.05-10(a).]

This case is just one of many cases that our Association encountered over the years. Most, but not all, cases involve the serious and longstanding **casualty reporting issues** that our Association seeks to alleviate.

In preparing this report, we believe that a general **anecdotal survey** of a number of cases involving our "limited-tonnage" mariners that came to our Association's attention and were collected in NMA Report #R-202, Rev. 5 sets the scene for this request to Congress to provide for greater attention to the safety, health, welfare and medical care for our mariners. [Enclosure A].

Recalling the OSH Act of 1970 and the Intent of Congress

"The Congress finds that personal injuries and illnesses arising out of work situations impose a substantial burden upon, and are a hindrance to, interstate commerce in terms of lost production, **wage loss, medical expenses**, and disability compensation payments.⁽¹⁾ The Congress declares it to be its purpose and policy through the exercise of its powers to regulate its powers among the several states and with foreign nations and to provide for the general welfare, to assure so far as possible **every working man and woman** in the nation safe and healthful working conditions and to preserve our human resources⁽²⁾ by providing for **appropriate reporting procedures** with respect to occupational safety and health which procedures will help achieve the objectives of this chapter and accurately describe the nature of the occupational safety and health problem⁽³⁾ by encouraging joint labor-management efforts to reduce injuries and disease arising out of employment."⁽⁴⁾ [⁽¹⁾OSH Act of 1970, 29 U.S. Code §651(a). ⁽²⁾ibid, §651(b). ⁽³⁾ibid, §651(b)(12). ⁽⁴⁾ibid, §651(b)(13).]

Pertinent Regulations Governing USCG Personal Injury Reporting Regulations

46 CFR §4.05-1 Notice of Marine Casualty.

- (a) Immediately after the addressing of resultant safety concerns, the owner, agent, master, operator, or person in charge, shall **notify** the nearest Sector Office, Marine Inspection Office or Coast Guard Group Office whenever a vessel is involved in a marine casualty consisting in –
- (5) A loss of life;
- (6) An injury that requires professional medical treatment (treatment beyond first aid) and, if the person is engaged or employed on board a vessel in commercial service, that renders the individual unfit to perform his or her routine duties...

46 CFR §4.05-10 Written Report of Marine Casualty.

- (a) The owner, agent, master, operator, or person in charge shall, **within five days**, file a **written report** of any marine casualty required to be reported under §4.05-1. ***This written report is in addition to the immediate notice required by §4.05-1.*** This written report must be delivered to a Coast Guard Sector Office or Marine Inspection Office. It must be provided on Form CG-2692 (Report of Marine Accident, Injury or Death), supplemented as necessary by appended Forms CG-2692A (Barge Addendum) and CG-2692B (Report of Required Chemical Drug and Alcohol Testing Following a Serious Marine Incident).
- (b) If filed without delay after the occurrence of the marine casualty, the report required by paragraph (a) of this section suffices as the notice required by §4.05-1(a). ***[Emphasis added. These requirements are further interpreted in the USCG Marine Safety Manual (MSM) in Enclosure #1 of this report.]***

Background: A Continuing Failure to Report Personal Injuries to Coast Guard Officials

On behalf of our Association, Attorney Mark L. Ross, Esq. presented evidence to the Federal District Court in Lafayette, LA, to the Department of Transportation (DOT) Inspector General [Enclosure #2], to Coast Guard Headquarters [Enclosure #3], and verbal testimony to the DHS Inspector General, describing how a single major maritime employer failed to report 44 serious mariner injuries as required by regulations cited above to the Coast Guard in writing within five days. He obtained this evidence by searching through court records where injured maritime employees subsequently sued their employer for their work-related injuries and illnesses. In addition to this case, other attorneys as well as officers of our Association found **at least 106 other instances** where employers failed to notify the Coast Guard in a timely manner of reportable personal injuries suffered by mariners. The Department of Homeland Security Office of the Inspector General (DHS OIG) had this information available to them since 2007 and did nothing with it.

In this example, ENSCO, a major offshore drilling company that operated drilling rigs and many offshore supply vessels, failed to report more than 44 such injuries in an eight-year period. The Coast Guard Marine Safety Office in Morgan City, LA, was notified but never punished the employer in any manner for failing to do as regulations required. [Enclosure #4] The same company still continues its egregious non-reporting conduct to this day. [Enclosure #5] Other companies have been equally lax in their reporting practices to the Coast Guard to the serious legal and financial detriment of our mariners. [Enclosure #6] illustrates that, during the same period, other companies along with ENSCO operating in the Gulf of Mexico engaged in activities judged to be "illegal" detrimentally affected their employees.

Using Coast Guard accident statistics supplied during the course of an advisory committee meeting on Sept. 27, 2001, we noted that the omission of the ENSCO accident reports alone skewed the Coast Guard personal injury statistics submitted by the entire offshore boat industry during an eight-year period by approximately 25%. Nevertheless, ***the local Coast Guard Marine Safety Office, the Marine Safety Directorate, and the Department of Justice expressed complete indifference about enforcing requirements to report personal injuries.***

In 2007, Attorney Mark L. Ross described his experiences to Mr. Richard Johnson, an audit leader with the Department of Homeland Security, Office of the Inspector General (DHS OIG) who was in the process of preparing audit report #OIG-08-51 on the entire Coast Guard investigative process. In working with Mr. Johnson over a period of many months, our Association supplied **15 volumes** of related background data from our files that dealt with casualty investigations in general including Attorney Ross' experience. We were impressed with Mr. Johnson's professional

background, his knowledge as a Merchant Marine officer who maintained his professional standing, and as a representative of the Department of Homeland Security. Although our Association's input was hardly recognizable in the final report, we took pride that the publication of these findings and with the professional work performed by Mr. Johnson and his audit team would be the basis for important changes. A contemporary report by retired Coast Guard Vice-Commandant James Card showed that the Coast Guard needed to change its approach to its supervision of the U.S. Merchant Marine.

We publicized Mr. Johnson's audit report by sending copies to all of our members and, after adding a cover sheet of comments, posted it on the internet as NMA Report #R-428-M. The Cosco Busan oil spill in San Francisco Bay, that occurred before the report was made public, proved to be a pointed *example* of the systemic shortcomings of the USCG investigative process and played out on a national stage. [Enclosure #7] However, apparently, as a result of his work on this report, Mr. Johnson, the only person in the Inspector General's office with merchant marine and investigative experience, was assigned other duties in the department far removed from Coast Guard activities immediately after his supervisor appeared before Congress to answer questions about the Coast Guard's investigative embarrassment following the Cosco Busan casualty in San Francisco. Although Mr. Johnson refused to discuss his re-assignment to other duties, this hasty transfer appeared to us to be retaliation for reporting the truth about Coast Guard casualty investigations. It appears that the Inspector General allowed the Coast Guard investigative process to slide for the next 5 years as is apparent in the key statement in the recent DHS audit report's revealing statement that "*The USCG does not have adequate processes to investigate, take corrective actions, and enforce Federal regulations related to the reporting of marine accidents.*" As a result, five years that should have been used to correct the problems unearthed by Mr. Johnson and his auditors were wasted. If the Coast Guard truly "*lacks the resources,*" our Association wants to take the lead in this report of informing Congressional committees of this important shortcoming in casualty reporting so that they can provide necessary resources or devise functional alternatives especially for casualties involving personal injury.

Mr. Johnson's earlier OIG audit report #08-51 that did so much to disclose the shortcomings in the Coast Guard investigations program initiated an important mini-investigation that disclosed an additional 106 cases of casualty reporting irregularities similar, but wider in scope, than those reported earlier by Attorney Mark Ross. Yet, after this report was released to the public in 2008, Ms. Anne L. Richards, the Assistant Inspector General for Audits, made no mention of any personal injury reporting problems to the House Transportation and Infrastructure Committee televised hearing on May 20, 2008 that discussed this audit in the context of the Cosco Busan incident.

Since the non-reporting of personal injuries issue poses a serious and unresolved problem for our mariners, we repeatedly drew attention to this issue in our reports to each Congress from 2002 to 2012.⁽¹⁾ On April 12, 2012 we discussed the matter in a phone conference initiated by representatives of a different DHS OIG audit team from Washington, Boston, and Denver who visited us in our office in Houma, LA. Attorney Mark L. Ross participated in the conference call where the DHS-OIG representatives discussed their latest audit of Coast Guard casualty reporting issues. [⁽¹⁾Refer to NMA Report #R-350, Rev. 7, Issue "Y" sent to Congress earlier this year.]

The Importance of Casualty Reporting

The Importance

According to the Coast Guard,⁽¹⁾ "Casualty reporting is the opening step in any Coast Guard casualty investigation. Receipt of a marine casualty report (CG-2692) is often the only way in which the Coast Guard becomes aware of a marine accident. It is therefore a necessary first step that provides the Coast Guard with the opportunity to determine the extent to which a casualty will be investigated. In the short term, the information provided in the report may also trigger: (a) corrective safety actions addressing immediate hazards or defective conditions; (b) further investigations of mariners' conduct or professional competence; and/or (c) civil or criminal enforcement actions by the coast Guard, other Federal agencies, or state and local authorities." We include the full OMB submission request to the Office of Management and Budget (OMB) as [Enclosure #8].

The Problems With Personal Injury Reporting

Casualty reporting using CG-2692 combines reports of property damage (e.g., collisions, sinkings, fires) with reports of personal injury or death. This combination dilutes the attention that should be given to reporting personal injuries. Nothing better illustrates the effect of this combination than the theme of OIG audit report #13-92 that we reiterate: "*The USCG does not have adequate processes to investigate, take corrective actions, and enforce Federal regulations related to the reporting of marine accidents.*"

Our concern with CG-2692 is limited to "Section III – Personnel Accident Information" that should be solicited immediately after any **reportable** personal injury. We will **not** be sidetracked into discussing the merits of related form CG-2692B or the "Barge Addendum" that also are functions of casualty reporting.

The Importance of Personal Injury Reporting Issue to Our Mariners

Many mariners learn the hard way that after they are injured and are unable to work that they are of little or no further value to their employer. Although some mariners are treated respectfully by their employers, many injured mariners are quickly forgotten or even fired and consequently often left without health or disability insurance coverage. **Injured seamen are not eligible for Workman's Compensation as shoreside workers are** and often face long periods of recovery without even minimal financial resources. **Often, employers arbitrarily deny a mariner's payments of "maintenance and cure" during his/her recovery.** In many cases, such "maintenance and cure" payments as low as \$8.00 per day are totally inadequate to meet normal living expenses during recovery. We assert that these practices play an important role in dissuading individuals from seeking employment in the merchant marine. We clearly stated our position and our actions known to the DHS audit team during the preparation of the OIG-08-51 Report in 2007 in [Enclosure #9] and again in 2012. DHS failure to take meaningful steps leaves us no other recourse other than to ask Congress to step forward on this issue.

We assert that there also are many instances where a vessel Master filed an officer's or crewmember's personal injury or illness report with his employer **but the employer never forwarded the report to the Coast Guard within the five-day period as required by existing regulations.** There are additional cases where employers fabricate accident reports **months after the personal injury occurred.** In fact, lack of enforcement is one of the major themes of DHS audit report #OIG-13-93. Our Association protests on behalf of our mariners when these tardy reports are **accepted by Coast Guard officials without penalty, protest, or further investigation.** On many reports contained in our accident files obtained under FOIA and from other sources,⁽¹⁾ the personal injury sections of many CG-2692 reports (i.e., Sections III and/or IV) were submitted to the Coast Guard with **incomplete information** and then filed with and accepted without question and never followed up by Coast Guard investigators. [⁽¹⁾Listed in NMA "Index M" – Marine Accidents.]

Our mariners, who are not eligible to receive "workmen's compensation" for work-related injuries, inevitably suffer when a casualty report involving their personal injury is thrown together months later and is accepted without question. It is also a violation of Coast Guard policy as stated in the Marine Safety Manual.⁽¹⁾ Since a mariner often must hire an attorney to resolve his or her personal injury case, the matter of whether the Coast Guard investigator even checked on the injury is often overlooked since the goal at this point becomes one of financial recovery. The mariner or his attorney must pay the bill for re-investigating the casualty all over again often months after the Coast Guard "investigator" washed his hands of the matter and the case has gone cold. We assert that a mariner's legal, medical, and financial recovery is prejudiced whenever the required paperwork is mishandled either by a Coast Guard investigator or by the employer. [⁽¹⁾Refer to Enclosure #1 of this report.]

With this in mind, our Association formally petitioned the Coast Guard to allow **an injured mariner** to submit his own personal injury report to the Coast Guard if he/she believes the "owner, agent, master, operator, or person in charge" (i.e., those persons currently authorized to submit such a report) either have not prepared or submitted the required personal injury report on form CG-2692 within the required five working days. [Enclosure #10] However, in a letter dated June 30, **2005**, responding to our petition, the Chief of the Coast Guard's Investigation Division, stated in part: "We have opted to add a section to (the Marine Safety Manual), rather than draft a new policy letter, to ensure investigating officers understand the policy that all incidents reported to the Coast Guard are investigated."

We deemed this response unsatisfactory. First, we never received nor were we subsequently able to locate any such policy statement in the 2009 edition of the Marine Safety Manual. In addition, **the 2008 Inspector General's report (OIG-08-51) indicated that several thousand casualties were either improperly investigated or never investigated at all.**⁽¹⁾ Hiding a policy in relatively inaccessible internal agency policy document such as a policy letter or even in the Marine Safety Manual does not come close to providing the unambiguous regulatory protection our working mariners need after suffering a job-related injury or illness. Consequently, this response, even if it had been carried out, would have been of little value in protecting our mariners and requiring employers to properly document their employees' workplace injuries. Frankly, we resented being stonewalled and misled by the investigations staff of the Marine Safety Directorate at Coast Guard Headquarters! [⁽¹⁾OIG-08-51, pgs 10-14.]

In addition to our original petition to the Coast Guard filed on Sept. 7, 2001, we filed an additional petition on Aug. 8, 2002 with the U.S. Department of Labor seeking "Improved Record Keeping and Accident Reporting for Lower-Level Mariners." This correspondence included in (Enclosure #10, pgs. 11, 12 & 13) shows no interagency cooperation between OSHA and USCG relative to personal injury reporting. ***This lack of interagency cooperation is important because it is necessary to solve this serious personal injury reporting problem.*** This is why we asked the DHS auditors to look into the problem when we met with them on April 11, 2012. There are no signs in their final audit that shows any of these steps were taken!

In reviewing the OSHA Series 300 documentation (Enclosure #10, pgs. 17-32 inclusive) it appears that the OSHA personal injury recording and reporting system may be far superior to the Coast Guard's system ***because it is designed to track a mariner's injuries, account for time lost from work, and is supported by the workforce of the entire Bureau of Labor Statistics.*** On the other hand, the DHS OIG-08-51 report (pgs. 15, 16) cites the fact that only one staff member in the Coast Guard Office of Investigations and Casualty Analysis who, ***overburdened with a backlog of thousands of cases*** she could not handle, was allowed to mishandle or simply "dump" thousands of pending cases.

Our Association, a consumer of over 800 accident reports of primary significance to our limited-tonnage mariners, is still suffering the effects of the Coast Guard casualty investigation program failure and from severely restricted access to important information in their investigative reports. We submitted a timely request for approximately 30 completed casualty files after "electronic" versions were posted on the internet. Unfortunately, the selected information posted on the internet was too sketchy in nature to respond to our needs. As a result of the reply we received, ***we ask Congress to reconsider the value of the brief summaries of the marine casualty reports posted on the internet*** in an electronic form on the internet as now required by 46 U.S. Code §6101(i). We requested hard copies of approximately 30 reports previously requested where the internet summaries had proven to be useless and were quoted a figure of \$9,020.55. A lump-sum figure of this magnitude effectively ended our Association's evaluation of accident reports. [Enclosure #11]

Interagency Confusion: While Bureaucrats Collect Their Salaries, Nobody Protects Our Mariners

The broad statement of principles in the OSH Act of 1970 includes ***every working man and woman*** and ***does NOT exclude protection for merchant mariners.***

The OSH Act also provides for ***appropriate reporting procedures*** for personal injuries that we maintain are long overdue for merchant mariners. The two DHS Inspector General reports prove that the Coast Guard's investigative functions, including the investigations of casualty reports, are a failure.

Over the years, Executive Branch agencies were left with the task of deciding what "appropriate reporting procedures" were. The Department of Labor appears to have taken this job seriously in regard to shoreside workers. However, in the case of merchant mariners, the task was divided between two different agencies first in 1983 by a Memorandum of Understanding (MOU) between the Coast Guard Commandant and the Assistant Secretary of Labor for OSHA. [Enclosure #12] The 1983 MOU was superseded by a further interpretation of the earlier MOU by OSHA in 1996. [Enclosure #13, pgs. 9-34 inclusive.]

Six Challenges

The First Challenge. ***OSHA policy asserts its jurisdiction over uninspected vessels*** including uninspected towing vessels, uninspected passenger vessels, and uninspected commercial fishing vessels while the ***Coast Guard's jurisdiction is limited to inspected vessels.*** Thus government recordkeeping over our mariners' personal injuries may fall under ***either*** the Coast Guard or OSHA depending upon the vessel the mariner serves on – ***or possibly may fall forgotten between both agencies.*** Yet, CG form 2692 is the only reporting form available to merchant mariners – if, without minimal support and/or cooperation from employers – this form is even readily available or conveniently accessible to merchant mariners at all.

Usually, there is only a "company" accident form available on most vessels. However, ***Coast Guard regulations*** applicable to ***all*** vessels served by our mariners⁽¹⁾ indicate that Coast Guard form CG-2692⁽²⁾ is to be filled out by "The owner, agent, master, operator, or person in charge." Consequently, any information submitted on a substitute "company" form would have to be transposed and submitted on the approved form CG-2692. Many companies, to protect their own interests, choose to use the company Human Resources Director, or other company

officer, or an attorney to "sanitize" the wording on any report before it is submitted to the Coast Guard. Where there may be a divergence of opinion on the cause or severity of an injury, ***the employer has the initial advantage of controlling the submission (or non-submission) of the required paperwork to the regulatory authorities.*** [(1) Exclusions from reporting requirements in 46 CFR §4.01-3 do not apply to the great majority of our mariners. (2) 46 CFR §4.05-10 clearly specifies the use of form CG-2692 and not some company substitute form.]

Consequently, even though OSHA may have jurisdiction over personal injury reporting on uninspected vessels (such as on over 6,200 towing vessels), the Coast Guard regulations specify the use of its reporting form CG-2692 and that the form must be submitted to the Coast Guard. ***However, there does not appear to be any mechanism to share this casualty reporting information with OSHA.*** Our Association asked the DHS audit team to look into this aspect of accident reporting, but OIG audit report #OIG-13-92 shows no evidence of such an inquiry.

It is worth noting at this point that most of the more than 30,000 limited-tonnage merchant mariners serving on 6,200 towing vessels (that remain uninspected) have no access to OSHA, its regulations or procedures, and have no clue as to that agency's claimed jurisdiction over uninspected towing vessels.

Employers, on the other hand, are much better informed. Following the U.S. Supreme Court decision in the *Mallard Bay Drilling* case,⁽¹⁾ towing vessel owners and their trade association lobby pushed Congress to allow their vessels to be inspected by the Coast Guard rather than by OSHA. Our Association does not disagree with the decision made by Congress or the direction of the current towing vessel inspection program. In fact, the record shows that our Association prodded the Coast Guard toward a towing vessel inspection as early as 2000. We congratulate the Coast Guard on developing their interim "bridging" program on the way to a full towing vessel inspection program that is long overdue.

We note that most towing vessel owners and operators have no intention of telling their employees of any OSHA jurisdiction over their vessels. This is evidenced by examining most company new employee orientation material – as our Association has done. There is no mention of the OSHA Series 300 forms that record and follow-up personal injuries and lost time for shoreside workers. ***If any of these OSHA Series 300 forms are used by a boat company, they are filled out "in the office" by the office staff and never are seen by working mariners. Nor are the company records of lost-time injuries generally posted on most vessels.***

[NMA Recommendation: We urge Congress to determine 1) whether all maritime employers are required to – and actually do – submit reports on mariner personal injuries and illnesses to OSHA on an annual basis and 2) whether the Bureau of Labor Statistics compiles statistics of these injuries and 3) determines the accuracy of these statistics. It is clear to our Association that personal injury statistics as compiled by the Coast Guard are grossly inaccurate.]

The Second Challenge. On Sept. 9, 2004 Congress amended 46 U.S. Code §3301 that changed the status of the nation's 6,200 towing vessels from "uninspected" to "inspected" vessels. To do this, it took the Coast Guard 7 years to draft a Notice of Proposed Rulemaking and will take an estimated additional six years for the Coast Guard to promulgate a Final Rule and actually bring all towing vessels under inspection. That leaves the *interim status* of these 6,200 vessels up in the air as far as the reporting of personal injuries for over 30,000 mariners serving on these towing vessels. Apparently, if nobody raised the issue as we have done, the two agencies (OSHA & USCG) would be left to bungle along with their existing procedures, crank out questionable and misleading statistics, shunt aside casualty investigations (e.g., the "open" cases) and ignore personal injury reporting.

In the meantime, our Association, brought this matter to the Office of Management and Budget in a timely manner [Enclosure #14] as well as to the DHS-OIG audit team representatives in a conference call with our Attorney on April 12, 2012. We advised the audit team of the potential size of the problem, the number of mariners affected, and the fact that we reported the problem to DHS in 2007 in considerable detail as part of the then ongoing OIG-08-51 audit. In our 2012 conference call, ***we asked the Inspector General's audit team to look into and resolve this interagency conflict as part of their proposed audit.*** If the Inspector General had taken this initiative it would have demonstrated a degree of interagency cooperation within the Executive Branch.

[NMA Follow-up Action: DHS OIG audit report #13-92 published in May 2013 (Enclosure #7A) reveals no indication of any such undertaking in spite of its unequivocal statement that "The USCG does not have adequate processes to investigate, take corrective actions, and enforce Federal regulations related to the reporting of marine accidents" (e.g., personal injury reporting). We now ask Congress to determine why these processes are inadequate.]

The Third Challenge. Most employees of our “limited-tonnage” merchant mariner’s (i.e., “boat companies”) are small businesses. These businesses not only employ mariners but also shoreside workers like office personnel, staff and supervisory personnel, warehouse personnel, janitors, mechanics, drivers, etc. who may not be credentialed mariners and generally do not work on the vessels. Consequently, accident reporting requirements for shoreside employees fall under the requirements of OSHA not the Coast Guard as *should* the reporting requirements for mariners on all types of *uninspected* vessels. *Are a mariner’s personal injuries required to be reported to both agencies?* If so, what arrangements exist to handle any duplication of data?

The Fourth Challenge. Personal injuries for merchant mariners are covered under the Jones Act and not under Workman’s Compensation – two very different systems. It should be important to determine the *required extent of accident reporting and follow-up* to meet the intent of the OSH Act that is supposed to protect and collect the accident statistics of *every working man and woman* in the nation. Is there a *duplication of requirements* between the OSHA system and the Coast Guard system, and how much duplication of information is involved? This issue should be of concern to the Office of Management and Budget under the Paperwork Reduction Act (see Enclosure #8)!

The Fifth Challenge is directed at the Coast Guard to tighten its *slack enforcement of collecting the personal injury data*. Renewal of the collection of data on controversial form CG-2692 was requested by the Coast Guard of the OMB in 2011 under control #1625-0001 that was re-authorized. (Refer to Enclosure #8).

Our Association responded to the notice in the Federal Register as required by the Paperwork Reduction Act in a timely manner by [Enclosure #15]. Our letter was addressed to the “Coast Guard Desk” at the OMB address. However, in reviewing the Docket #USCG-2011-0710, we noticed that our letter was never published. We must assume that our comments were never considered and that the reauthorization of CG-2692 was rubber stamped. We note that the comments by other parties including the Passenger Vessel Association and the Lake Carriers Association were extremely controversial in reauthorizing CG-2692. Although there was mention of a Coast Guard NVIC touching upon the province of casualty reporting, but we saw no sign that work on any such guidance document was completed in the past two years.

The Sixth Challenge. The *maximum* civil penalty for “Failure to give proper notice as soon as possible of a marine casualty”⁽¹⁾ or for “Failure of a Marine Employer to report a maritime casualty in writing to the OCMI”⁽²⁾ is \$1,000. [Enclosure #16]⁽³⁾ [⁽¹⁾46 CFR §4.05-5. ⁽²⁾46 CFR §4.05-10. ⁽³⁾Encl. 5 to COMDTINST 16200.3A (p.10).]

It is clear to our Association that this amount has never deterred the wholesale violations of the personal injury reporting regulations that our Association documented to DHS-OIG by our reports in 2007 as well as in the DHS’s own unpublished investigation conducted as part of the OIG-08-51 audit. Nor did the recent audit report #OIG-13-92 specifically take note of the problem with personal injury reporting our Association directed to the audit team on April 12, 2012.

We point out that the initial cost for a merchant mariner to hire an attorney to take on the challenges that accompany medical and financial recovery that are initiated by the non-reporting of a serious personal injury by his employer and/or immediate supervisor can easily range between \$5,000 and \$10,000.

[NMA Recommendation: That Congress consider our comments and those of other parties in Docket #USCG-2011-0710 and clarify reporting requirements to deter non-reporting of personal injuries.]

[NMA Recommendation: That Congress increase civil penalties for non-reporting of personal injuries for merchant mariners, provide the Coast Guard with adequate resources to enforce reporting requirements, or transfer reporting of all personal injuries to OSHA.]

[NMA Recommendation: That the Coast Guard review the text of Encl. 5 to COMDTINST 16200.3A [Enclosure #16] and place greater emphasis upon §10(a)(b)(c) on page 7 of these instructions. In addition, emphasize the prompt and complete reporting of every reportable personal injury suffered by any mariner or other person on board a commercial vessel and require documentation of follow-up procedures.]

The OSHA Personal Injury Reporting System

Of the two accident reporting systems, the OSHA system using Form 300 series reports *appears* much more comprehensive than the Coast Guard Form CG-2692 system. Our Association recommends to Congress that an investigation and comparison of the two reporting systems is necessary to determine which system better complies with the intent of the OSH Act. We had asked the DHS OIG auditors to do this in April 2012 but without success. We are hopefully that Congress will be more attentive to the needs of our merchant mariners.

In 1970, Congress passed the Occupational Safety and Health Act, which established regulations and rules requiring the businesses and employers provide workers with safe and sanitary work environments. The act also established the Occupational Safety & Health Administration to oversee the implementation and enforcement of the legislation. Section 8 of the act states that employers must maintain a "Log of Work-related Injuries and Illnesses" as part of the reporting process. *In contrast, current Coast Guard requirements mention no such log of work-related injuries.* Consequently, all statistics advanced by the Coast Guard officials regarding personal injuries on board American-flag commercial vessels must be considered erroneous. We cite DHS OIG audit report #13-92 (May 2013) that the Coast Guard does not have the resources to accurately arrive at reliable personal injury statistics.

The OSH Act also requires that employers post a "Summary of Work-related Injuries and Illnesses" in a location easily accessible to employees or OSHA inspectors. *In contrast, there is no comparable USCG requirement.*

Internet Instruction Available From OSHA

There are a number of internet web sites available to instruct the public on the OSHA system. One internet website lists the following procedure (below): *In contrast, the Coast Guard offers little in the way of public instruction in regard to personal injury and illness reporting.*

1. Navigate to the OSHA website. Download OSHA Form 300 and the instructions. Save the PDF file to your computer. Print the form out on your printer. You must complete Form 300 and Form 300A every year. It is best to update Form 300 as injuries or illnesses occur. Waiting to record all incidents at once could result in reporting errors and mistakes. *In contrast, there is no annual Coast Guard summary of injuries and illnesses required.*
2. Enter the following information for each work related injury or illness on OSHA Form 300:
 - Case Number (start at "1" for the first reported injury or illness for the calendar year);
 - Worker's full name;
 - Job title of worker;
 - Location of incident or injury (i.e. workshop or sales floor);
 - Description (note describing the accident or illness).
3. Place a check under one of the following headers in the "Classify the case" section of the form, based on the most serious outcome for the injury or illness: Death, Days away from work, Job transfer or restriction, or Other recordable cases.
4. Place a check in the check box in the final column of the form that best describes the type of injury or illness. The choices are: Injury, Skin Disorder, Respiratory Condition, Poisoning, Hearing Loss, or All Other Illnesses.
5. Enter information for other injuries or illnesses during the calendar years on the lines of the form. Total the number of entries in the corresponding fields on the bottom of OSHA Form 300 for the entire calendar year. Use additional sheets if needed.
6. Transfer all of the totals from OSHA Form 300 to OSHA Form 300A. Post OSHA Form 300A in a clearly marked and easily accessible site. Post Form 300A before Feb. 1 of the year following the calendar year for which the business completed Form 300. For example, you must post Form 300A for injuries and illnesses recorded on the 2011 Form 300 before Feb. 1, 2012. *In contrast, there is no USCG posting requirement.*

The Coast Guard Personal Injury Reporting System

The Coast Guard combines its casualty reporting of both *property damage* and *personal injury* on the same CG-Form 2692, Report of Marine Accident, Injury or Death. This is a one-time report that does not suggest any need

for follow-up. The system is so minimal in both its requirements *and especially in its enforcement* that it is often viewed by management with contempt. DHS audit report OIG #13-92 scoffs at Coast Guard non-enforcement of casualty reporting enforcement while not specifically citing personal injuries. However, both material damage and personal injury reporting are joined like Siamese twins by the controversial form CG-2692. Yet the Office of Management and budget recently approved its information collection requirements⁽¹⁾ – a fact our Association protested (see enclosures 8 & 14). In its paperwork Reduction Act Submission, the Coast Guard makes no mention of the OSH Act or any information collection on personal injuries done by OSHA. We believe that this should have been considered prior to any future approval to continue to use this form for years to come. [⁽¹⁾OMB Control #1625-0001]

We Ask Congress to Legislate New Requirements for Filing Personal Injury Reports

Our Association challenges both the Coast Guard and OSHA to adequately protect our merchant mariners in their workplaces and help them cope with personal injuries. In 2003, the federal government created an enormous bureaucracy charged with domestic protection. The Department of Homeland Security (DHS) is now the third largest agency in the federal government. *But the push to improve homeland security was plagued by ignoring the needs of our merchant mariners and by a lack of oversight and accountability.* Our Association respectfully asks Congress to improve the process of reporting personal injuries in a complete and transparent fashion to make our mariners as well as the U.S. public more safe and secure.

[Request for Congressional Action: We ask Congress to review the Congressional intent of the Occupational Safety and Health Act of 1970 and to reassess today's personal injury reporting requirements for all merchant mariners.]

[Request for Congressional Action: We ask that Congress enact additional safeguards that require employers to immediately report, treat, and compensate all mariners and offshore workers injured on the job. We ask that these safeguards include updating and re-evaluating the "maintenance and cure" requirements for all merchant mariners.]

[Request for Congressional Action: We ask that Congress impose deterrent civil penalties on employers who fail to report and track every "accident, injury, illness, and death" to a seaman, passenger, or other person on any inspected or uninspected vessel or fail to immediately provide injured mariners with adequate "maintenance and cure" payments.] [Refer to Enclosure #18]

[Request for Congressional Action: We ask that Congress amend the applicability of 46 U.S. Code §10603 to apply to all mariners, not just mariners on fishing industry vessels, and require a copy of the statute to be prominently displayed on every commercial vessel.] [Refer to Enclosure #19]

[Request for Congressional Action: We ask Congress to permanently separate reports of personal injury and illness from vessel and equipment casualty reporting and direct the Coast Guard to vigorously enforce the prompt submission of reports on every "reportable" personal injury as defined by 46 CFR §4.05-1(a)(5)(6).]

[Request for Congressional Action: We ask that Congress examine the benefits of reassigning the personal injury data collection responsibility for health and safety issues from the Coast Guard to the Bureau of Labor Statistics (DOL).]

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 Mariners Speak Out on Violations of the 12-Hour Work Day. 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. 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 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 until the seaman reaches maximum medical cure.



NMA REPORT #R-202, Revision 5

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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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[**Publication History:** This report compiles a number of earlier reports including #R-202-A; #R-309; #R-320; #R-333, Rev.1; #R-379-K, #R-433-A. The report was **renumbered** as #R-202, Rev. #4 on June 5, 2008. Revision 5 three cases. On Jan. 1, 2008 our Association changed its name from Gulf Coast Mariners Association (GCMA) to NMA.]

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)**

[Source: Mark L. Ross, Esq, Lafayette, La. 70501. Telephone (337) 266-2345. Fax: (337) 266-2346.]

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 on 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

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

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

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 charts 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 the vessel's entire 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 gearbox on the vessel's winch. Mr. V did 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 on 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 seamen 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 rest 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 States 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.

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, immediately 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 within three hours 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 under oath 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.

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 Hulens to fall into.

Bill Hulens 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 Schlichter, 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...

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.

"...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 Hulén. 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 Hulén 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 Hulén.** ■■■ 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 Hulén 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

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. Patricia 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.

Calix's job was to clean diesel and bilge tanks, the family said, adding he wasn't provided with the necessary protective gear. 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 know that happens in a hundred different forms but never sees in print. When a whiff of scandal does reach the newspapers, it may as be 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 *Matter of Gulf Pride Marine Service, Inc.*, 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.

The M/V Gulf Pride was supposed to have a minimum of a four-man crew when operating more than twelve hours per day. However, Jamie was part of only a three-man crew when he drowned. Captain Smith testified that with a three-man crew, the vessel was considered undermanned. 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

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,

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, An Appeal to the 111th. Congress on Lifesaving Issues that Affect Our Limited Tonnage Mariners.]

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. Jones knew that he was required to have two licensed personnel on board the vessel.

[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 slightest 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 exceptional duty and accountability. 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 seaman is missing is not a prerequisite to the duty of search and rescue. 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 Hanshaw, 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 Hanshaw. Unbeknownst to Newton, Adam Hanshaw previously contracted and continued to suffer from a staph infection known as Methicillin-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 Hanshaw, 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 Hanshaw's nose was swollen and was "real red". Hanshaw's nose continued to get "really big and really sore and it started draining". At that point, Hanshaw 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 Hanshaw's infection continued to worsen it began to drain a "pussey mucus type drain."

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

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 Hanshew 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 Rhonda 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 April 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 choose 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 "pussey 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 hiping it and that, because the barge was hiped, 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 hiping 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 00009757NMA 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. The last thing he remembers was standing by the weather machine getting the updated weather.⁽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 theory of what may have occurred, it just touched the surface. Many other theories 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 uncoded 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-VIII/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, Malmö, 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 its mariners 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: nwofff@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 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.

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. ACBL admitted that he was not capable of returning to work, yet did not offer him any other employment. 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 Shreve had done nothing wrong, had not violated any safety rules, and was simply using the company's methods.

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, ACBL's lawyers asked the jury to deny Shreve any compensation for his injuries.

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 not subject to USCG inspection. Our mariners report that the barge owners maintain some 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 effective 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 all 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 not been effective 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 all 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 ACBL knew that other employees previously were injured attempting to jerk slack from barge wires as a result of an "unsafe method." 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 increased 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: nwo Wolff@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 Messenger, 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.]



USCG MARINE SAFETY MANUAL, VOLUME V: INVESTIGATIONS AND ENFORCEMENT
PART B: INVESTIGATION
CHAPTER 2: DETECTION OF INCIDENTS

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B2-1-1



A. INTRODUCTION

A.1. ACTIVE AND PASSIVE DETECTION

The Coast Guard detects incidents in one of two ways: (1) when we are notified by the public or other agencies, called *passive detection*, and (2) when we conduct operations specifically designed to detect an incident, called *active detection*. Both active and passive detection's are important to the Coast Guard's Marine Investigation Program.

A.2. TRENDS IN INCIDENTS

Because Coast Guard units respond to incidents on a case-by-case basis, it is easy to treat the incident out of context. When detecting incidents, IOs should pay particular attention to the incident history of a vessel, organization, person, facility, or area of the waterway. For instance in some cases, apparently unrelated unknown source discharges portray a trend in an area, and may uncover a pattern of violation. Similarly, a repeated history of accidents by a single company (perhaps on many vessels) may indicate an unsafe condition endemic to the company. Accordingly, IOs are strongly encouraged to view their detection efforts within the context of trends of incidents.

B. NOTIFICATIONS FROM THE PUBLIC

B.1. NOTICE OF MARINE CASUALTIES

B.1.a. Required Notice and Report

Commercial vessel owners, agents, operators, masters, and persons in charge are each responsible under 46 CFR 4.05-1 for notifying the Coast Guard that a marine casualty has occurred. Under 46 CFR 4.05-10, the same people are responsible for providing the Coast Guard with a written report (on form CG-2692 series) providing details about the accident.

B.1.b. Timing and Contents of Notice

The notice of marine casualty required by 46 CFR 4.05-1 must be given to the nearest Coast Guard Marine Safety or Inspection Office, or Coast Guard Group Office, as soon as practical after addressing the immediate safety concerns caused by the accident. Under 46 CFR 4.05-10(b), however, a written report can serve the purpose of the notice if that report is filed "without delay." Without delay should not be interpreted to mean the five-day standard found in 46 CFR 4.05-10(a). If operators wish to submit written reports in lieu of the required notice, such reports must be written and delivered quickly in order to allow the Coast Guard to determine appropriate action. The contents of the notice are listed in 46 CFR 4.05-5. Note that reports of hazardous conditions (often the same conditions that cause or resulted from a casualty) are required under 33 CFR 160.215 (See 33 CFR 160.204 for a definition of "hazardous condition"). Also note that the reports under 33 CFR 160.215 may not be delayed under 46 CFR 4.05-10(a).



USCG MARINE SAFETY MANUAL VOLUME V: INVESTIGATIONS AND ENFORCEMENT
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B.1.c. Timing and Contents of Report

The report of marine casualty required by 46 CFR 4.05-10(a) **must** be given to the nearest Marine Safety / Inspection Office within five days of the casualty. The report must contain all relevant information on the CG-2692 (Report of Marine Accident, Death, or Injury), CG-2692A (Barge Addendum), and CG-2692B (Report of Required Chemical Drug And Alcohol Testing following a serious marine incident). Additional requirements related to post-casualty drug and alcohol testing information required in the report are listed in 46 CFR 4.05-12.

B.1.d. Over-reliance on Notices and Reports

While commercial operators are required to report all marine casualties, IOs are cautioned not to rely exclusively upon such reports in detecting incidents. The commercial maritime community is composed of a variety of operations ranging from large companies well versed in the rules for reporting accidents to small one-person operations that may be completely unfamiliar with the relevant regulations and forms. Accordingly, IOs must not assume an entirely passive stance with regard to detection of commercial vessel accidents.

B.2. REPORTS OF ACCIDENTS TO AIDS TO NAVIGATION

Under Title 46 CFR 4.05-20, whenever a commercial vessel collides with or otherwise damages an aid to navigation maintained by the Coast Guard, the person in charge must report the incident to the nearest Officer in Charge, Marine Inspection (OCMI). Such incidents may not be reportable under the rules in 46 CFR 4.05-1 because the resulting damage may fall below the reporting threshold. In this situation, no CG-2692 report is required, and the person in charge may fulfill his obligations merely by phoning in a report.

B.3. REPORTS OF BOATING ACCIDENTS

The statutory requirement to report recreational boating accidents is contained in 46 U.S.C. 6101. The implementing regulations, including the content of the reporting form and submittal procedures, are in 33 CFR 173-174. In summary, the owner or operator of a boat or vessel involved in a boating casualty or accident shall report the casualty or accident to a state reporting authority or, if no approved state reporting authority exists, to the Coast Guard. The report shall be made on either the Coast Guard Boating Accident Report, Form CG-3865, or on a state boating accident report form. Boating Accident investigations are discussed in detail in Chapter B12 of this volume.

B.4. REPORTS OF POLLUTION INCIDENTS

The responsible party (RP) must report all discharges of oil or hazardous material to the National Response Center (NRC). On occasion, IOs or Pollution Investigators (PIs) receive these reports. In such cases, the IO/PI should not assume that the NRC has been notified, and should request that the RP contact the NRC directly at 1-800-424-8802. When the RP is unknown, the IO/PI shall contact the NRC to assure the discharge was reported. The NRC will provide the cognizant Captain of the Port (COTP) with a summarization of the report. Many if not most pollution incident



U.S. Department of
Transportation

Office of the Secretary
of Transportation

Office of Inspector General

January 16, 2002

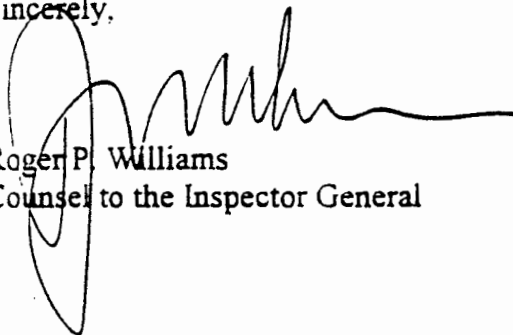
Mr. Richard A. Block
Secretary, Gulf Coast Mariners Association
P.O. Box 3589
Houma, Louisiana 70360-3589

Dear Mr. Block:

This responds to your December 21, 2001 letter, with enclosures, requesting an investigation relative to the collection of accident and personal injuries statistics by the United States Coast Guard.

We opened an investigation based upon the False Claims Act lawsuit filed on behalf of your Association against ENSCO Marine Company, Inc., in October 2000. The results of that investigation was thereafter presented to the United States Attorney's Office in Lafayette, Louisiana. That office declined to take any action, recommending that the United States Coast Guard take appropriate action to correct the non-reporting of accidents and injuries. Based thereon, we closed our investigation in August 2001.

Sincerely,



Roger P. Williams
Counsel to the Inspector General

* We note the United States Coast Guard responded to your concerns by letter dated November 5, 2001

Gulf Coast Mariners Association



Mailing Address: P.O. Box 3589 • Houma, Louisiana 70360-3589
Toll Free Phone: (800) 979-GCMA(4262)
Telephone: (985) 537-4885
Fax: (985) 537-4860
e-mail: gcma@gs.verio.net

February 2, 2002

ATTN: Mr. Roger P. Williams
Counsel to the Inspector General
U.S. Department of Transportation
400 Seventh Street, SW
Washington, DC 20590

SUBJECT: Non-Reporting of Work-Related Accidents and Injuries.
FILE #: GCM-64; JCMA0202.1J

THIS LETTER CONTAINS TWO FREEDOM OF INFORMATION ACT REQUESTS

Dear Mr. Williams,

Thank you for your letter of January 16, 2002 in response to our letters concerning ENSCO Marine Company, Inc. and its non-reporting of personal injuries. [ENCLOSURE #1].

Although your office "...opened an investigation based upon the False Claims Act lawsuit filed on behalf of...(GCMA)...in October 2000" our attorney informs me that neither your office nor the United States Attorney's Office in Lafayette, LA, ever told him of this investigation. Therefore, we respectfully request a copy of your findings in this investigation under the Freedom of Information Act. [FOIA Request #1]

The fact that the United States Attorney declined to take action did not and will not dissuade us from asserting and protecting the rights of "lower-level" mariners (i.e., maritime transportation workers) working on vessels of less than 1,600 gross tons who suffer at the hands of their maritime employers.

Our correspondence of last October 4th and November 14th did not and this letter will not and speak further to the GCMA False Claims Act lawsuit. Our concern expressed herein is with DOT's oversight of the administration of 46 CFR 4.05-1(a)(6), "Notice of Marine Casualty" regulations involving reporting injuries that require treatment beyond first aid. After all, not reporting at least 45 personal injuries and perhaps as many as 150 personal injuries is more than a slight oversight as we previously pointed out.

Our Association makes a point of attending and contributing our expertise to three federal advisory committees. We strongly object to being misled and subsequently being prevented from

discussing a crucial mariner health and welfare issue in an open forum where marine personnel issues are aired. Furthermore, we believe a Letter of Warning as pointed out in Captain Brusseau's letter of November 5th [ENCLOSURE #2] is totally inadequate relative to the egregious nature and extent of this violation. This is especially true in light of the fact that a number of ENSCO workers have come forward to our attorney in Lafayette alleging mistreatment by their employer in handling on-the-job injuries sustained in the workplace. We are further offended by not even able to obtain a copy of the Letter of Warning mentioned in Captain Brusseau's letter over 2½ months after our request! [ENCLOSURE #3].

ENSCO is a large corporation with vast financial resources. We firmly believe they have both a legal and moral obligation to treat employees on the job in a fair and equitable manner. They have not always done so in the past and now find themselves as parties to a major class action lawsuit. [ENCLOSURE #4]. We intend to see that they treat their maritime transportation employees fairly when injured in the workplace.

On January 9, 2002, the United States Supreme Court decided CHAO, SECRETARY OF LABOR v. MALLARD BAY DRILLING, INC. [ENCLOSURE #5]. Although the case dealt primarily with uninspected vessels, the Syllabus states in part: "With respect to inspected vessels, the parties do not dispute that OSHA's regulations have been pre-empted because the Coast Guard has exercised its broad statutory authority over workers' occupational health and safety, 46 USC §3306. Indeed, OSHA and the Coast Guard signed a Memorandum of Understanding (MOU) over all working conditions on inspected vessels, including those not addressed by specific regulations..."

We respectfully disagree with this statement relative to the Coast Guard's existing accident reporting procedures in 46 CFR 4.05-1.

The MOU deals with inspected offshore supply vessels like those operated by ENSCO. The penultimate paragraph of this MOU signed on March 8, 1983 states: "RECORDKEEPING: OSHA and the Coast Guard will continue to discuss the extent of their respective jurisdictions to require owners of inspected vessels to keep records concerning occupational injuries and illnesses. This MOU does not resolve any issues concerning recordkeeping obligations." (Emphasis ours.) [ENCLOSURE #6].

Presumably, "discussions" have been going on between the Coast Guard and OSHA for the past eighteen years.⁽¹⁾ It does not appear that these discussions reached fruition because existing 29 CFR §1904.2(b) does not appear to exempt the "transportation" industry from OSHA accident reporting requirements spelled out in detail in OSHA regulations at 29 CFR Part 1904. [ENCLOSURE #7]. [FOIA REQUEST #2: We respectfully request copies of the minutes of all meetings and all documents related to any and all agreements reached that may have resolved the MOU's "recordkeeping" issue subsequent to March 8, 1983.]

I have reviewed 29 CFR Part 1904 in its entirety as noted by the markings in the enclosure. In comparing its text with the text of the existing Coast Guard accident reporting requirements in 46 CFR 4.05-1 and 4.05-5 I can plainly see that our maritime workers, like other American workers, would be much better served by the OSHA accident reporting regulations than by those supposedly "enforced" by the U.S. Coast Guard. Since the MOU cited in the Supreme Court decision plainly states that the matter of recordkeeping for occupational injuries is not resolved, I will approach the Department of Labor on behalf of our mariners on this and related matters.

I truly regret that the Department of Transportation and the U.S. Coast Guard have let us down in their unwillingness to stand up and protect the interests of our nation's "lower-level" merchant mariners. Clearly the interests of employers have taken precedence over those of mariners on

uninspected vessels as shown in CHAO v. MALLARD BAY. This only scratches the surface; mariners on inspected vessels have also been deprived of OSH Act protection for over 30 years. Mariners note that the Coast Guard stalled for 20 years in resolving "workplace" issues required by the Outer Continental Shelf Lands Act.⁽¹⁾ [⁽¹⁾Refer to Docket # USCG-1998-3868.]

I am enclosing a copy of our book Mariners Speak Out on Violation of the 12-Hour Work Day. [ENCLOSURE #8]. This is significant area of "workplace safety" the Coast Guard and industry have teamed up to keep from public view. It is an area I encourage your office to investigate.

Very truly yours,



Richard A. Block

Master #830614

Secretary, Gulf Coast Mariners Association

U.S. Department
of Transportation

United States
Coast Guard



Commandant
United States Coast Guard

2100 Second Street, SW
Washington, DC 20593-0001
Staff Symbol: G-MO
Phone: (202) 267-1430
Fax: (202) 267-1416

16200

NOV 5 2001

Mr. Richard Block
Secretary, Gulf Coast Mariners Association
P.O. Box 3589
Houma, LA 70360-3589

Dear Mr. Block:

This is in response to your letter dated September 19, 2001, in which you raised several questions concerning the Coast Guard's enforcement of the Federal Regulations regarding the reporting of injuries requiring medical attention beyond first aid. The Coast Guard agrees that the failure to report accidents is a serious matter. In accordance with the Code of Federal Regulations and Coast Guard policy guidance, Officers In Charge of Marine Inspection (OCMI) are vested with the authority and charged with the responsibility to make case-specific determinations as to whether or not the Coast Guard will pursue civil penalty fines for violations of the Laws and Regulations we enforce. The OCMI must evaluate the nature and seriousness of the offense, the likelihood of recurrence, the availability of other remedial actions, and other factors before selecting the proper tool or tools for enforcement purposes. A civil penalty is just one of those tools.

You asked whether Federal Advisory Committees are prohibited from discussing matters of "enforcement" of government regulations. There is no such prohibition. The agenda for each committee meeting must be approved in advance by the Executive Director or designated Coast Guard representative in consultation with the Committee Chair. It is my understanding that your Association submitted a request to have several topics placed on the agenda for the recently concluded TSAC/MERPAC meeting and you were informed that the Executive Director declined your request. You were also informed that a more appropriate avenue for raising your concerns of the Coast Guard's enforcement policies would be to communicate with my office. I concur with the Executive Director and consider this matter resolved.

You requested a full review of how the Coast Guard treats the failure of persons and organizations to file their reports of all legally reportable accidents and injuries. Form CG-2692 "Report of Marine Accident, Injury, or Death" is required to be filed by a marine employer when an employee sustains an injury that requires professional medical treatment (treatment beyond first aid) and, if the person is engaged or employed on board a vessel in commercial service, that renders the individual unfit to perform his or her routine duties. When made aware of alleged cases of non-filing of CG-2692s, our Marine Safety Offices (MSO) conduct an investigation into the matter to determine the best course of action. Current policy gives our MSOs substantial discretion in determining the appropriate investigative action.

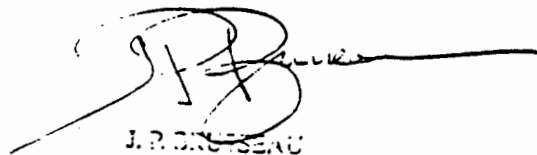
ENCLOSURE #3 PAGE #1

Subj: RESPONSE TO MR. BLOCK'S LETTER OF SEPTEMBER 19, 2001, REGARDING
THE COAST GUARD'S ENFORCEMENT OF THE FEDERAL REGULATIONS
REGARDING THE REPORTING OF INJURIES REQUIRING MEDICAL
ATTENTION BEYOND FIRST AID

Once informed of the alleged non-compliance by ENSCO, MSO Morgan City conducted a thorough investigation. The OCMI concluded that ENSCO had not engaged in a deliberate policy of refusing to report marine casualties involving personnel injuries. It was equally clear, though, that their reporting procedures were flawed and that personnel injuries were underreported. The OCMI elected to issue a Letter Of Warning and to work with ENSCO to improve their reporting procedures. The District Commander concurred with this course of action. No further Coast Guard review of this case is warranted.

If you have any further questions or concerns about this matter, please contact Lieutenant Commander Scott Budka at (202) 267-2026.

Sincerely,

A handwritten signature in black ink, appearing to read 'J. R. DUNN', with a long horizontal line extending to the right.

J. R. DUNN
Captain, U.S. Coast Guard
Director of Staff, Division
Marine Safety and
Environmental Protection

U.S. Department
of Transportation

United States
Coast Guard



Officer in Charge
Marine Inspections
Marine Safety Office

800 David Drive
Morgan City, LA 70380-1304
Staff Symbol
Phone (504) 380-5340
FAX (504) 385-1687

1673100301
PA01000338
NV01000629
February 16, 2001

CERTIFIED MAIL # 7099 3220 0002 0715 0269

ENSCO Marine Company
620 Moulin Road
Broussard, LA 70518

OFFICER IN CHARGE, MARINE INSPECTION: LETTER OF WARNING

Based on the results of a Coast Guard investigation concerning the non-reporting of injuries during the period of 1993 through 1998 that occurred on various ENSCO vessels, the Coast Guard determined you were in violation of federal regulation 46 C.F.R. 4.05-1 & 5.

This violation can result in a \$25,000.00 penalty for each incident. The Coast Guard has initiated casualty cases for the unreported injuries; and noted that there were an additional five reportable injuries but Coast Guard policy did not require initiation of a casualty case. In consideration of the nature of this violation, and that it does not appear to be the standard policy (since other injuries were reported by ENSCO during this time period) I am issuing this Letter of Warning to you rather than initiating civil penalty action. However, I urge your cooperation in preventing future occurrences of this kind.

This matter will not be pursued further unless you wish to contest this Letter of Warning. You do not have to accept this warning; should you feel that it is unwarranted, you may refuse it. If you refuse this Letter of Warning, and I still believe the violation occurred and that you were responsible, I will process the violation. If no response is made to this letter within 30 days, I will assume you accept this Letter of Warning and responsibility for the alleged violation. A record of this violation and a copy of this letter will then be kept on file and considered if future violations occur.

Sincerely,

A large black rectangular redaction box covering the signature of the Officer in Charge.

Lieutenant, U. S. Coast Guard
Chief, Investigation Department
By direction of the
Officer in Charge, Marine Inspection

ENCLOSURE #4 PAGE #1



GCMA NEWSLETTER

The Voice for Mariners

Volume 3, Number 3

May 2001

GCMA FILES SUIT AGAINST ENSCO FOR FAILURE TO REPORT ACCIDENTS

Out of 44 Accidents, ENSCO Only Had One USCG Accident Report Filed

The Gulf Coast Mariners Association has filed suit in federal court against ENSCO Marine Company and ENSCO Offshore Company, two large offshore supply vessel and offshore drilling companies operating in the Gulf of Mexico. The GCMA's complaint asserts that ENSCO violated federal law by consistently failing to report accidents involving their offshore employees to the U.S. Coast Guard. The lawsuit was originally filed on August 30, 2000, but has remained under seal until last month in compliance with federal law.

The suit was brought under the False Claims Act, a federal whistleblower statute, and was filed in U.S. District Court in Lafayette, Louisiana. GCMA contends that federal law requires ENSCO to report all employee accidents requiring a doctor's care. In particular, ENSCO must file an accident report (known as CG-2692) with the Coast Guard within five days of any such accident. GCMA alleges that for many years, ENSCO systematically failed to report such employee accidents to the Coast Guard except in cases involving fatalities.

GCMA's investigation of ENSCO's compliance with the law followed requests under the Freedom of Information Act, seeking copies of ENSCO's Form CG-2692 reports for employee accidents that were the subject of other lawsuits brought against the company. Out of 44 accidents resulting in lawsuits in various federal and state courts, the U.S. Coast Guard only had one CG-2692 on file for ENSCO.

RENDERS USCG DATABASE USELESS

"Our investigation shows that the U.S. Coast Guard's marine safety database, which the Coast Guard uses to track accidents and make inspection decisions in the Gulf of Mexico, is effectively rendered useless by ENSCO's

refusal to report all relevant accidents," said GCMA President Penny Adams. "The safety aspects of offshore work are not as rosy as the Coast Guard's database portrays them."

GCMA's complaint also alleges that ENSCO failed to produce copies of the employee accident reports during the discovery process in prior lawsuits. A court transcript included with the GCMA's complaint shows that an ENSCO attorney denied that any accident reports existed in conjunction with a particular plaintiff's injury. GCMA subsequently determined that the accident report did exist, but that ENSCO had failed to provide the report to the plaintiff's counsel or to the Coast Guard.

"Following that revelation, we asked the Coast Guard to write to ENSCO and demand an explanation of why the Company had failed to file accident reports," said Richard Block, a GCMA board member. "Our members often ask us to notify the Coast Guard about boat companies that break the law."

A FIVE YEAR COVER-UP?

Following the Coast Guard's inquiries, ENSCO's safety manager responded that ENSCO accident reporting to the Coast Guard had "fallen through the cracks" during a change in the ENSCO safety group in the preceding few months. However, GCMA's lawsuit alleges that ENSCO's failure to report reaches back much further and covers at least a five-year period between 1993 and 1998. "We doubt that these reports had just fallen through the cracks for the five years," said Block, adding that "the failure to file these reports suggests a broader undermining of federal safety regulations."

The GCMA's lawsuit charges that ENSCO violated the False Claims Act by providing the Coast Guard with a false explanation of the company's failure to

report accidents.

The GCMA's lawsuit is in the early stages of litigation and no trial date has yet been scheduled. One of the Association's first goals is to determine how many accident reports are maintained in ENSCO's records but have never been filed with the U.S. Coast Guard. "Proper reporting of accidents is a critical component of the Coast Guard's safety strategy," said Block. "When companies fail to file the proper reports, mariners and regulators have no ability to assess safety concerns at sea. Our suit is aimed at holding ENSCO accountable to this important standard. We will also assess the compliance of other companies on these counts."

PENALTIES SEVERE

The GCMA's lawsuit seeks the proper filing of all accident reports by ENSCO, modification of ENSCO's reporting requirements, and imposition of civil penalties. Federal law provides that ENSCO can be fined up to \$25,000 for each failure to report an accident. The False Claims Act also provides for treble damages and additional penalties of \$5,000 to \$10,000.

The GCMA is an association of mariners employed in the Gulf region. The Association represents mariners on issues important to their profession and advocates for mariners and their families before the Coast Guard and other government agencies.

A copy of the complaint is available upon request from GCMA.

INSIDE THIS NEWSLETTER

*USCG Accident Reports
Information for Mariners*

— Page 3

*See Newsletter
Special Report:*

*45 Musts for Effective
Watchkeeping*

Law Offices of
MARK L. ROSS
600 Jefferson Street, Suite 512
Lafayette, La 70501
(337) 266-2345
Fax: (337) 266-2346
email: mlross1@bellsouth.net

March 21, 2012

U.S. Department of Homeland Security
United States Coast Guard
2100 Second Street, S.W. Stop 7581
Washington, D.C. 20593-7581

Attn: D. Patterson, Chief, Data Administration Division

Re: Ensco Rig 99 well blowout
Mobil Block 112
February 16, 2011

Dear Chief Patterson:

Please find enclosed an accident report detailing one of several injuries stemming from a well blowout aboard the ENSCO RIG 99 in Mobile Bay, Alabama on February 16, 2011.

I enclose your response to me of February 10, 2012 stating that the U.S. Coast Guard had no information on this incident. I therefore hope this accident report is of some value to you

Sincerely,

A handwritten signature in dark ink, appearing to read "Mark L. Ross", with a stylized flourish at the end.

Mark L. Ross

U.S. Department of
Homeland Security

United States
Coast Guard



Commandant
United States Coast Guard

2100 Second Street, S.W. Stop 7581
Washington, DC 20593-7581
Staff Symbol: CG-5453
Phone: (202) 372-1286
Fax: (202) 372-1922
Email: Andrea.D.Tobias@uscg.mil

5720
FOIA 12-1247
February 10, 2012

Mr. Mark L. Ross
Law Offices of Mark L. Ross
600 Jefferson Street, Suite 512
Lafayette, LA 70501-8916

Dear Mr. Ross:

This letter is in response to your Freedom of Information Act (FOIA) request of January 27, 2012 records on the incident involving Ensco Rig 99/Exxon Well No. 2 located near Mobil Block 112 on February 16, 2011.

A search of the Marine Information for Safety and Law Enforcement (MISLE) database found no records responsive to your request. The search looked for any records involving the Ensco Rig 99/Exxon Well No. 2 located near Mobil Block 112 on or about February 16, 2011 in the MISLE database. The keywords used includes "Exxon", "Ensco", "Mire", "Dauphin Island", "Superior Energy Services", "Mobil", "block 112", "Rig 99" and "February 16". This records search was conducted on February 7, 2012 by Ms. Andrea "Angie" Tobias, FOIA Specialist, and on February 10, 2012 by Mr. Rodney Levy, IT Specialist of Commandant (CG-5453). We conducted a reasonable search for records responsive to your request and conclude there are no responsive records.

This is not a denial. You may appeal the adequacy of our search. Your appeal must be made in writing and you must submit it within 60 days from the date of receipt of this letter. Your letter should indicate that you are making an appeal based on a "no records" determination of a request made under the Freedom of Information Act and the envelope should be prominently marked "FOIA Appeal." Include in your appeal the reason(s) why you believe the search was inadequate and a copy of this letter. Send your appeal to:

Commandant (CG-611)
U.S. Coast Guard
Attn: FOIA/PA Officer
2100 Second Street, S.W. STOP 7101
Washington, DC 20593-7101

If you have any questions concerning this matter, please contact Ms. Andrea "Angie" Tobias of my staff at the phone number or email address above.

Sincerely,

D. PATTERSON
Chief, Data Administration Division
U.S. Coast Guard
By direction

Copy: CG-DCO Directorate FOIA Coordinator

ENCLOSURE #5 PAGE #2



HEALTH, SAFETY AND ENVIRONMENTAL MANAGEMENT SYSTEM

Injury / Illness Report Form

Compliant with OSHA 301 Form: 29 CFR 1904.29

☒ Injury	☐ Illness	☐ Biological Exposure	☐ Near Miss	Case Number: 508
Name: <u>Jason Mire</u> Home Phone: <u>3377839772</u> Gender: ☒ Male ☐ Female				
Address: <u>27280 Crowley Eunice Hwy</u> Mobile Phone: _____ Date Of Birth: <u>2/11/1975</u>				
City: <u>Crowley</u> State: <u>LA</u> Zip: <u>70526</u> Social Security Number: <u>438454807</u>				
Job Title: <u>SUP039</u> Supervisor At Worksites: _____ Date Of Hire: <u>7/1/2005</u>				
PSL: <u>Superior Well Services</u> Phone: <u>337-769-7110</u> Manager: <u>Chad Abadie</u>				
Division: <u>SES WS Broussard</u> Address: <u>1117 Maurice Road</u>				
City: <u>Broussard</u> State: <u>LA</u> Zip: <u>70518</u>				
Incident Date: <u>02/17/2011</u> Incident Time: <u>1:15</u> ☒ AM ☐ PM ☐ Check if time cannot be determined				
Report Date: <u>02/18/2011</u> Time Since Sleep: <u>6</u> Hrs <u>30</u> Min Time Shift Began: <u>6:00</u> ☐ AM ☒ PM				
State in which incident occurred: <u>LA</u> Did employee stop work immediately: ☒ Yes ☐ No				
Loss of time beyond day or shift of incident? ☐ Yes ☒ No Date return to work: <u>02/17/2011</u> Time: <u>2:00</u> ☒ AM ☐ PM				
Location / Vessel: <u>Mobil Bay Blk 112 Well 2</u> Vessel Name: _____				
☐ Office ☐ Shop ☐ Yard ☒ Offshore Location ☐ Onshore Location ☐ Auto				
Customer: <u>Exxon/ Wild Well</u> Customer Rep: <u>Jerry Wise</u> OCSG/State Lease: <u>S/L 537</u>				

Check all applicable:

- ☒ A. Employee is injured or reporting symptoms indicating an injury
☐ B. Employee is ill or reporting symptoms indicating an illness
☐ C. Employee is reporting symptoms indicating a biological exposure
☐ D. Employee was sent for medical evaluation
☐ E. None of the above - this is a Near Miss

If A, B, C and/or D are checked, does the employee assert that the injury, illness, biological exposure or reason for medical evaluation is a result of a work related activity or developed while in the workplace?

☒ Yes ☐ No ☐ Employee did not indicate

Describe events leading up to the incident: (Be specific-activity, tools, equipment, materials) "Employee was spraying chlorine from hand sprayer".

At 01:00 AM the injured employee called the company man and told me he was on depth and ready to start cutting window in the 13 3/8" casing and said Tim the night pusher and Exxon Mobil Comp Rep. was going down to check for pressure on the 13 3/8" x 20" casing annulus I said Ok, then I went down to the well head and the Night tool pusher and a roughneck was there, Tim the night tool pusher opened the 13 3/8" x 20" casing valve and there was no pressure. Tim called the rig floor and gave them the OK to make cut with our blessing.

Describe what happened: (Be specific - tell how the injury occurred) "Employee was sprayed with chlorine when gasket broke during replacement".

18 minutes into the cut there was a bang and the fluid unloaded from the well bore, lifting the bushings and covering the rig floor with sea water, whereas the gas detectors went off. Jason and the driller were setting beside each other in chairs and Jason said the water knocked him over. It only took 5 to 8 seconds and it was over. Jason went to see the rig medic and was checked out said he had some lower back pain and a scratch on the right side of his head and returned to work. We filled the well with sea water, and monitored same. There were a few bubbles and the well was static. We continued cutting window in the 13 3/8" casing.

Injury, illness or exposure cause (Example: "Lifting", "Struck by", "Fall from elevation", etc.): Struck By

What object or substance directly harmed the employee (Example: "Chlorine")? A jacket and chair

Work activity involved (Example: "Washing equipment"): employee was sitting down behind the control panel



HEALTH, SAFETY AND ENVIRONMENTAL MANAGEMENT SYSTEM
Injury / Illness Report Form

Nature	Soreness/Pain/Stiffness	Part Of Body	Back Low Back (lumbar or lumbo-sacral)
Nature	Brush burn/Scrape/Scratch/Abrasion	Part Of Body	Head

Name:	<u>Raymond Andrus</u>	Company:	<u>Ensco</u>	Phone:	_____
Name:	<u>Douglas Belton</u>	Company:	<u>Ensco</u>	Phone:	_____
Name:	<u>Chris Dings</u>	Company:	<u>Ensco</u>	Phone:	_____

Details of Initial Treatment	
Was employee examined by a physician, medic or other medical professional? ☒ Yes ☐ No	
If so, please complete this entire section (Details of Initial Treatment) and upload a copy of ALL documentation including what's provided by the physician and any other documentation received subsequent to the initial visit.	
If no to the above and the employee received ANY other type of medical or first aid treatment, please describe (Example: "Employee used supplies from the first aid kit to clean and bandage his cut"):	

Medical Facility: <u>medic on location</u>	Yes No
Medical Attendant: _____	☐ ☒ Was Medical Provider listed on Approved Physician List?
Address: _____	If no, explain: _____
City: _____ State: _____ Zip: _____	☐ ☒ Was employee treated in an emergency room?
Phone: _____	☐ ☒ Was employee hospitalized overnight inpatient?
Diagnosis: <u>sore back and a scratch on right side of forehead</u>	
Was employee discharged from care/follow-up? ☒ Yes ☐ No	If employee died, when did death occur? Date: _____ Time: _____ ☐ AM ☐ PM
	Time notified of death? Date: _____ Time: _____ ☐ AM ☐ PM
	Time OSHA was notified? Date: _____ Time: _____ ☐ AM ☐ PM
Comments:	

Report Completed By: <u>Garth Miles</u>		Date: <u>02/18/2011</u>
Title: <u>QHSE Manager</u>	Phone: <u>504 362-5558</u>	

Injured Employee: _____	Date: _____
Supervisor: _____	Date: _____
Person Completing Report: _____	Date: _____

HOUSTON CHRONICLE ARCHIVES

Paper: Houston Chronicle

Date: FRI 11/09/01

Section: A

Page: 01

Edition: 3 STAR

Offshore firms to settle wage suit for \$75 million

By ROSANNA RUIZ

Staff

More than a dozen offshore *drilling* firms have agreed to pay about \$75 million to settle an antitrust *lawsuit* that alleged fixing of offshore laborers' wages and benefits for three decades.

Up to 60,000 workers or their estates could be affected.

Minor details of the settlement, which was reached last April, were worked out during a hearing in U.S. District Judge Sim Lake's courtroom Thursday. Final approval will be granted in April.

The 15 groups of companies, representing about 50 affiliated businesses, are essentially the bulk of the offshore firms that primarily drill in the Gulf of Mexico.

The class-action *lawsuit* filed in August 2000 alleged the companies "conspired to avoid competition amongst them for *drilling* labor by illegally fixing the wages and benefits paid their *drilling* employees."

The companies conducted quarterly surveys to ensure that all were adhering to the agreed-upon wages, the suit alleged. It said the fixed wages meant lower turnover, decreased training costs and the reduced likelihood of widely fluctuating labor costs.

The affected laborers will receive notice of the settlement by early next year. Those eligible to participate include all those aboard offshore rigs from drillers and mechanics to the maintenance crew and kitchen staff.

"I'm very proud these workers are going to get this money, they deserve it," said Anthony G. Buzbee, an attorney representing the plaintiffs.

The offshore laborers would likely receive back paychecks by spring. Each employee's amount will depend on the number who file claims to participate and the amount of time on the job.

Attorneys representing the *drilling* firms declined to comment or were not available.

Buzbee said offshore employees complained to him last year about their wages, and he found that wages had remained fairly constant over the years despite market trends.

Robert Palmer, chairman and CEO of oil service giant Rowan Cos., testified during previous court

proceedings that wages "paid in the offshore *drilling* industry are 25 percent too low across the board."

Transocean Sedco Forex Inc., one of the largest offshore drillers, agreed to settle for \$15 million, the most by any firm named in the suit. Transocean recently merged with R&B Falcon, also involved in the litigation.

The settlement will cost other firms about \$9 million to \$600,000.

Pride International Inc., which bills itself as "one of the world's largest *drilling contractors*," will pay \$9 million. Nabors *Drilling* Inc. \$9.7 million.

Marine *Drilling* will pay out \$5 million, Diamond Offshore Inc. \$9.5 million and Chiles Offshore Inc. \$1 million.

The other firms, whose payouts were not available, include Parker *Drilling* Offshore Corp., Pool International, Noble *Drilling*, Sundowner, Helmerich & Payne International, Santa Fe International, Cliffs *Drilling* Co., Enso International Offshore Co. and Atwood Oceanics Inc.

Two experts retained by the defendants in their bid to prevent class certification argued that the wage surveys "can increase competition," records show.

One expert, Michael Keely, testified that "wage suppression could have led to higher-quality individuals leaving the industry, which could have led to lower-quality workers being hired."

Buzbee characterized Keely's arguments that the wage suppression was of benefit to some employees as "silly," according to court records.

One could argue, Buzbee wrote, that "because of wage suppression, there was less money for high-cholesterol foods; thus individuals were benefited by eating more healthy. The point is that individuals working for suppressed wages are damaged."

Attorneys representing the larger firms objected Thursday to paying for the bulk of the notice fees. If necessary, another hearing will be conducted Nov. 23 to iron out any loose ends in the settlement.

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NMA REPORT #R-429-M

DATE: MAY 9, 2008

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

[Formerly Gulf Coast Mariners Association, Founded in 1999.]

UNITED STATES COAST GUARD'S MANAGEMENT OF THE MARINE CASUALTY INVESTIGATIONS PROGRAM

DHS INSPECTOR GENERAL'S OFFICE UNCOVERS THE "BIG LIE"

The latest "bombshell" to hit the Coast Guard was an in-depth report from the Department of Homeland Security Inspector General's Office (DHS OIG) titled United States Coast Guard Management of the Marine Casualty Investigations Program. In reality, the operative word in the title should have been "mis-management" because that term best characterizes the long-term handling of thousands of accident investigations.

The report (#OIG-08-51) issued by the Department of Homeland Security on May 9, 2008 was requested on Dec. 16, 2005 by both the Chairmen and Ranking Members of the House Transportation and Infrastructure Committee and the Senate Committee on Commerce, Science and Transportation in a truly bi-partisan manner.

Our Association frequently requests copies of Coast Guard and NTSB marine casualty reports (over 770 to date) and is very familiar with many of the problems revealed in this scathing criticism of the Coast Guard's long-term, day to day performance of its casualty investigation and reporting duties. We were informed of the original Congressional request and were contacted later by DHSOIG field auditors from the Boston office and contributed raw data to the auditors. The Inspector General's concern stands in stark contrast to the Coast Guard's policy of totally ignoring any input whatsoever from our nation's 126,000 merchant mariners who are licensed and documented to man vessels of up to 1,600 gross register tons.

A Congressional hearing was convened to discuss this topic on Tuesday May 20, 2008, only 11 days after the report was released to them. The "Casualty Investigations Program" is a critical part of the larger Coast Guard's Marine Safety program – a program that the House of Representatives voted 395 to 7 to revise from the ground up in H.R. 2830. Our Association reported on past problems with "Investigations" by reprinting two previous landmark reports on the Internet. The Coast Guard should have focused on and handled these problems as early as 14 years ago but was remiss in doing so. This should have been clear to Coast Guard leaders as their own reports illustrate. Refer to the following reports on our website:

- **Report #R-429-A, Rev 1. U.S. Coast Guard Marine Casualty Investigations and Reporting: Analysis and Recommendations for Improvement By James G. Byers, Susan G. Hill, & Anita Rothblum. August 1994.**
- **Report #R-429-B, Rev. 1. Report of the USCG Quality Action Team on Marine Safety Investigations. July 26, 1996.**

The shortcomings revealed in the latest Inspector General's report were shocking. We believe that a number of senior Coast Guard officers now in comfortable retirement and some who have assumed elevated positions in industry based upon their past "connections" need to be identified and held accountable by Congress and the American People. These Coast Guard officers covered up problems that were well known at least 14 years ago, but during the intervening years, the Coast Guard did little or nothing to correct the problems. Nevertheless, these remarkable shortcomings are a serious departure from the way that Congress expected the Coast Guard to handle casualty investigations. These shortcomings are also tied very closely to the current ALJ scandal unveiled in Congressional hearings last July 31st.

We want to congratulate the following Congressional leaders for requesting the DHS OIG investigation in 2005: Senators Ted Stevens and Daniel K. Inouye, Representatives James L. Oberstar and Don Young. We want to congratulate Rep. Elijah Cummings and Rep. Steven Latourette for bringing this matter out in public view in the recent hearing. We also want to thank the Department of Homeland Security's Office of Inspector General's staff for its hard work in revealing yet another fraud perpetrated on the American people by flawed and failed leadership within the Coast Guard.

DEPARTMENT OF HOMELAND SECURITY
Office of Inspector General

**United States Coast Guard's Management
of the Marine Casualty Investigations Program**



OIG-08-51

MAY 2008

Office of Inspector General

U.S. Department of Homeland Security
Washington, DC 20528



**Homeland
Security**

MAY 9 2008

Preface

The Department of Homeland Security (DHS) Office of Inspector General (OIG) was established by the Homeland Security Act of 2002 (*Public Law 107-296*) by amendment to the Inspector General Act of 1978. This is one of a series of audit, inspection, and special reports prepared as part of our oversight responsibilities to promote economy, efficiency, and effectiveness within the department.

This report addresses a congressional request from the Committee on Transportation and Infrastructure, U.S. House of Representatives, and the Committee on Commerce, Science and Transportation, U.S. Senate, regarding the United States Coast Guard's management of the marine casualty investigations program. It is based on interviews with employees and officials of relevant agencies and institutions, direct observations, and a review of applicable documents.

The recommendations herein have been developed to the best knowledge available to our office, and have been discussed in draft with those responsible for implementation. It is our hope that this report will result in more effective, efficient, and economical operations. We express our appreciation to all of those who contributed to the preparation of this report.

A handwritten signature in cursive script, reading "Richard L. Skinner".

Richard L. Skinner
Inspector General

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 Abbreviations	
1988 Standard	June 1988 Marine Casualty Investigation Standard
Basic Course	Basic Marine Investigator Course
Coast Guard	United States Coast Guard
CFR	Code of Federal Regulations
DHS	Department of Homeland Security
FY	Fiscal Year
OIG	Office of Inspector General
Marine Board	Marine Board of Investigation
MISLE	Marine Information for Safety and Law Enforcement
NTSB	National Transportation Safety Board



*Department of Homeland Security
Office of Inspector General*

Executive Summary

This report provides our response to a joint request from the Committee on Transportation and Infrastructure of the House of Representatives and the Committee on Commerce, Science, and Transportation of the Senate on the United States Coast Guard's management of the marine casualty investigations program. The Committees requested that we audit the extent to which marine casualty investigations and reports result in information and recommendations that prevent or minimize the effect of similar casualties.

Although the Coast Guard's marine casualty investigations program has resulted in numerous safety alerts and recommendations designed to prevent similar casualties, the program is hindered by unqualified personnel conducting marine casualty investigations; investigations conducted at inappropriate levels, and ineffective management of a substantial backlog of investigations needing review and closure. Because of these management shortfalls, the Coast Guard may not be able to determine the causal factors of accidents and may miss opportunities to issue safety alerts or recommendations that could prevent or minimize similar casualties. To address these shortfalls, in September 2007, the Coast Guard issued a plan to enhance its marine safety program. Many of the actions of this plan are similar to the recommendations in our report.

To improve the management and accountability of the marine casualty investigations program, we are making eight recommendations to the Commandant, United States Coast Guard, including:

- Developing and implementing a plan to increase the number of qualified marine casualty investigators, including hiring civilians; and
- Implementing quality control procedures to ensure marine casualty investigations are conducted at the recommended levels.

The Coast Guard agreed to seven of the recommendations, but did not concur with our recommendation to revise the August 2007 marine casualty investigation qualification standard to include the prequalification of Hull or Machinery, and Small Vessel Inspectors. The Coast Guard's comments to our report are incorporated into the body of this report, as appropriate, and are included in their entirety as Appendix B.

Background

The United States Coast Guard has been responsible for conducting marine casualty investigations for over 60 years. The marine casualty investigation program presently resides in the Coast Guard's Prevention Directorate, employing approximately 150 uniformed and civilian staff nation-wide.

According to the Coast Guard's Marine Safety Manual, the objective of the marine casualty program is to obtain information for the prevention of similar casualties, 'as far as practicable. According to 46 Code of Federal Regulations (CFR) § 4.07-1, the investigations of marine casualties and accidents and determinations made are for the purpose of taking appropriate measures to promote safety of life and property at sea, and are not intended to fix civil or criminal responsibility. Based upon information gathered during an investigation, the Coast Guard may take corrective actions, such as instituting standards for safety and recommending marine safety legislation.

Further, according to 46 CFR § 4.05-1, upon the occurrence of a marine casualty and immediately after addressing resultant safety concerns, the owner, agent, master, operator, or person in charge of a vessel, shall notify the Coast Guard whenever the vessel is involved in-

- (1) An unintended grounding, or an unintended strike of (allision with) a bridge;
- (2) An intended grounding, or intended strike of a bridge, that creates a hazard to navigation, the environment, or the safety of a vessel, or that meets any criterion in paragraphs (3) through (8);
- (3) A loss of main propulsion, primary steering, or any associated component or control system that reduces the maneuverability of the vessel;
- (4) An occurrence materially and adversely affecting the vessel's seaworthiness or fitness for service or route, including but not limited to fire, flooding, or failure of or damage to fixed fire-extinguishing systems, lifesaving equipment, auxiliary power-generating equipment, or bilge-pumping systems;
- (5) A loss of life;
- (6) An injury that requires professional medical treatment (treatment beyond first aid) and, if the person is engaged or employed on board a vessel in commercial service, that renders the individual unfit to perform his or her routine duties;
- (7) An occurrence causing property damage in excess of \$25,000, including the cost of labor and material to restore the property to

-
- its condition before the occurrence, but not including the cost of salvage, cleaning, gas-freeing, drydocking, or demurrage; or
- (8) An occurrence involving significant harm to the environment [§ 4.03-65].

Types of Marine Casualty Investigations

The Coast Guard defines the following levels of marine casualty investigations:

- Preliminary investigations are initial investigative efforts of casualties to determine whether to assign a case as a data collection activity, an informal investigation, or a formal investigation, depending on the severity and value to marine safety. If a case is not assigned, it remains a preliminary investigation.
- Data collection activity investigations do not require any significant investigative effort, and usually consist only of collecting basic factual information and entering it into the Coast Guard's Marine Information for Safety and Law Enforcement (MISLE) database for future reference and analysis. Only minimum follow-up to verify accuracy and completeness of the data collected should be conducted, as necessary.
- Informal investigations are less exhaustive than formal investigations, but include the determination and reporting on the causes of a casualty. This is the minimum level of investigative effort required to initiate enforcement actions. Some of the criteria for an informal investigation include casualties in which property damage exceeds \$100,000 but is less than \$1 million, any collision or allision resulting in property damage exceeding \$25,000, and a medium discharge of oil, i.e., between 1,000 and 10,000 gallons to inland waterways and between 10,000 and 100,000 gallons to coastal waters.
- Formal investigations are reserved for the more serious or significant incidents in which the most investigative value can be gained. Some of the criteria for conducting a formal investigation include two or more deaths, property damage exceeding \$1 million, and a major discharge of oil, i.e., more than 10,000 gallons to inland waterways and over 100,000 gallons to coastal waters.

In addition, the Commandant of the Coast Guard may convene a Marine Board of Investigation (Marine Board) as a result of preliminary evidence, recommendation by a District Commander, or information from any other source, when it appears that a marine casualty is of such magnitude or

significance that a detailed formal investigation will promote safety of life and property at sea and serve the public interest. The decision to convene a Marine Board is influenced primarily by the lesson to be derived from the casualty. When the information to be derived has considerable significance or indicates a problem within a class of vessels or areas of technical importance, convening a Marine Board helps ensure that every aspect of the case will be probed. Additionally, widespread or intense public interest may warrant the formalities of a Marine Board.

The Coast Guard has conducted 282 Marine Boards since 1947. The Coast Guard is currently convening a Marine Board for the March 23, 2008, sinking of a fish processing vessel, the Alaska Ranger, which resulted in the tragic loss of four lives and one missing and presumed dead. Previously, the last Marine Board was convened in April 2001 when the Arctic Rose sank in the Bering Sea, with one person dead and 14 missing and presumed dead. Coast Guard officials stated the decline in convening Marine Boards is primarily due to the extensive amount of resources needed to support them.

Coast Guard's Investigative Efforts

In the past few years, the Coast Guard has conducted thousands of investigations of a wide variety of marine incidents, including injured persons, deaths, and damaged vessels and property. Table 1 is an extract from the Coast Guard's MISLE database categorizing the 15,327 marine casualties that occurred during the period January 1, 2003, through October 31, 2006. As shown, on the next page, 93% of the Coast Guard's investigations conducted during this period were at the preliminary or data collection activity level.

Table 1: Investigations of Marine Casualties that Occurred During the Period January 1, 2003, through October 31, 2006

Level Of Investigation	2003	2004	2005	Through October 31, 2006	Total Investigations	% of Investigative Effort
Preliminary	201	69	44	0	314	2
Data Collection Activity	3,529	3,623	3,617	3,178	13,947	91
Informal	311	166	184	392	1,053	7
Formal	2	2	4	5	13	0
Grand Totals	4,043	3,860	3,849	3,575	15,327	100

Source: Coast Guard's MISLE Database

Based on the total investigations illustrated in Table 1, the Coast Guard issued 396 recommendations to mariners, industry, and to other Coast Guard components. The Coast Guard issues safety alerts for general operations, cargo operations, engineering, navigation equipment, safety equipment, and local waterways and industries.

Table 2 is an extract from the Coast Guard's MISLE database outlining the types and property damage costs of marine casualties. The large increase in property damage costs in 2005 was primarily due to Hurricane Katrina.

Table 2: Types of Marine Casualties that Occurred During the Period January 1, 2003, through October 31, 2006

Type of Casualty	2003	2004	2005	Through October 31, 2006
Number of Injured	850	733	684	859
Number of Missing	16	34	18	11
Number of Deaths	190	175	169	158
Number of Damaged Vessels	1,791	1,771	1,661	1,494
Total Property Damage	\$193,543,494	\$215,153,568	\$809,840,431	\$109,125,089

Source: Coast Guard's MISLE Database

National Transportation Safety Board

The National Transportation Safety Board (NTSB) is an independent federal agency charged by the Congress to investigate civil aviation accidents and significant accidents involving railways and waterways. The NTSB investigates major marine casualties on navigable waters of the United States involving U.S. merchant vessels in international waters and collisions involving U.S. public and nonpublic vessels. In addition, NTSB investigates selected marine casualties, including those of a recurring nature. The NTSB does not assign fault or determine liabilities, but is focused on promoting safety and preventing similar casualties.

Outside of the United States, there are foreign government agencies that perform functions similar to those of the NTSB. The United Kingdom's Marine Accident Investigation Branch, Australian Transportation Safety Board, and Transportation Safety Board of Canada focus on maritime safety and do not assign fault or determine civil or criminal liabilities. Like the NTSB, these organizations do not have enforcement powers. On average, each of these agencies conducted 18 marine casualty investigations per year,

while the Coast Guard conducts an average of 266 informal/formal casualty investigations per year. According to Coast Guard officials, having both enforcement powers and responsibility for assigning fault does not prevent the Coast Guard from determining the causal factors of marine casualties and making recommendations for improvement.

Coast Guard's Marine Casualty Budget

Table 3, below, illustrates the funding for the marine casualty investigations program. Funding, like the total number of annual investigations conducted, has remained relatively consistent since fiscal year (FY) 2005.

**Table 3: Marine Casualty Investigations Program Obligation Activity
FYs 2005 to 2008**

2005	2006	2007	2008
Actual	Actual	Enacted	Request
\$31,600,000	\$32,200,000	\$36,000,000	\$35,300,000

Source: Coast Guard

Results of Audit

The Coast Guard's marine casualty investigations program has been hindered by:

- Less than fully qualified personnel conducting investigations;
- Investigations conducted improperly; and
- A substantial backlog of investigations, which headquarters closed without appropriate review.

As a result, the Coast Guard may not be able to determine the causal factors of accidents and, therefore, prevent or minimize the effects of similar casualties. In September 2007, the Coast Guard issued a plan to enhance its marine safety program. Many of the actions of this plan are similar to the recommendations in our report.

Qualifications of Marine Casualty Investigators

Based on the Coast Guard's June 1988 marine casualty investigation standard (1988 standard), 68% of investigators in our sample were not qualified to conduct marine casualty investigations.¹

Qualifications for Marine Casualty Investigators Not Fully Met

The Coast Guard's 1988 standard required a combination of experience, investigative tasks, and training for an investigator to be qualified. Specifically, to be considered prequalified for the marine casualty investigations program, personnel had to be:

- Qualified as a Hull Inspector or Machinery Inspector, and a Small Vessel Inspector, all of which are responsible for checking the maintenance and capability of vessels, or
- Trained in Port Operations as:
 - o A Boarding Officer, responsible for verifying the legitimacy of those on board and vessel systems;
 - o A Facility Inspector, responsible for verifying the safety of waterfront assets, such as oil and natural gas buildings; and
 - o A Harbor Safety Officer, responsible for conducting patrols and enforcing safety zones.

The 1988 standard also required that personnel satisfactorily (1) initiate a marine casualty investigation, (2) conduct a marine casualty investigation, (3) prepare a written investigative report, (4) prepare marine investigation products, (5) conduct a boating accident investigation, and (6) assure Privacy Act and Freedom of Information Act requirements are maintained during and after the investigation. In addition, personnel were to satisfactorily complete the Basic Marine Investigator Course (Basic Course). Once these tasks and training were completed, the commanding officer certified that the qualification standards had been met.

Based on our site visits, 15 of the 22 (68%) marine casualty investigators reviewed were not qualified under the 1988 standard. Five of the 15 did not attend the required Basic Course. Table 4, on the next page, illustrates the

¹ According to the Coast Guard's Office of Investigations and Casualty Analysis, the standard for determining who is qualified to conduct marine casualty investigations was the 1988 standard. The Coast Guard issued a revised standard in August 2007.

results of our testing of marine casualty investigator prequalifications and basic training attendance. As the worst case scenario, investigators 15, 16, 19, and 21 did not meet any of the requisite qualifications, nor did they attend the Basic Course.

Conversely, 7 personnel met the prequalification standards by either fulfilling all Port Operations requirements or through a combination of inspector qualifications. For example, investigator 1 met the prequalification standard because the investigator was qualified as a Boarding Officer, Facility Inspector, and Harbor Safety Officer. Investigator 3 also met the prequalification standard because the investigator was qualified as a Machinery Inspector and a Small Vessel Inspector.

Table 4: Summary of Marine Casualty Prequalification and Course Attendance								
#	Marine Casualty Investigator - Prequalification						Met Prequals Yes/No	Attended Basic Course
	Or		And	All				
	Hull Inspector	Machinery Inspector	Small Vessel Inspector	Boarding Officer	Facility Inspector	Harbor Safety Officer		
1	No	No	Yes	Yes	Yes	Yes	Yes	Yes
2	No	No	Yes	Yes	Yes	Yes	Yes	No
3	No	Yes	Yes	No	No	No	Yes	Yes
4	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
5	No	Yes	Yes	No	No	No	Yes	Yes
6	Yes	No	Yes	No	No	Yes	Yes	Yes
7	Yes	No	No	Yes	Yes	Yes	Yes	Yes
8	No	No	Yes	No	No	No	No	Waived
9	No	No	Yes	Yes	No	Yes	No	Yes
10	No	No	Yes	Yes	No	No	No	Yes
11	No	No	No	No	No	No	No	Yes
12	No	No	No	No	No	No	No	Yes
13	No	No	No	No	No	No	No	Yes
14	No	No	Yes	Yes	Yes	No	No	Yes
15	No	No	No	No	No	No	No	No
16	No	No	No	No	No	No	No	No
17	No	No	No	No	No	No	No	Yes
18	Yes	No	No	No	No	Yes	No	No
19	No	No	No	No	No	No	No	No
20	No	No	No	No	No	No	No	Yes
21	No	No	No	No	No	No	No	No
22	Yes	Yes	No	No	No	No	No	Yes
							Yes- 7	Yes - 15
							No- 15	No- 6
								Waived -1

Source: DHS OIG analysis, based on Coast Guard data

Although our testing represented approximately 15% of all marine casualty investigators, Coast Guard officials stated that the results reflect the qualifications problem facing the marine casualty investigation program nation-wide.

Coast Guard Sector personnel also did not always follow the 1988 standard. Instead, they developed their own local standards for determining who was prequalified and qualified to be a marine casualty investigator. For example, Sector Hampton Roads marine casualty investigators did not use the 1988 standard, but developed and used a training and qualifications program

checklist that required knowledge of local industry, waterways, and jurisdictions, as well as interviewing techniques, MISLE, and chemical testing. Additionally, Sector New York did not use the 1988 standard. Instead, it developed a training and qualifications program checklist based on the one used in Sector Hampton Roads. Neither Sector Hampton Roads nor Sector New York received approval from Coast Guard headquarters to use local standards. Such diverse application of the 1988 standard contributed to inconsistency in investigator qualifications across the Coast Guard.

In August 2007, the Coast Guard issued a revised standard, which both added to and detracted from the qualifications for marine casualty investigators. The Coast Guard added to the standards by updating the tasks that an investigator must perform to qualify for the position. Those tasks include preparing for an investigation, initiating an investigation, generating an incident timeline, conducting causal analysis, conducting human error analysis, drawing and recording conclusions, developing safety recommendations/alerts, recommending enforcement actions, and completing the Basic Course.

The August 2007 standard also removed the prequalification requirement of a Hull or Machinery and Small Vessel Inspector, which, in essence, lowered the standard. Coast Guard personnel stated knowledge in these specialty areas is essential to the ability of investigators to correctly identify the causes of marine casualties and issue appropriate safety alerts and recommendations. Removing this standard may affect the qualifications and capabilities of Coast Guard marine casualty investigators. When investigators do not have the experience or ability to determine that a hull failure or loss of propulsion are possible causes of a marine casualty, they may not be able to issue the appropriate safety alerts or recommendations to possibly prevent or minimize the effect of similar casualties in the future.

By way of contrast, the United Kingdom's Marine Accident Investigation Branch, Australian Transport Safety Bureau, and Transportation Safety Board of Canada all require their investigators to be Master Mariners or Chief Engineers with several years of experience. Although these foreign entities have had difficulty recruiting individuals who meet the experience requirements, officials from the entities indicated that such standards help ensure that marine casualty investigations are conducted by qualified investigators.

Management Controls to Ensure Qualified Investigators

The Coast Guard has not effectively managed and controlled aspects of the marine casualty investigation program to ensure that it obtains and develops qualified investigators. The difficulty in assigning qualified investigators can

be attributed to competing Coast Guard priorities and a limited number of experienced personnel. This makes it difficult to ensure that all investigator positions are filled with qualified staff. Specifically, headquarters assignment officials select personnel to fill sector investigator positions from a pool of available candidates. There are a limited number of candidates from which to draw.

The Coast Guard has not established a clear and desirable career path for investigators, which can further impede recruitment efforts. At the Sectors, commanders have the discretion to assign experienced and qualified investigators to meet higher priority mission needs, leaving less trained and qualified personnel to perform investigative duties. Given competing mission demands, there is no assurance that an investigator will perform investigative work. Instead, investigators may be called upon to work in areas such as inspections or facilities, outside of their specialty area. For example, a tour in the Prevention Directorate could mean yearly rotations across specialty areas, such as waterways management and drug and alcohol testing. Given the lack of a career path and the unpredictable nature of investigation assignments, potential Coast Guard candidates also may not want to become investigators. Hull and Machinery Inspectors told us that promotion to the position of marine casualty investigator would not advance their careers.

Additionally, according to Coast Guard personnel, tour of duty rotations hinder investigators in acquiring the experience needed for career development. The agency's uniformed investigators generally are not in their positions for more than a single, three-year tour of duty in the same location. The forced rotations preclude the investigators from acquiring the extensive knowledge of local waterways and industries that experienced casualty investigators have told us is needed to be an effective investigator.

In contrast, civilian marine casualty investigators are not subject to the three-year tour of duty rotation standard. Over time, they can gain a greater knowledge of specialties such as local waterways and industries or experience in enforcing maritime regulations to enhance their qualifications. Of the 22 marine casualty investigators that we reviewed, one was a civilian. In FY 2007, the Coast Guard reported there were six civilians serving as full time marine casualty investigators.

Prior Reports on Marine Casualty Investigations

Unqualified marine casualty investigators are not a new issue. Coast Guard studies in the mid 1990s of various aspects of the marine casualty program also identified problems with marine casualty investigator qualifications:

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- The Coast Guard Research and Development Center report, *U.S. Coast Guard Marine Casualty Investigation and Reporting: Analysis and Recommendations for Improvement*, August 1994, included recommendations for organizational change, such as encouraging specialization in investigations and using civilian investigators to help increase the numbers and qualifications of marine casualty investigators.
 - The Coast Guard's *Report on the Quality Action Team on Marine Safety Investigation*, January 1995, included recommendations for maximizing staff utilization and updating the marine casualty investigation process.

The Coast Guard has implemented a number of these study recommendations, resulting in improvements to the program. For example, as defined in the G-MOA Policy Letter 1-00, the Coast Guard instituted the levels of investigation. In addition, the Coast Guard now requires investigators to complete causal analysis training. However, more needs to be done. The Coast Guard has not focused on addressing recommendations related to investigator qualifications. Until it does, unqualified personnel may continue to conduct marine casualty investigations, inhibiting the ability of the Coast Guard to identify causes and make appropriate recommendations for preventing or minimizing similar casualties.

Marine Casualty Investigations

The Coast Guard did not always conduct marine casualty investigations according to its own policies. Due to the September 11, 2001, terrorist attacks and to promote consistency and free staff resources for other duties, the Coast Guard permitted formal marine casualty investigations to be conducted at the informal level, not to be downgraded further, and informal investigations to be conducted at the data collection activity level, not to be downgraded further. This initiative became known within the Coast Guard as the "9/11 downgrade."

In September 2002, the Coast Guard issued a policy letter that superseded the "9/11 downgrade" and returned the investigative levels to the pre-September 11, 2001 levels. (See Appendix D for the Coast Guard's G-MOA Policy Letter 2-02.) However, the Coast Guard headquarters did not effectively communicate to the Sectors that the "9/11 downgrade" was rescinded. Some Sectors did not stop the "9/11 downgrades" until mid-2006, four years later.

Our review of marine casualty investigations from five Coast Guard locations throughout the United States showed that 53% of the investigations in our sample were conducted at a lower level than recommended by Coast Guard guidance. For example, the Coast Guard conducted eight investigations at the data collection activity level, two levels below the formal level recommended by the guidance. Specifically,

- A barge carrying construction equipment capsized and sank; the owners reported \$12 million in damages.
- A barge under tow ran aground causing \$1.5 million in damages to the vessel, and also resulted in the discharge of approximately 10,000 gallons of gasoline into a river. The marine casualty investigators referred the incident for enforcement action because of the discharge.

According to the Coast Guard's G-MOA Policy Letter 2-02 and based on the dollar values in both incidents and the discharge of gasoline in the second incident, the Coast Guard should have conducted an investigation to identify the causal factors of the casualty. Further, a formal investigation of the second incident would have been useful in providing the evidence needed to support a judge's decision in an enforcement action. Coast Guard officials stated that Sector commands made the decision to conduct the investigations at two levels below the prescribed level. The Sector commands have the leeway to conduct investigations at other than the recommended level. However, to maintain control over the program, the Sector commands should document departures from Coast Guard guidance.

As summarized in Table 5, on the next page, 48 marine casualty investigations were conducted at the incorrect level pursuant to the "9/11 downgrade."

Table 5: Summary Judgmental Samples of Marine Casualty Investigations								
Sample Size (All Locations)	Number of Locations Tested	Sample Type	Improper Downgrades				Total Incorrect Level	% of Error
			Preliminary That Should Have Been Data Collection Activity	Data Collection Activity That Should Have Been Informal	Data Collection Activity That Should Have Been Formal	Informal that Should Have Been Formal		
145	5	Not stopping 9/11 downgrade	0	40	6	2	48	33%
		All other	1	23	2	3	29	20%
		Totals	1	63	8	5	77	53%

Source: DHS OIG analysis, based on Coast Guard data

We also analyzed an extract from the Coast Guard's MISLE database of 15,327 marine casualties that occurred during the period of January 1, 2003, through October 31, 2006. Using the Coast Guard's G-MOA Policy Letter 2-02 as guidance, and based on the extracted data, we identified:

- 134 marine casualties that should have been investigated at the formal level but were not, including 55 conducted two levels below at the data collection activity level. For example, a fishing vessel capsized and sank, resulting in 2 deaths, 1 missing, 1 injured, and total property damage of \$945,000. In addition there were enforcement action referrals. Despite the seriousness of the marine casualty with two deaths and high dollar value damage, the investigation was conducted as a data collection activity, which may not include steps to identify the causes of the marine casualty.
- 952 marine casualties that should have been investigated at the informal level, but were not. For example, a vessel allided with a rig, resulting in four injuries to persons on board the vessel and \$825,000 in property damage. The Coast Guard also made a referral for enforcement action. This was investigated at the data collection activity level, which may not be sufficient to support an enforcement action.
- 169 marine casualties that should have been investigated at the data collection activity level or higher, but were not. For example, a vessel

struck a platform, causing \$275,000 in property damage. This preliminary investigation should have been conducted two levels higher at the informal level. The preliminary investigation does not include steps to identify causal factors.

These investigations were not conducted at recommended levels for varying reasons. For example, some Coast Guard Sectors did stop the "9111 downgrade" until mid-2006 because of communication problems from Coast Guard headquarters regarding issuance of the G-MOA Policy Letter 2-02. According to Coast Guard officials, there were also conflicting interpretations of how to apply the Coast Guard's G-MOA Policy Letter 2-02. For example, according to the policy letter, loss of propulsion should be investigated at the informal level. However, some marine casualty investigators defined loss of propulsion as lost propulsion from one engine even though there might be multiple engines, whereas others defined loss of propulsion as when a vessel cannot remain underway.

Further, some marine casualty investigators relied on the Coast Guard's outdated Marine Safety Manual for investigation guidance, which also created confusion. The Coast Guard has not substantially updated its Marine Safety Manual since February 1989. As such, the manual does not include the investigation levels defined in G-MOA Policy Letter 2-02, nor does it refer to MISLE. In November 2004, the Coast Guard issued a Draft Marine Safety Manual for comment and review to ultimately update the February 1989 version. Since this update has not been finalized and approved to supersede the February 1989 version, marine casualty investigators are not certain which manual is the authoritative guidance for conducting marine casualty investigations.

As a result of formal and informal investigations conducted at the lower data collection activity level, causal factors were not always determined. Without such determinations, the Coast Guard may have lost the opportunity to issue safety recommendations or alerts to prevent or minimize the effect of similar casualties occurring again.

Backlog of Marine Casualty Investigations

Coast Guard headquarters is not timely in reviewing or closing marine casualty investigation reports. On November 9, 2006, Coast Guard headquarters had a backlog of 4,240 investigations, of which 2,466 (58%) were open and had been awaiting review and closure for more than six months. However, one Coast Guard headquarters staff was responsible for reviewing and closing all of the investigations. This staff member estimated that, at best, she could devote 50% of her time to this function. Assigning this

significant workload to one person is not sufficient and contributes even further to creating a backlog in marine casualty investigations.

To reduce the backlog, the Coast Guard resorted to a mass closure of investigations without the proper headquarters review. Specifically, on September 29, 2006, Coast Guard headquarters closed 3,848 investigations that it deemed "low risk" based on the criteria that the casualty:

- Occurred in calendar years 2002-2004;
- Involved no fatalities or missing persons;
- Involved injuries to fewer than six persons;
- Involved total dollar damages of less than \$250,000;
- Involved less than 100 gallons of oil spilled; and
- Involved no total losses of vessels.

Included in the September 29, 2006, closure project were 194 informal investigations and 1 formal investigation. Although the Coast Guard deemed them low risk, some investigations merited reviews because they involved serious incidents requiring causal analysis. Enforcement actions also may have resulted from these investigations.

Further, closing investigations without thorough review resulted in lost opportunities to identify errors input to the MISLE database. The MISLE data can support trend analysis and studies that may result in recommendations and safety alerts. Likely, no one will go back to check for errors or make corrections to those included in the mass closure project. In our testing of 145 marine casualty investigations, we identified 43 (30%) that contained at least one MISLE data error. The Coast Guard corrected the errors, such as incident dates, numbers of persons at risk, and levels of investigation, that we brought to their attention. With a thorough review at headquarters, the number of errors could be further reduced. Assigning more staff to manage the investigation review and closure process would also help.

Recommendations

To improve the management and accountability of the marine casualty investigations program, we recommend that the Commandant, United States Coast Guard:

1. Develop and implement a plan to increase the number of qualified marine casualty investigators, including hiring civilian marine casualty investigators, and improving the career path for marine casualty investigators.

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2. Evaluate re-instituting the four-year tour of duty for active duty marine casualty investigators and ensure that they complete the entire tour of duty as a marine casualty investigator.
 3. Develop and implement a plan to ensure attendance at the basic and advanced courses for those qualified to attend.
 4. Revise the August 2007 marine casualty investigation qualification standard to include the prequalification of Hull or Machinery, and Small Vessel Inspectors.
 5. Implement quality controls to ensure that marine casualty investigations are conducted at the recommended levels; consistent information is gathered; and causal factors are determined when appropriate.
 6. Review and revise the criteria for the levels of marine casualty investigations, make any appropriate changes to reduce or eliminate conflicting interpretations, and ensure criteria are consistently applied throughout the Coast Guard.
 7. Finalize and issue the Marine Safety Manual.
 8. Reorganize the headquarters review and closure process to include sufficient staff responsible for reviewing and closing marine casualty investigations, and ensure that the review and closure process is completed in a timely and effective manner.

Management Comments and OIG Analysis

The Coast Guard agreed to seven of the recommendations, but it did not concur with our recommendation to revise the August 2007 marine casualty investigation qualification standard to include the prequalification of Hull or Machinery, and Small Vessel Inspectors. We consider this recommendation unresolved until the standard has been revised. Four of the recommendations will remain open until details and documentation are provided on actions taken so that we can determine whether these actions adequately address the substance of our findings and recommendations.

Management Comments to Recommendation #1:

The Coast Guard concurred with our recommendation and stated that it is seeking to increase both field investigating officers and marine investigations staff support personnel. Consistent with the Coast Guard's efforts to enhance its marine safety program, the FY 2009 President's Budget includes a request for 276 additional Coast Guard marine safety personnel. Of the 276 positions

in this request, 221 will be marine inspectors and investigators, 28 positions are for program management and training, and 27 positions are for support.

OIG Analysis

We agree with the actions the Coast Guard has taken to address the intent of our recommendation. However, the recommendation will remain open until the Coast Guard provides us with documentation that specifically details actions taken to ensure that the number of qualified marine casualty investigators is increased and the career path for marine casualty investigators is improved. The documentation should include annual reporting requirements and the identity of organizational entities responsible for the implementation.

Management Comments to Recommendation #2:

The Coast Guard concurred with our recommendation and stated that it has issued Coast Guard-wide guidance directing field units to ensure personnel remain in their original assigned position for their entire tour, and will continue to enforce a four-year tour of duty as broadly as possible.

OIG Analysis

The Coast Guard has been responsive to our recommendation by enforcing a four-year tour of duty as broadly as possible and ensuring personnel complete their entire tour in their assigned position. We consider the recommendation closed.

Management Comments to Recommendation #3:

The Coast Guard concurred with our recommendation and stated that priority to attend the basic and advanced courses is given to individuals who are assigned to investigating officer positions and conducting investigations.

OIG Analysis

The Coast Guard has been responsive to our recommendation in developing and implementing a plan to ensure attendance at the basic and advanced courses for those qualified to attend. We consider the recommendation closed.

Management Comments to Recommendation #4:

The Coast Guard did not concur with our recommendation and stated the prequalification as a hull, machinery, or small vessel inspector is required to attend the basic marine investigator course. In addition, the Coast Guard stated that anyone of these inspection qualifications provides the basic knowledge needed to begin investigator officer training.

OIG Analysis

We maintain that the Coast Guard should revise its marine casualty investigation qualifications standard to include the prequalification of Hull or Machinery, and Small Vessel Inspectors because the August 2007 guidance removed the prequalification requirement which, in essence, lowered the standard. We consider this recommendation unresolved until the standard has been revised. Coast Guard personnel stated that knowledge in these specialty areas is essential to the ability of investigators to correctly identify the causes of marine casualties and issue appropriate safety alerts and recommendations. In addition, based on our site visits, 15 of the 22 (68%) marine casualty investigators reviewed were not qualified under the June 1988 marine casualty investigation qualification standard. Ten of the 15 attended the required basic marine investigator course.

Management Comments to Recommendation #5:

The Coast Guard concurred with our recommendation and stated that it delineated quality control measures, outlining suggested levels of effort and types of investigations in the updated edition of the Marine Safety Manual, promulgated on April 24, 2008. In addition, the Coast Guard stated that its headquarters staff review investigation activities prior to closure to ensure compliance with policy.

OIG Analysis

We agree with the actions the Coast Guard has taken to address the intent of our recommendation. However, the recommendation will remain open until the Coast Guard provides us with documentation that specifically details actions taken to ensure that marine casualty investigations are conducted at the proper levels, that consistent information is gathered, and that casual factors are determined when appropriate. The documentation should also include annual reporting requirements and identify the organizational entities responsible for implementing these corrective actions.

Management Comments to Recommendation #6:

The Coast Guard concurred with our recommendation and stated that it established clear and sufficient criteria for the levels of marine casualty investigations in the updated edition of the Marine Safety Manual, promulgated on April 24, 2008. In addition, the Coast Guard stated that it ensures consistent application of the criteria through courses at Training Center Yorktown, periodic training at various units, and informal postings on its web portal.

OIG Analysis

We agree with the actions the Coast Guard has taken to address the intent of our recommendation. However, the recommendation will remain open until

the Coast Guard provides us with documentation that specifically details actions taken to ensure that the criteria for the levels of marine casualty investigations are reviewed and revised, any appropriate changes to reduce or eliminate conflicting interpretations are made, and the criteria are consistently applied throughout the Coast Guard. The documentation should include annual reporting requirements and identify the organizational entities responsible for implementing these corrective actions.

Management Comments to Recommendation #7:

The Coast Guard concurred with our recommendation and stated that it issued an updated edition of the Marine Safety Manual on April 24, 2008.

OIG Analysis

The Coast Guard has been responsive to our recommendation in finalizing and issuing the Marine Safety Manual. We consider the recommendation closed.

Management Comments to Recommendation #8:

The Coast Guard concurred with our recommendation and stated that sufficient resources need to be in place to review and close marine casualty investigations in a timely and effective manner.

OIG Analysis

We agree with the actions the Coast Guard has taken to address the intent of our recommendation. However, the recommendation will remain open until the Coast Guard provides us with documentation that specifically details actions taken to ensure that Coast Guard headquarters assigns sufficient staff to manage the investigation review and closure process and timely review and close marine casualty investigation reports. The documentation should also include annual reporting requirements and identify the organizational entities responsible for implementing the corrective actions.

Appendix A
Purpose, Scope, and Methodology

Our audit was performed in response to a congressional request from the Committee on Transportation and Infrastructure of the House of Representatives and the Committee on Commerce, Science and Transportation of the Senate regarding the Coast Guard's management of its marine casualty investigations program. Our objective was to determine the extent to which marine casualty investigations and reports resulted in information and recommendations that prevent or minimize the effect of similar casualties.

We reviewed Coast Guard documentation and manuals related to marine casualty investigations, including the Coast Guard's G-MOA Policy Letters 1-00, 2-02, 2-04 and 6-02.

In addition to conducting fieldwork in Washington, D.C., we also made site visits to five Coast Guard locations: Sector St. Petersburg, Florida; Sector Portland, Oregon; Sector Hampton Roads, Virginia; Sector New Orleans, Louisiana; and Sector New York, New York.

We also interviewed officials from the Coast Guard, the NTSB, Gulf Coast Mariners Association, and the Towing Vessel Safety Advisory Committee. We communicated with officials from the United Kingdom's Marine Accident Investigation Branch, the Australian Transport Safety Bureau, and the Transportation Safety Board of Canada.

We analyzed an extract of the MISLE database of 15,327 marine casualties and related enforcement actions to determine the optimal sampling methodology. We determined our sampling based on those Coast Guard Districts with the highest percentage of informal and formal investigations. From these Districts, we identified the following Sectors with the highest percentage of informal and formal investigations: Sector St. Petersburg, Florida; Sector Portland, Oregon; Sector Hampton Roads, Virginia; and Sector New Orleans, Louisiana. We randomly selected 100 investigations from those four Sectors. In addition, we judgmentally selected five investigations from each of the four Sectors. Further, we judgmentally selected 25 data collection activity investigations from the District with the highest incidence of these investigations and selected the Sector within the District with the highest incidence of these investigations, which was Sector New York, New York.

We relied on an extract from the Coast Guard's MISLE database on 15,327 marine casualties that occurred during the period January 1, 2003, through October 31, 2006. Although we identified some data input errors as discussed

Appendix A

Purpose, Scope, and Methodology

in the body of the report, we concluded that the data was sufficiently reliable to be used to support our audit findings.

We conducted our audit between November 2006 and April 2008 under the authority of the Inspector General Act of 1978, as amended, and according to generally accepted government auditing standards.

We would like to extend our appreciation to the Coast Guard for the cooperation and courtesies extended to our staff during this review.

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Management Comments to the Draft Report

U.S. Department of
Homeland Security
United States
Coast Guard



Commandant
United States Coast Guard

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7500

MEMORANDUM

MAY - 2 2008

From: R.J. Papp, Jr., VADM
Chief of Staff, U.S. Coast Guard

Reply to: CG-823
Attn of: Mark Allen Kulwicki
372-3533

To: Inspector General

Subj: DHS OIG REPORT: "UNITED STATES COAST GUARD'S MANAGEMENT OF
THE MARINE CASUALTY INVESTIGATIONS PROGRAM"

Ref: (a) 010 Draft Report

1. This letter transmits our proposed response to the Office of Inspector General (OIG) draft report findings and recommendations contained in reference (a).

2. Please contact Mark Kulwicki at (202)-372-3533, if you have any questions.

#

Enclosures: (1) U.S. Coast Guard Response to OIG Audit

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UNITED STATES COAST GUARD
STATEMENT ON INSPECTOR GENERAL REPORT

TITLE: "UNITED STATES COAST GUARD'S MANAGEMENT OF THE MARINE CASUALTY INVESTIGATIONS PROGRAM" (Draft Report dated April 28, 2008)

The United States Coast Guard generally concurs with the orG's recommendations included in this report and appreciates the efforts of DHS OIG in documenting areas for improvement. We are currently taking actions to address these recommendations. The Coast Guard provides the following comments in response to the findings of the report. They are **organized** under five sections: introduction, recommendation and responses, supplemental comments, technical comments, and editorial comments.

RECOMMENDATIONS AND RESPONSES

Recommendation #1: Develop and implement a plan to increase the number of qualified marine casualty investigators, including hiring civilian marine casualty investigators, and improving the career path for marine casualty investigators.

Concur. The Coast Guard is seeking to increase both field Investigating Officers (IOs) and marine investigations staff support personnel. We are taking into account current staffing levels and increasing demand for services in our planning efforts. These efforts are part of a broad plan to improve marine safety which is attached as Enclosure I.

On September 25, 2007, the Coast Guard delivered this plan (Enclosure I) to Congress to outline efforts to enhance the Marine Safety Program. Our plan provides a vision and multi-year roadmap for improving the effectiveness, consistency, and responsiveness of the Coast Guard Marine Safety program to promote safe, secure, and environmentally sound maritime commerce. The Coast Guard will reinvigorate industry partnerships, improve mariner credentialing services, bolster inspector and investigator capacity, improve technical competencies, and expand rulemaking capability to ensure that we meet current and future industry needs.

Consistent with this plan, the Fiscal Year 2009 President's Budget includes a request for 276 additional Coast Guard Marine Safety personnel. Of the 276 positions in this request, 221 will be marine inspectors and investigators, 28 positions are for program management and training, and 27 positions are for support. There are currently 552 marine inspectors and investigators in the field at Coast Guard units. Therefore, the additional 221 personnel added to the field represent a 40% growth in the existing number of marine inspectors and investigators. These personnel will begin to increase our capacity to perform both vessel inspections and casualty investigations.

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Recommendation #2: Evaluate re-instituting the four-year tour of duty for active duty marine casualty investigators and ensure that they complete the entire tour of duty as a marine casualty investigator.

Concur. A return to a four-year tour would provide additional time and training opportunities to develop a strong knowledge base for investigating officers. We also agree that assigned personnel should complete their entire tour in their assigned billet. The Coast Guard Personnel Command recently issued Coast Guard-wide guidance directing field units to ensure personnel remain in their original billet assignment, and will continue to enforce a four-year tour of duty as broadly as possible.

Recommendation #3: Develop and implement a plan to ensure attendance at the basic and advanced courses for those qualified to attend.

Concur. Priority is given to individuals who are assigned to Investigating Officer billets and conducting investigations. This was recently re-emphasized in a directive from Coast Guard Headquarters to field units (Enclosure 2).

Recommendation #4: Revise the August 2007 marine casualty investigation qualification standard to include the prequalification of Hull or Machinery, and Small Vessel Inspectors.

Do not concur. Prequalification as a hull, machinery, or small vessel inspector is required to attend the basic marine investigator course. Anyone of these inspection qualifications provides the basic knowledge needed to begin investigating officer training. On April 24, 2008, the Coast Guard's Assistant Commandant for Marine Safety, Security, and Stewardship, sent Coast Guard-wide guidance to reiterate and emphasize the importance of policies currently in place that strive to ensure the integrity of the Marine Casualty Investigations program (Enclosure 2). This message states the importance of proper training and upholds core competencies and prerequisites for becoming a qualified Marine Casualty Inspector. We are working to ensure billets are staffed in the field with a corps of well-trained, certified, and experienced Marine Casualty Investigators.

Recommendation #5: Implement quality controls to ensure marine casualty investigations are conducted at the proper levels to make certain that consistent information is gathered and that causal factors are determined when appropriate.

Concur. However, quality control measures are already delineated in Chapter A5 of the Marine Safety Manual Vol. V, Commandant Instruction M16200.10A. The Marine Safety Manual outlines suggested levels of effort and types of investigations. Quality control also exists within the MISLE database that requires specific data entries based on the level of investigation. For example, if an informal level of investigation is selected, MISLE requires that Causal Analysis be entered. Policy in the MISLE Process Guide also requires at least one level of review of an investigation prior to forwarding to Coast Guard Headquarters. Coast Guard Headquarters staff

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reviews investigation activities prior to closure to ensure compliance with policy. These quality control measures will be enhanced by additional personnel.

Recommendation #6: Review and revise the criteria for the levels of marine casualty investigations, make any appropriate changes to reduce or eliminate conflicting interpretations, and ensure criteria are consistently applied throughout the Coast Guard.

Concur. We believe the criteria for the levels of marine casualty investigations established in the Marine Safety Manual Vol. V are clear and sufficient. We ensure consistent application through courses at Training Center Yorktown, periodic training at various units, and informal postings on our web portal. However, we agree there is room for improvement in applying the criteria consistently and are committed to reviewing and revising all criteria.

Recommendation #7: Finalize and issue the Marine Safety Manual.

Concur. An updated edition of the Marine Safety Manual (MSM) was promulgated on 24 April 2008 as Commandant Instruction M16200.10A.

Recommendation #8: Reorganize the Headquarter review and closure process to include sufficient staff responsible for reviewing and closing marine casualty investigations, and ensure that the review and closure process is completed in a timely and effective manner.

Concur. We agree there needs to be sufficient resources in place to review and close marine casualty investigations in a timely and effective manner.

Encl (1): Marine Safety Improvement Plan
(2): ALCOAST 241806 Z APR 2008

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Executive Summary

"Enhancing the Coast Guard Marine Safety Program"
25 September 2007

Background. The Coast Guard ensures the **safety** of maritime transportation and commerce through a layered, interwoven system of authorities, compliance, collaboration, enforcement and public dialogue. We have been a **leader** in promoting global maritime safety, security, and environmental protection. Notwithstanding, the maritime industry is experiencing unprecedented complexity and growth, while **also** facing **increased risk from** transnational threats. **These dynamics** lead to a greater demand for Coast Guard Marine Safety **services** and call for a renewed **focus** on this core Coast Guard **mission**.

Way Ahead. While we have taken **steps** to improve this **system**, we acknowledge much more must be done. I am directing the development of a strategy that provides a vision and roadmap for improving the effectiveness, consistency, and **responsiveness** of the Coast Guard Marine Safety program to promote safe, secure, and environmentally sound maritime commerce. The Coast Guard will reinvigorate **industry** partnerships, improve mariner credentialing services, bolster inspector and investigator capacity, improve technical competencies, and **expand** rulemaking capability to ensure that we meet current and future industry needs. The Coast Guard will develop metrics to continually assess our progress towards achieving Marine Safety goals and objectives.

This strategy, to be developed in consultation with industry partners, will include the following decisive actions (some of which are underway) to improve Marine Safety mission effectiveness:

Improve the Coast Guard's Marine Safety **Capacity and Performance**

- o Increase marine inspector and investigator capacity.
- o Strengthen marine inspection and investigation consistency through addition of civilian positions.
- o Increase accessions from U.S. Merchant Marine Academy and maritime **institutions**.
- o Strengthen Marine Safety career paths.
- o **Expand** professional Marine Safety training and education.
- o **Expand** opportunities for maritime industry training.
- o Enhance engineering capacity for plan review, policy and standards **development**.

Enhance Service Delivery to Mariners and Industry Customers

- o Establish Centers of Excellence.
- o Improve information technology systems.
- o Increase rulemaking capacity to meet regulatory implementation.
- o Improve credentialing **through** greater efficiency, transparency and capacity.

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Expand Outreach and Advisory Mechanisms for Industry and Communities

- o Establish Assistant Commandant for Marine Safety, Security, and Stewardship.
- o Establish a national council of maritime advisors for the Commandant.
- o Exercise leadership at international, national, regional, state, and local safety, security, and environmental committees.

We are confident these courses of action will result in needed improvements, although many require additional planning to ensure proper implementation and efficacy. A more thorough review of resource requirements is needed before developing specific timelines and milestones.

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"Enhancing the Coast Guard Marine Safety Program"

Current state. The Coast Guard's Marine Safety program is responsible for ensuring the safe operation and navigation of some 20,000 U.S. and foreign-flagged vessels. We conduct over 70,000 domestic vessel inspections and 10,000 port state control examinations each year to safeguard maritime commerce, international trade and supply chain security. We also conduct 14,000 casualty, suspension and revocation, and civil penalty cases annually to leverage lessons-learned and prevent future maritime tragedies. These missions are accomplished by a cadre of approximately 1,000 uniformed and civilian inspectors, investigators and port state control officers stationed domestically and around the world. They are carried out through a shared commitment with industry to facilitate safe, secure, and environmentally sound marine transportation.

Discussion. The Coast Guard's responsibility to improve Marine Safety service delivery is time-critical given growth trends in the maritime industry and increase in demand for Marine Safety services. Industry growth and increased complexity over the last 10 years outpaced commensurate growth in the Coast Guard Marine Safety program, resulting in a performance gap. For example, last year United States deep-draft seaports and seaport-related firms employed over 8 million American citizens while adding nearly \$2 trillion to our domestic economy. From 2002 to 2005, U.S. port calls of large, ocean-going merchant vessels (i.e., over 10,000 gross tons) increased nearly 10 percent to 61,047 according to U.S. Department of Transportation statistics. Moreover, over the last five years, the number of U.S.-flag passenger vessels increased by seven percent and offshore oil industry vessel growth exceeded 35 percent. We recognize industry's concern that our Marine Safety program lacks sufficient capacity to be responsive, inclusive, accessible, and customer-focused. We share in their desire to aggressively address this concern.

Projected growth areas for Marine Safety services include:

- o New inspection requirements for as many as 7,000 uninspected towing vessels;
- o Market-driven shifts in port activity due to increased demand for such products as liquefied natural gas, petroleum, dangerous cargoes, and containerized freight;
- o Proportional growth in marine investigations resulting from industry growth;
- o Increased demand for commercial fishing vessel examinations; and
- o Continued growth in requirements to publish implementing regulations.

An integrated Coast Guard approach to safety, environmental protection, waterways management, and security best ensures the long-term success of the global maritime transportation system. The goal in preventing or responding to major marine incidents, regardless of cause, is the same: to save lives, preserve property, protect the environment, and minimize disruption to the maritime transportation system. The Coast Guard's operational model is flexible, adaptive, efficient and capable of succeeding with myriad

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maritime scenarios. Today, as in the past, our safety, security, and stewardship program goals and authorities to act are inextricably linked.

Following the terrorist attacks of 9/11, our longstanding industry partnerships were critical to protecting the global marine transportation system. These partnerships remain vital today. We must ensure resources match the growing demand for our Marine Safety services. Our marine safety capacity and effective engagement with stakeholders demand senior leadership's attention. We will improve Marine Safety program focus and performance.

Course of Action. The Commandant is directing the development of a strategy that includes the following courses of action, (some of which are underway):

Improve the COGSI Guard's Marine Safety Program Capacity and Performance

Increase marine inspector and investigator capacity.

Within budget, the Coast Guard will add more marine inspectors, port state control officers, and investigators. We will use these full-time positions to meet current and anticipated growth in maritime commerce and expansion of the regulated fleet. Demand for inspection and investigation work is increasing and capacity to match these demands must be built and sustained as a result of growth factors such as projected Liquefied Natural Gas (LNG) ships and facilities, thousands of towing vessel examinations, non-tank vessel response plan reviews, ballast water management oversight, and regulatory development.

Strengthen marine inspection and investigation consistency by adding civilian positions.

Within budget, we intend to increase the number of civilian inspectors and investigators. Additional civilian inspector/port state control officer positions and investigating officers will help the Coast Guard retain expertise and geographic-specific competencies while ensuring long-term continuity in critical mission areas. We will distribute civilian positions according to demand and to complement the military workforce. Military personnel must continue to serve as marine inspectors and investigators to ensure innovation, and garner requisite experience for future program management and command responsibilities. A blend of military and civilian personnel is critical to building and sustaining consistency and competence.

Increase accessions from U.S. Merchant Marine Academy and maritime institutions.

The Coast Guard will strengthen recruiting efforts at the maritime colleges through additional liaison officers and by seeking opportunities for Coast Guard officers to serve as faculty at those institutions. Maintaining and sustaining competency within the Marine Safety program begins with recruitment and accession of additional maritime professionals, and active partnerships with maritime educational institutions.

Strengthen Marine Safety career paths.

We will demonstrate the value the organization places on the Marine Safety profession by revising personnel management policies. These policies must continue to ensure a viable career path to the most senior ranks in the Coast Guard, and value and promote the competencies of marine safety specialists. These policies could include, but are not limited

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to: direct commission programs; direction and guidance to officer selection panels relating to the need for specific Marine Safety specialties; increased tour lengths; incentives to retain qualified inspectors and investigators; institutional recognition of Marine Safety leadership positions in the field; and continuation contracts for officers possessing critical skills. Recognize those who advance from apprentice, to journeyman, to expert marine safety professional status.

Expand professional Marine Safety training and education.

We recently completed extensive review, update, and field testing of Marine Safety course and qualification material. The Coast Guard will expand formal and informal training and education opportunities to improve Marine Safety competencies, skills and qualifications. These programs will include additional resident educational opportunities for the military and civilian marine safety workforce, and enhanced pipeline training for field personnel to ensure better continuity and consistency in service. Through continuous evaluation, we will ensure training, education and qualification standards are responsive to the dynamics of the marine transportation system. A robust marine inspector and investigator workforce also requires additional expert field personnel to conduct unit training in order to build and sustain these critical competencies.

Expand opportunities for maritime industry training.

The Merchant Marine Industry Training (MMIT) program is a model of industry partnership and professional development. Therefore, the MMIT program will be expanded to include both formal and informal assignments to maximize interaction and experience. We will adjust the MMIT to industry's technological innovations, complexity, and growth as a means for the Coast Guard to better understand and address emerging safety, security, stewardship, and economic issues. The Coast Guard will engage industry within applicable legal and ethical guidelines to maximize training opportunities and fully immerse participants in industry operations. The Ship Rider and other industry familiarization programs will be offered to a larger group of Marine Safety professionals.

Enhance engineering capacity for plan review, policy, and standards development.

We will seek additional capacity and expertise for plan review of vessels and facilities. Increased technical capacity is needed to address plan review of commercial non-tank vessels, marine fire fighting and salvage, standards development and vessel construction specialties at Coast Guard Headquarters and the Marine Safety Center. Increased growth and complexity in ship design and construction, including high capacity fast ferries, LNG ships, mega container and cruise ships, and novel structural designs, call for an innovative and knowledgeable technical staff to develop guidance, standards, and policy. As industry evolves, so too does the demand for technical expertise.

Enhance Service Delivery to Mariners and Industry Customers

Establish Centers of Excellence.

We plan to establish additional Centers of Excellence (CaE) to provide venues for professional development and exchange between industry and Coast Guard personnel. COEs will focus on specialized areas of industry to improve inspector competencies and promote consistency across ports. For example, the Coast Guard Cruise Ship CaE in Miami, Florida was created to recognize and address cruise ship complexity, industry

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growth, and attendant risk. Specialized vessel inspection approaches were developed to improve inspector competence, effectiveness, and efficiency in nationwide cruise ship inspections. The support staff manages a resident 6-day course which provides instruction on USCG policy, and covers technical and management issues for foreign flagged cruise ships. COEs are appropriate for existing industry sectors and projected growth areas including investigations, LNG ships, towing vessels, fishing industry vessels, and outer continental shelf activity. COEs also will provide deployable casualty response and surge capacity.

Improve information technology systems.

The Coast Guard will incorporate tools to improve access and the exchange of information between industry and government using existing marine exchanges as a model. Such systems provide real-time, technology-based information to capture and manage the maritime transportation system. The Coast Guard will enhance web-based portals for sharing information and lessons learned between Coast Guard field personnel and industry, and include Coast Guard office directories and contact methods. The Coast Guard also will provide help-desks and FAQs to facilitate transparency.

Increase rulemaking capacity to expedite regulatory implementation.

The Coast Guard will increase capacity to address current and anticipated rulemaking projects. Increased rulemaking capacity requires additional support for project management, rulemaking development, economic analysis, environmental analysis, technical writing, and administrative law capacity to ensure legal sufficiency and efficacy of implementing regulations. We will publish timely guidance to assist regulated industry with implementation. To the extent practicable, the Coast Guard also will prepare legislative change proposals that minimize required rulemaking process time.

Improve mariner credentialing through greater efficiency, transparency and capacity.

The National Maritime Center (NMC) consolidation began in 2005. Located in West Virginia, recent accomplishments include implementation of the Mission Management System and reduction in cycle time by 25 percent since September 2006. The following milestones will further improve service delivery to the mariner:

- o Credentialing help desk fully staffed by February 2008;
- o Online self-help application tracking and payment options via www.pay.gov;
- o Bulk application processing for academies, schools and industry groups;
- o Issue of merchant mariner licensing documents in less than one week; and
- o Rebuild primary computer system and implement web-based processing.

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Expand Outreach and Advisory Mechanisms/or Industry and Communities

Establish an Assistant Commandant for Marine Safety, Security, and Stewardship

The Assistant Commandant for Marine Safety, Security, and Stewardship will direct and integrate Marine Safety, security, and environmental protection doctrine, policy, plans, and regulations. This flag officer will be the Coast Guard's national Marine Safety **leader** and will ensure alignment throughout the Coast Guard and among federal and international **partners**. This flag officer will be responsible for developing and promulgating national **policy** in prevention, response and waterways management, as well as leading and overseeing the important work of numerous federal advisory committees and industry **partnerships**.

Establish a national council of maritime advisors for the Commandant.

A council of maritime advisors will inform the Commandant of national maritime trends and issues of concern. This council will draw its membership from industry leaders, governors, academics, former **military** and government officials, and media.

Exercise leadership at international, national, regional, state, and local **safety, security, and environmental** committees

We will commit resources to lead, support, and engage these committees to collectively advance the shared goals of safety, security, and environmental stewardship. These fora also offer important opportunities to shape regulatory initiatives, and develop non-regulatory solutions where appropriate. We will incorporate customer engagement using quality processes to elicit **maritime** input as previously done with the "Prevention through People" philosophy.

Conclusion. The Coast Guard has established a clear way ahead to enhance the Marine Safety program. The proposed courses of action are responsive to external stakeholders and overseers, and supportive of work in progress and ongoing initiatives.

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DC/ICG-51/ TO ALCOAST BT UNCLAS IIN1673211 ALCOAST 194/08 COMDTNOTE
16732

SUBJ: MARINE CASUALTY INVESTIGATING OFFICER DOCTRINE A. COMDT COGARD
WASHINGTON DC 191735Z NOV 07/ALCOAST 541/07 B. MARINE SAFETY MANUAL
VOLUME V, COMDTINST M16000.10A C. MARINE SAFETY MANUAL VOLUME I,
COMDTINST M16000.6 D. COMCOGARD PERSCOM ARLINGTON VA 250057Z MAR
08/ALCGOFF 037/08 E. COMDT COGARD WASHINGTON DC 081630Z AUG 07/ALCOAST
387/07 1. REFERENCE A PROVIDED INITIAL GUIDANCE ON RESPONSE DOCTRINE
FOLLOWING SIGNIFICANT INCIDENTS. THIS MESSAGE REITERATES AND EMPHASIZES
THE IMPORTANCE OF POLICIES CURRENTLY IN PLACE THAT STRIVE TO ENSURE THE
INTEGRITY OF THE MARINE CASUALTY INVESTIGATIONS PROGRAM. IN SUPPORT OF
THIS EFFORT, THIS MESSAGE ANNOUNCES THAT REFERENCE B HAS BEEN
PROMULGATED THIS DATE AND WILL BE PUBLISHED SHORTLY.

2. THERE HAS BEEN AN OVERALL DECREASE IN THE EXPERIENCE OF COAST GUARD
MARINE CASUALTY INVESTIGATING OFFICERS (10). THIS IS DUE IN PART TO THE
ASSIGNMENT OF NEWLY COMMISSIONED OFFICERS AND OTHER OFFICERS THAT DO
NOT MEET THE ESTABLISHED PREREQUISITES AND HAVE NO PRIOR EXPERIENCE AS
INVESTIGATING OFFICERS AND TO THE INFORMAL, BUT ROUTINE, PRACTICE OF
ROTATING THESE OFFICERS THROUGH SEVERAL "PROFESSIONAL GROWTH
ASSIGNMENTS" DURING THEIR TOUR AT A SECTOR OR SUBORDINATE UNIT.

3. IN AN EFFORT TO STRENGTHEN THE MARINE CASUALTY INVESTIGATION
PROGRAM, COMDT (CG-545) IS DEVELOPING AN ACTION PLAN THAT WILL ENSURE
10 BILLETS ARE STAFFED WITH A CORPS OF WELL TRAINED, CERTIFIED AND
EXPERIENCED MARINE CASUALTY INVESTIGATING OFFICERS.

UNTIL THE PLAN IS FULLY COMPLETED AND IMPLEMENTED THERE ARE SEVERAL
STEPS THAT SECTOR COMMANDERS AND MSU COMMANDING OFFICERS MUST TAKE TO
ENSURE THAT THE OVERSIGHT AND COMPLETION OF MARINE CASUALTY
INVESTIGATIONS IS DONE BY CERTIFIED MARINE CASUALTY INVESTIGATORS.

4. I CANNOT OVERSTRESS THAT PROPER TRAINING IS ONE OF THE MOST
IMPORTANT ASPECTS OF ENSURING OUR PERSONNEL ARE PREPARED AND MOTIVATED
TO DO THE JOB. CORE COMPETENCIES, PREREQUISITES FOR BECOMING A MARINE
CASUALTY INVESTIGATOR AND COMPLETING EACH STEP IN THE TRAINING AND
CERTIFICATION PROCESS, MUST BE UPHELD.

5. COMDT (CG-545) IS RESPONSIBLE FOR DETERMINING MISSION ESSENTIAL
TRAINING REQUIREMENTS FOR ALL MARINE CASUALTY INVESTIGATORS IN ORDER TO
MEET COAST GUARD AND PROGRAM OPERATIONAL COMMITMENTS.

ONLY COMDT (CG-545) MAY GRANT A WAIVER TO ANY CERTIFICATION OR MINIMUM
STANDARD FOR TRAINING. UPDATED PERFORMANCE QUALIFICATION STANDARDS WERE
ANNOUNCED IN REFERENCE E. COAST GUARD COMMANDS SHALL ENSURE THAT ALL
PERSONNEL REQUESTING AND ASSIGNED TO TRAINING MEET ALL COURSE
PREREQUISITES.

6. IN ACCORDANCE WITH POLICY IN REFERENCES BAND C, PERSONNEL ASSIGNED
TO AN OPERATIONAL BILLET AS A MARINE CASUALTY INVESTIGATOR SHOULD
ALREADY BE FAMILIAR WITH MARINE SAFETY LAWS AND REGULATIONS THROUGH
PRIOR TRAINING AND QUALIFICATIONS. GENERALLY, AS A MARINE INSPECTOR
PRIOR TO BEING ASSIGNED TO MARINE CASUALTY INVESTIGATION DUTIES, TO
FACILITATE THIS REQUIREMENT DURING AY 2009 ASSIGNMENT SEASON AND
BEYOND, I HAVE DIRECTED COMDT (CG-545) TO WORK WITH THE APPROPRIATE
HEADQUARTERS OFFICES AND PERSONNEL COMMAND TO ENSURE THAT ALL
INVESTIGATING OFFICER BILLETS ARE PROPERLY CODED TO INDICATE THE
PREREQUISITE QUALIFICATIONS REQUIRED FOR PERSONNEL TO BE ASSIGNED AND
TO FACILITATE THE EFFORTS BY PERSONNEL COMMAND TO FILL THE BILLETS WITH
APPROPRIATE CERTIFIED PERSONNEL.

7. THE MARINE CASUALTY INVESTIGATIONS PROGRAM IS CONSIDERED AN
ADVANCED LEVEL OF THE COAST GUARD MARINE SAFETY COMMUNITY.

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Management Comments to the Draft Report

ACCORDINGLY, QUICK INTERNAL ROTATION THROUGH AN INVESTIGATING OFFICER BILLET IS INAPPROPRIATE. PERSONNEL ASSIGNED ARE EXPECTED TO HAVE HAD PRELIMINARY TOURS RENDERING SUCH TICKET-PUNCHING UNNECESSARY. AS WITH SHORT TOURS, ACTIVE DUTY MARINE CASUALTY INVESTIGATORS MAY OCCASIONALLY BE SELECTED FOR REASSIGNMENT WITHIN A UNIT. SUCH REASSIGNMENTS ARE BASED ON THE NEEDS OF THE COMMAND AND ARE OFTEN REQUIRED TO FILL CRITICAL POSITIONS WITHIN THE COAST GUARD. BECAUSE OF THE ENORMOUS INVESTMENT OF TRAINING AND EXPERIENCE REQUIRED TO CERTIFY AS A MARINE CASUALTY INVESTIGATOR AND TO GAIN TECHNICAL COMPETENCE, INTERNAL ROTATIONS AND SHORT TOURS ARE HIGHLY DISCOURAGED AND SHOULD BE MADE ONLY IN ACCORDANCE WITH REFERENCE D.

8. IN ORDER TO BECOME CERTIFIED AS A MARINE CASUALTY INVESTIGATOR, THE 10 MUST COMPLETE PQS AND SIT BEFORE A QUALIFICATION BOARD CONSISTING OF PERSONNEL THAT ARE CERTIFIED IN THAT SPECIALTY. TO BE CONSIDERED CERTIFIED AS A MARINE CASUALTY INVESTIGATOR THE 10 MUST BE ASSIGNED TO AN OPERATIONAL BILLET AS A MARINE CASUALTY INVESTIGATOR, BE DESIGNATED IN WRITING AS AN 10 BY THE COGNIZANT OCMI, HAVE ATTENDED THE BASIC INVESTIGATING OFFICER COURSE (IOC) AT TRACEN YORKTOWN AND HAVE COMPLETED THE MARINE CASUALTY INVESTIGATOR (FO) QUALIFICATION. UNTIL THE 10 HAS COMPLETED THEIR CERTIFICATION, THEY SHALL, AT ALL TIMES, BE UNDER THE SUPERVISION OF A CERTIFIED MARINE CASUALTY INVESTIGATOR AND SHALL NOT BE AUTHORIZED TO CONDUCT AN INDEPENDENT MARINE CASUALTY INVESTIGATION. PERSONNEL MUST COMPLETE THE PQS ANNOUNCED IN REFERENCE E. LOCAL QUALIFICATIONS ARE NOT AUTHORIZED. IN ORDER TO ALLOW PROPER IDENTIFICATION OF CERTIFIED PERSONNEL, UNITS SHOULD ENSURE THEY KEEP THE TMT DATA BASE UP TO DATE WITH 10 AND OTHER CERTIFICATIONS.

9. IF YOUR UNIT LACKS THE APPROPRIATE CERTIFIED PERSONNEL TO CONDUCT A MARINE CASUALTY INVESTIGATION, THEN YOU SHALL SEEK ASSISTANCE OUTSIDE OF YOUR UNIT. COMDT (CG-545) IS CONDUCTING A STUDY OF THE STATUS OF 10 QUALIFICATIONS, INCLUDING PERSONNEL CURRENTLY ASSIGNED TO 10 BILLETS AND THOSE WITH 10 CERTIFICATIONS NOT ASSIGNED TO 10 BILLETS. ON APRIL 18, COMDT (CG-545) REQUESTED DATA FROM ALL UNITS DOCUMENTING CERTIFICATION AND BILLET INFORMATION ON ALL INVESTIGATING OFFICERS. IF, IN THE PROCESS OF COMPLETING THE DATA CALL, A UNIT WITH A SHORTFALL OF CERTIFIED MARINE CASUALTY INVESTIGATORS IDENTIFIES A CERTIFIED MARINE CASUALTY INVESTIGATOR NOT CURRENTLY ASSIGNED TO AN 10 BILLET, THE UNIT SHOULD CONSIDER FOLLOWING THE GUIDANCE OF REFERENCE D TO INTERNALLY ROTATE THAT CERTIFIED PERSON INTO AN 10 BILLET, OR AS AN ALTERNATIVE, IDENTIFY THEM AS A RESOURCE TO SUPERVISE ALL MARINE CASUALTY INVESTIGATIONS UNTIL SUCH TIME AS THE UNIT IS ASSIGNED CERTIFIED PERSONNEL. IF A UNIT HAS NO CERTIFIED MARINE CASUALTY INVESTIGATORS, COMDT (CG-545) WILL WORK TO IDENTIFY AVAILABLE RESOURCES TO ASSIST.

10. RDML BRIAN SALERNO, ASSISTANT COMMANDANT FOR MARINE SAFETY, SECURITY AND STEWARDSHIP, SENDS:

11. INTERNET RELEASE AUTHORIZED.

BT

NNNN

Congress of the United States

Washington, DC 20515

December 16, 2005

Mr. Richard L. Skinner
Inspector General
Department of Homeland Security
Washington, DC 20528
Attn: Office of Inspector General

Dear Mr. Skinner:

On behalf of the Committee on Transportation and Infrastructure of the House of Representatives and the Committee on Commerce, Science and Transportation of the Senate, we are writing to request your office to conduct a study of the Coast Guard's marine casualty investigation program and to report to these Committees the findings and recommendations of that study not later than June 30, 2007.

The Committees expect that the study and report shall examine the extent to which marine casualty investigations and reports result in information and recommendations that prevent similar casualties; minimize the effect of similar casualties, given that it has occurred; and maximize lives saved in similar casualties, given that the vessel has become uninhabitable.

The Committees also suggest that the study include the following to promote the safety of all who work on or travel by water and to protect the marine environment:

- the adequacy of resources devoted to marine casualty investigations considering caseload, and duty assignment practices;
- training and experience of marine casualty investigators;
- investigation standards and methods, including a comparison of the formal and informal investigation processes;
- use of best investigation practices considering transportation investigation practices used by other Federal agencies and foreign governments; including British Marine Accident Investigation Branch programs;
- usefulness of the marine casualty data base for marine casualty prevention programs;

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United States Coast Guard's Management of the Marine Casualty Investigations Program

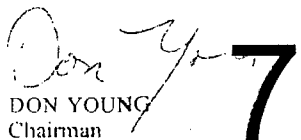
Appendix C
Congressional Request for Audit

2

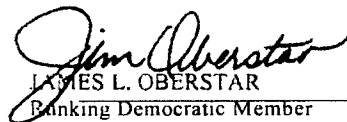
- the extent to which marine casualty data and information have been used to improve the survivability and habitability of vessels involved in marine casualties;
- any changes to current statutes that would clarify Coast Guard responsibilities for marine casualty investigations and report; and
- the extent to which the Coast Guard has reduced the frequency of formal investigations, or changed the types of incidents for which it has carried out a formal investigation process, in the past five years.

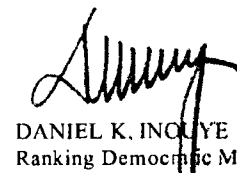
We thank you for your important contribution to our Committees' oversight over the Coast Guard's marine safety missions, and we look forward to receiving your report.

Sincerely,


DON YOUNG
Chairman
Committee on Transportation
and Infrastructure
United States House of Representatives


TED STEVENS
Chairman
Committee on Commerce,
Science and Transportation
United States Senate


JAMES L. OBERSTAR
Ranking Democratic Member
Committee on Transportation
and Infrastructure
United States House of Representatives


DANIEL K. INOUE
Ranking Democratic Member
Committee on Commerce,
Science and Transportation
United States Senate

Appendix D
Coast Guard's G-MOA Policy Letter 2-02

U.S. Department
of Transportation
United States
Coast Guard



Commandant
United States Coast Guard

2100 Second Street, S.W.
Washington, DC 20593-0001
Staff Symbol: G-MOA
Phone: (202) 267-1430
FAX: (202) 267-1416

16732
G-MOA Policy Letter 2-02
SEP - 4 2002

MEMORANDUM

From: *M. B. Karr*
M. B. Karr
COMDT (G-MOA)

To: Distribution

Subj: **CONDUCTING MARINE INVESTIGATIONS: CASUALTY INVESTIGATIONS**

- Ref: (a) G-MOA Policy Ltr 1-00, Conducting Marine Casualty Investigations
(b) G-MOA Policy Ltr 1-96, Marine Investigation Reports and MINMOD
(c) G-MOA Policy Ltr 2-95, Written Report of a Marine Casualty
(d) Msg P 192030Z JUN 02, Subj: MISLE Data Entry Policy for Incident Response and Investigation Activities
(e) Report of the Quality Action Team on Marine Safety Investigations, 18 Sep 95

1. References (a), (b) and (c) are cancelled. Reference (d) with regard to investigation issues is superseded. This policy letter and the Investigations and Enforcement Process Guide update current policy with regard to data entry into the Marine Information for Safety and Law Enforcement (MISLE) data system.
2. Reference (e) discusses several proposals for updating the marine investigation process. As a result of that report, this letter provides guidance on the appropriate minimum level of investigative effort for marine casualty investigations.
3. All Officers in Charge, Marine Inspection (OCMIs) and Captains of the Port (COTPs) shall take the enclosure to this letter for action in determining consistent minimum levels of investigative effort for marine casualty investigations. Nothing herein is intended to limit or change OCMI/COTP authority or responsibility to determine appropriate actions in any specific case. This policy will be incorporated into the next change to Volume V of the Marine Safety Manual. Questions concerning this policy may be directed to LCDR Chuck Barbee at (202) 267-1430.

#

Enclosure: (1) Levels of Investigative Effort

Distribution: All Activities/Marine Safety Offices
All Area/District (m)
Commandant (NMC)
TRACEN Yorktown (tmil)

United States Coast Guard's Management of the Marine Casualty Investigations Program

Appendix D
Coast Guard's G-MOA Policy Letter 2-02

Enclosure (1)

Levels of Investigative Effort

I. Purpose

This enclosure provides guidance to implement new policy and process for the investigation, reporting, and record-keeping associated with Coast Guard marine casualty investigations. This policy does not apply to:

- 46 CFR 4.05 requirements for notice and written reports of casualties;
- 46 CFR 4.06 and 33 CFR 95 requirements for post-casualty chemical testing and the reporting of chemical test results;
- Regulations and policy regarding pollution investigations;
- Personal action investigations of licensed or documented mariners; and
- Investigation of civil or criminal offenses.

II. Levels of Investigative Effort

The Quality Action Team on Marine Safety Investigations suggested that three levels of investigation are necessary once a preliminary investigation verifies an incident has occurred and assesses its apparent severity. This policy implements those levels of investigation:

- **Preliminary Investigations** are initial investigative efforts undertaken to ascertain whether a report is genuine, how severe the incident is or will become, whether the Coast Guard has jurisdiction, whether other agencies or offices must be notified, and what level of Coast Guard investigative effort is necessary. Once a preliminary investigation verifies that a reportable marine casualty as defined in 46 CFR 4.05-1 has occurred, the cognizant investigative authority assigns the incident for investigation as a data collection activity, informal investigation, or formal investigation, depending on severity and value to marine safety.
- **Data Collection Activities** do not require any significant investigative effort, and usually consist only of collecting and entering basic factual information into MISLE for future reference and analysis. Only minimum follow-up to verify accuracy and completeness should be conducted as necessary.
- **Informal Investigations** are less exhaustive investigative efforts than formal investigations, but include the determination and reporting of the causal factors of a casualty and violation analysis, when applicable. This is the minimum level of investigative effort required to initiate enforcement actions.
- **Formal Investigations** are reserved for the more serious or significant incidents investigated under 46 USC Chapter 63 from which the most value can be gained. Marine Boards of Investigation convened by the Commandant and other formal investigations convened by the District Commander or OCMI/COTP fit into this category.

AppendixD
Coast Guard's G-MOA Policy Letter 2-02

III. Conduct of Investigations and Data Collection Activities

Preliminary Investigations A preliminary investigation shall be conducted for any report or evidence of a reportable marine casualty as defined in 46 CFR 4.05-1 involving a U.S. or foreign flag commercial vessel. The following criteria applies:

- When a preliminary investigation reveals that a reportable marine casualty as defined in 46 CFR 4.05-1 has in fact occurred, the level of investigative effort shall be raised to a data collection activity, informal investigation, or formal investigation.
- When a preliminary investigation reveals that a marine casualty meets the MISLE Data Entry Exemption below, is not reportable under 46 CFR 4.05-1, or it cannot be verified that a marine casualty has occurred, no additional investigative effort is required and the results of the preliminary investigation shall be documented in MISLE in accordance with the Investigations and Enforcement Process Guide.
- Investigations closed at the preliminary level never require finding of fact (timeline) entries.

Data Collection Activities A data collection activity shall be conducted for all reportable marine casualties as defined in 46 CFR 4.05-1 not assigned to Informal Investigation or Formal Investigation. MISLE data entry requirements shall be in accordance with the Investigations and Enforcement Process Guide.

- MISLE incident Investigation Data Entry. Normally, the reported casualty information should be entered into MISLE with only minimum effort expended to verify its accuracy and completeness in accordance with the Investigations and Enforcement Process Guide. The intent of this policy is to reduce the unit workload resulting from investigation of minor marine casualties to an absolute minimum while retaining basic event information for trend and statistical analysis.
- MISLE Incident Investigation Data Entry Exceptions. No MISLE data entry beyond the MISLE notification information is necessary or desired for marine casualties meeting the below criteria. For incidents meeting this criteria, the CG-2692 and any other material received should be documented in the notification after minimal review to verify that the incident meets one of the criteria. When feasible, the unit shall electronically attach the CG-2692 and other material to the MISLE notification. Until that time, the CG-2692 and other material shall be sent to Commandant in accordance with current policy.
 1. Groundings involving "bump and go" touching of the bottom on Western Rivers (as defined in 33 USC 2003) by uninspected towing vessels and uninspected barges in the navigation channel with no damage, no pollution, no personnel injuries, no breaking apart of the tow, and no assistance required to resume voyage.
 2. Casualties involving only minor injury. A minor injury is any injury that does not result in broken bones (other than fingers, toes, or nose), loss of limbs, severe hemorrhaging, severe muscle, nerve, tendon, or internal organ damage, or in hospitalization for more than 48 hours within 5 days of the injury.

AppendixD
Coast Guard's G-MOA Policy Letter 2-02

3. Casualties involving injuries when the injuries result from a pre-existing medical condition and not from a marine operation. (Le. a mariner with **diabetes** suffers a spell of blurry vision, and during the spell trips because he did not see a deck fitting and breaks a leg.) If the mariner holds license or merchant mariner's document the incident should be investigated to **determine** if suspension and revocation proceedings should be pursued by reason of medical incompetence.
4. Casualties (other than collisions and allisions) reported only because of property damage in excess of \$25,000 where the property damage does not exceed \$100,000.
5. Casualties involving U.S. state-numbered commercial vessels exempt from reporting to the Coast Guard under 46 CFR 4.01-3(a), **unless** a formal or informal investigation is conducted.

Informal Investigations An informal investigation should be conducted for any casualty involving a U.S. or foreign flag commercial vessel and meeting any of the below criteria. MISLE data entry requirements shall be in accordance with the Investigations and Enforcement Process Guide.

- **Death**: One death. Death cases may be downgraded to the *Data Collection Activity* level of investigation after credible evidence (such as a death certificate) indicates death from natural causes (including a pre-existing medical condition) or suicide.
- **Injury**: One injury which results in **fractured bones** (other than fingers, toes, or nose), loss of limbs, severe **hemorrhaging**, severe muscle, **nerve, tendon**, or internal organ damage, or in hospitalization for more than 48 hours within 5 days of the injury.
- **Vessel loss**: Loss of an uninspected vessel of less than 500 GT, or loss of a barge of more than 100 GT on inland waters (as defined in 33 USC 2003).
- **Property damage**: An event involving a vessel and resulting in property damage exceeding \$100,000 but less than \$1,000,000. The damage value comprises the cost of labor and material to restore the property (vessels, shoreline facilities, pipelines, OCS facilities, etc.) to its original condition before the occurrence, but does not include damage to natural resources, or the cost of salvage, cleaning, gas-freeing, dry-docking, or demurrage. Damage values should be the best estimates available immediately following the accident.
- **Collision**: Any collision or allision resulting in property damage exceeding \$25,000.
- **Loss of propulsion or steering**: Any loss of propulsion or steering, even if momentary, affecting an inspected U.S. vessel anywhere, or affecting a foreign flag vessel or an uninspected U.S. vessel over 100 GT on U.S. navigable Waters.
- **Flooding or fire**: Flooding or fire that adversely affect a vessel's fitness for service on an inspected U.S. vessel anywhere, or on a foreign flag vessel or an uninspected U.S. vessel over 100 GT on U.S. navigable waters.

Appendix D
Coast Guard's G-MOA Policy Letter 2-02

- Equipment failure: Failure of Coast Guard-approved **primary** lifesaving equipment or Coast Guard-approved firefighting equipment.
- Discharge: Medium discharge of oil or medium release of a hazardous substance (as defined in 40 CFR 300.5), or of hazardous cargoes regulated under 46 CFR Subchapter O, in which a vessel is the source or the cause of the discharge or release.
- Commercial Diving Casualty: Death or injury of persons diving from a vessel for commercial purposes.
- Recreational Diving Casualty: Death or injury of persons diving from a vessel in federal waters for recreational purposes.

Formal Investigation A formal investigation should be conducted for any casualty involving a U.S. or foreign flag commercial vessel and meeting any of the below criteria. MISLE data entry requirements shall be in accordance with the Investigations and Enforcement Process Guide.

- Death: 2 or more deaths.
- Injury: 2 or more seriously disabling injuries or 6 or more injuries which result in fractured bones (other than fingers, toes, or nose), loss of limbs, severe hemorrhaging, severe muscle, nerve, tendon, or internal organ damage, or in hospitalization for more than 48 hours within 5 days of the injury.
- Vessel loss: Loss of an **inspected** vessel, or loss of an uninspected vessel of 500 GT or more.
- Property damage: An event involving a vessel and resulting in property damage exceeding \$1,000,000. The damage value comprises the cost of labor and material to restore the property (vessels, shoreline facilities, pipelines, OCS facilities, etc.) to its original condition **before** the occurrence, but does not include damage to natural resources, or the cost of salvage, **cleaning, gas-freeing, dry-docking, or demurrage**. Damage values should be the best estimates available immediately following the accident.
- Discharge: Major discharge of oil or major release of a hazardous substance (as defined in 40 CFR 300.5), or of hazardous cargoes regulated under 46 CFR Subchapter O, in which a vessel is the source or the cause of the discharge or release.

Foreign Flag Exception: A formal investigation is not required for a casualty involving **only** a foreign flag vessel (i.e., no U.S. vessel involved, no damage to U.S. property, and no injury of U.S. citizens).

Barge Exception: A formal investigation is not required for the loss of a barge on inland waters (as defined in 33 USC 2003).

AppendixE
Responses to Committees' Concerns

The Committee on Transportation and Infrastructure of the House of Representatives and the Committee on Commerce, Science and Transportation of the Senate requested us to examine the extent to which marine casualty investigations and reports result in information and recommendations that prevent, minimize the effect of, and maximize lives saved in similar casualties. See Appendix C for the Committees' request. The Committees also suggested that our review include the following:

- a. The adequacy of resources to marine casualty investigations considering caseload and duty assignment practices. The majority of personnel conducting marine casualty investigations are not qualified to conduct investigations, and the resources for the review and closure process of investigations are inadequate, resulting in a substantial backlog of investigations at Coast Guard headquarters.
- b. The training and experience of marine casualty investigators. 15 of the 22 marine casualty investigators who we tested were not qualified under Coast Guard policy to conduct these investigations. Also, 3 of 15 marine casualty investigators have not taken either the basic or advanced marine casualty training course. Further, marine casualty investigators are not generally in their positions for more than one tour of duty at the same location. According to Coast Guard personnel, a reasonable career path to become an experienced marine casualty investigator would entail more than one tour of duty in the same location. Increasing the number of civilians in the marine casualty investigations program or extending the tour of duty for Coast Guard personnel could result in increased knowledge of local waterways and industries.
- c. Investigation standards and methods, including a comparison between the Formal and Informal investigation processes. Informal investigations are less exhaustive than formal investigations, but still include the determination and reporting of the causal factors. Formal investigations are reserved for the more serious or significant casualties where the most value can be gained.
- d. The use of best investigation practices considering transportation investigation practices used by other federal agencies and foreign government, including British Marine Accident Investigation programs. The United Kingdom's Marine Accident Investigation Branch, Australian Transportation Safety Board, and Transportation Safety Board of Canada focus on maritime safety and do not assign fault or determine civil or criminal liabilities. Similarly, the United States National Transportation Safety Board does not assign fault or determine

AppendixE
Responses to Committees' Concerns

liabilities, but is focused on safety and preventing similar casualties. Further, these organizations on average conduct 18 marine casualty investigations per year, while the Coast Guard on average conducts 3,800 investigations, including approximately 266 informal and formal investigations per year. Also, these organizations do not have enforcement powers. According to Coast Guard officials, the Coast Guard's enforcement powers and assignment of fault do not prevent the Coast Guard from determining the causal factors of the marine casualties.

- e. Usefulness of the marine casualty database (MISLE) for marine casualty prevention programs. While there are various types of data input errors in MISLE, it is useful. With a thorough review at Coast Guard headquarters, these errors could be further minimized. Coast Guard provides routine training to the field personnel for MISLE. Coast Guard officials stated MISLE is a better system than the previous system; it is user-friendly and can be used to identify patterns with casualties. Yet, these officials and an official from an external entity stated that in some areas the causal analysis function could be improved. Safety advisory committees and other customers have used MISLE data. The Towing Safety Advisory Committee used MISLE data to develop a report regarding the proposed towing vessel inspection regulations. This report utilized Coast Guard-gathered marine casualty data on towing vessels from 1994-2005. This information was used to determine the severity and causes of these marine casualties.
- f The extent to which the marine casualty data and information have been used to improve survivability and habitability of vessels involved in marine casualties. The Coast Guard has issued numerous safety alerts and recommendations based on its marine casualty investigations. For example, as a result of a charter fishing vessel capsizing while crossing the Tillamook Bay Inlet in Oregon, the Coast Guard issued a risk based matrix to mariners to determine whether crossing of the inlet was permitted. Another example resulted from multiple allisions by a casino vessel with the St. John's Pass Bridge, in St. Petersburg, Florida. The Coast Guard came to an agreement with the casino operators not to pass by the bridge unless currents and winds are at a safe level. Sector Hampton Roads issued a safety alert for full body harnesses for towing vessel operators, which, according to a towing vessel operator, vastly improved the safety in the industry. The Coast Guard also issues safety alerts for general operations, cargo operations, engineering, navigation equipment, and safety equipment. These safety alerts and recommendations by the Marine Casualty Investigations Program contribute to the general safety of the waterways.

AppendixE
Responses to Committees' Concerns

- g. Any changes to current statutes that would clarify Coast Guard's responsibilities for marine casualty investigations and reports. Although we did not identify any required changes in statutes or regulations regarding marine casualty investigations, we did identify conflicting interpretations and applications of the Coast Guard's September 2002 policy letter. For example, per the policy letter, loss of propulsion should be investigated at the informal level. However, some marine casualty investigators define loss of propulsion as lost propulsion from one engine even though there might be multiple engines, whereas others defined loss of propulsion as when a vessel cannot remain underway. In addition, the dollar estimates for damages should be updated to reflect more current costs of repair. The Coast Guard should review the criteria for various levels of investigations and make appropriate changes, and ensure that the criteria are consistently applied throughout the Coast Guard. Further, the Coast Guard must finalize an updated version of the Marine Safety Manual.
- h. The extent to which the Coast Guard has reduced the frequency of Formal investigations, or changed the types of incidents for which it has carried out Formal investigations, in the past five years. Based on our review of an extract from the MISLE database on the 15,327 marine casualties that occurred during the period January 1, 2003 through October 31, 2006, the Coast Guard conducted 13 formal investigations. However, based on our testing, we identified an additional 134 marine casualties that should have been conducted at the formal level. The Coast Guard conducted these investigations at the lesser informal or data collection activity levels.

Appendix F
Major Contributors to this Report

Washington, D.C. Office

Richard T. Johnson,
Director, Coast Guard and Maritime Security Operations Division

Boston, MA Field Office

Maureen Duddy, Auditor Manager
Edward Jeye, Auditor-in-Charge
Michael Brunelle, Program Analyst
Lindsey Cabral, Auditor
David DeHaven, Auditor
Paul Exarchos, Program Analyst
Jeanne Genao, Program Analyst
Colin Sullivan, Auditor

Appendix G
Report Distribution

Department of Homeland Security

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Deputy Chief of Staff
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Director, GAO/DIG Liaison Office
Assistant Secretary for Office of Policy
Assistant Secretary for Office of Public Affairs
Assistant Secretary for Office of Legislative Affairs
Commandant, USCG
USCG Audit Liaison

Office of Management and Budget

Chief, Homeland Security Branch
DHS DIG Budget Examiner

Congress

Committee on Transportation and Infrastructure of the House of
Representatives
Committee on Commerce, Science and Transportation of the Senate
Congressional Oversight and Appropriations Committees, as appropriate



Additional Information and Copies

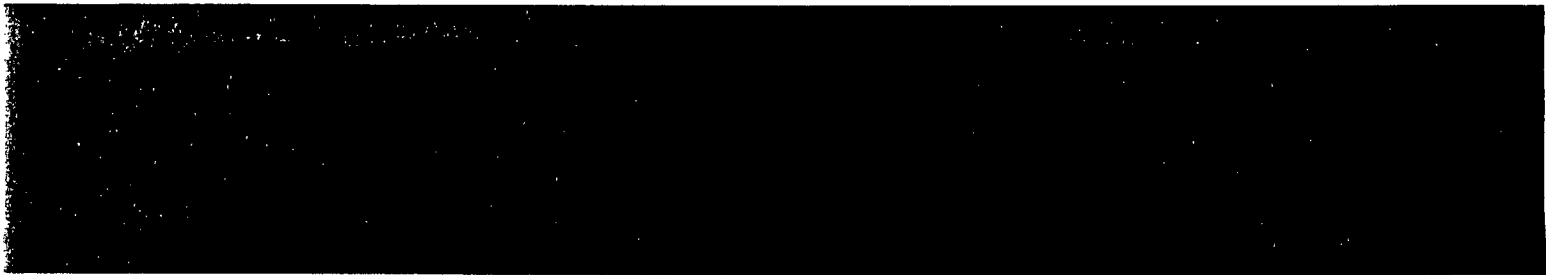
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- Write to us at:
DHS Office of Inspector General/MAIL STOP 2600, Attention:
Office of Investigations - Hotline, 245 Murray Drive, SW, Building 410,
Washington, DC 20528.

The OIG seeks to protect the identity of each writer and caller.



Department of Homeland Security Office of Inspector General

Marine Accident Reporting, Investigations, and
Enforcement in the United States Coast Guard





OFFICE OF INSPECTOR GENERAL

Department of Homeland Security

Washington, DC 20528 / www.oig.dhs.gov

MAY 23 2013

MEMORANDUM FOR: Rear Admiral Stephen P. Metruck
Assistant Commandant for Resources and
Chief Financial Officer
United States Coast Guard

FROM: Anne L. Richards *Anne L. Richards*
Assistant Inspector General for Audits

SUBJECT: *Marine Accident Reporting, Investigations, and
Enforcement in the United States Coast Guard*

Attached for your action is our final report, *Marine Accident Reporting, Investigations, and Enforcement in the United States Coast Guard*. We incorporated the formal comments from the United States Coast Guard in the final report.

Based on information provided in your response to the draft report, we consider recommendations 1 through 3 and 5 through 7 open and resolved, and recommendation 4 resolved and closed. As prescribed by the Department of Homeland Security Directive 077-01, Follow-Up and Resolutions for Office of Inspector General Report Recommendations, within 90 days of the date of this memorandum please provide a written update for each open recommendation. Once your office has fully implemented the open recommendations, please submit a formal closeout letter to us within 30 days so that we may close the recommendations. The memorandum should be accompanied by evidence of completion of agreed-upon corrective actions.

Consistent with our responsibility under the *Inspector General Act*, we are providing copies of our report to appropriate congressional committees with oversight and appropriation responsibility over the Department of Homeland Security. We will post the report on our website for public dissemination.

Please call me with any questions, or your staff may contact Mark Bell, Deputy Assistant Inspector General for Audits, at (202) 254-4100.

Attachment



OFFICE OF INSPECTOR GENERAL
Department of Homeland Security

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Abbreviations

CFR	Code of Federal Regulations
CGBI	Coast Guard Business Intelligence
CY	calendar year
DHS	Department of Homeland Security
GAO	Government Accountability Office
INCOE	Investigations National Center of Expertise
MISLE	Marine Information for Safety and Law Enforcement
MSM	<i>Marine Safety Manual</i>
MSU	Marine Safety Unit
NOV	Notice of Violation
OIG	Office of Inspector General
USCG	United States Coast Guard



OFFICE OF INSPECTOR GENERAL

Department of Homeland Security

Executive Summary

The purpose of the investigations program in the United States Coast Guard (USCG) is to ensure the safety of mariners and vessel passengers by preventing marine accidents, protecting the environment from oil spills, and minimizing property loss and disruptions to commerce. The USCG is responsible for identifying, investigating, and enforcing reporting requirements related to marine accidents involving commercial vessels. Our audit objective was to determine whether the USCG has adequate processes to investigate, take corrective actions, and enforce Federal regulations following reported marine casualties.

The USCG does not have adequate processes to investigate, take corrective actions, and enforce Federal regulations related to the reporting of marine accidents. These conditions exist because the USCG has not developed and retained sufficient personnel, established a complete process with dedicated resources to address corrective actions, and provided adequate training to personnel on enforcement of marine accident reporting. As a result, the USCG may be delayed in identifying the causes of accidents; initiating corrective actions; and providing the findings and lessons learned to mariners, the public, and other government entities. These conditions may also delay the development of new standards, which could prevent future accidents.

We made seven recommendations to improve the efficiency and effectiveness of USCG's marine accident investigations and enforcement of reporting requirements. USCG has concurred with all seven recommendations and is implementing corrective actions.



OFFICE OF INSPECTOR GENERAL

Department of Homeland Security

Background

USCG is charged with preventing and responding to major marine accidents. Its Marine Safety Program is responsible for ensuring the safety of tens of thousands of U.S. mariners and millions of passengers on ferries and other vessels. Through the prevention of marine accidents, which minimizes property loss and disruptions to maritime commerce, the USCG also protects the marine environment from oil spills and the introduction of other harmful substances, and strengthens the economy.

The USCG Marine Safety Program accomplishes these goals through a multifaceted approach that includes standards development, compliance enforcement, investigation and casualty analysis, and public outreach. The program is responsible for ensuring the safe and environmentally sound operation of U.S. flagged vessels and foreign vessels operating in U.S. waters. The USCG is the lead Federal agency for operations within the nation's marine transportation system, which consists of 25,000 miles of inland, intracoastal, and coastal waterways. According to the Marine Safety Performance Plan, the majority of the Nation's food, clothing, oil, and other raw materials reach warehouses, stores, and gas tanks through use of the marine transportation system.

The USCG reported that it conducted approximately 6,200 incident investigations for reportable vessel and pollution marine accidents in 2011, using teams of inspections and investigations staff. Inspectors and investigators are required to train extensively, ensuring they have the proper knowledge to conduct investigations after accidents occur. The USCG has extensive training requirements and qualifications related to specific vessel types to ensure its staff has the requisite knowledge to identify accident causes and develop corrective actions to prevent accidents in the future.

This audit was initiated to review both the USCG's process for accident reporting and its personnel who respond to accidents once they are reported. Federal regulations mandate that mariners report marine accidents, including those that involve property damage of more than \$25,000 or injuries requiring treatment beyond first aid. Once an accident occurs that meets these requirements, mariners must immediately notify the USCG and then follow up with a written report of the accident within 5 days. Mariners failing to either immediately notify the USCG or file a written report can be cited with an enforcement action including a written warning, a Notice of Violation (NOV), or a Civil Penalty ranging up to \$35,000. The USCG is responsible for conducting accident investigations, identifying corrective actions that can prevent future accidents, and enforcing accident reporting requirements when mariners fail to immediately notify the USCG of an accident and file a written report.



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Results of Audit

The USCG does not have adequate processes or sufficient personnel to investigate, take corrective actions, and enforce regulations related to the reporting of marine accidents as required by Federal regulations and USCG policy. These conditions exist because the USCG has not developed and retained sufficient personnel, established a process with dedicated resources to address corrective actions, and provided adequate training. As a result, the USCG may be delayed in identifying the causes of accidents; initiating corrective actions; and providing the findings and lessons learned to mariners, the public, and other government entities. These conditions may also delay the development of new standards that could prevent future accidents.

Coast Guard Marine Accident Response Personnel

The USCG has not developed and retained sufficient staff to perform inspections and investigations work in response to marine accidents, and does not have a sufficient number of qualified staff to train new inspectors and investigators.¹ In addition, the Director of Prevention Policy provides personnel with career management guidance that suggests they should leave this specialty to improve their promotion potential, because of the USCG's emphasis on personnel attaining a wide variety of experience. Personnel indicated that both investigations and inspections suffer from investing time and money into training people only to have them leave the specialty. The USCG has initiated development of a Human Capital Plan to revamp its career guidance and improve retention, but it has not yet finalized and implemented this plan. The *Coast Guard Authorization Act of 2010*, as amended, allows promotions by specialty in order to encourage retention and continuity to maintain sufficient, qualified personnel. However, the USCG has not implemented these provisions of the Act.

In 2011, the USCG established requirements for inspectors and investigators, which included formal training, on-the-job training, and work experience to ensure that personnel can perform their assigned duties. The USCG's Investigations Division is primarily responsible for conducting investigations into marine accidents. However, according to USCG personnel, inspectors are part of the two-person team that responds to marine accidents. To determine if staff met these requirements, we conducted testing at five sites for inspections personnel and six sites for investigations personnel. Although the USCG has made some progress in training personnel, the majority of inspectors and

¹ Qualifications were established for inspectors and investigators, with new guidance issued in October 2011.



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investigators did not meet USCG's requirements for their assigned positions, as shown in Figures 1 and 2.²

Personnel Meeting United States Coast Guard Qualifications³

Figure 1. Inspections Personnel

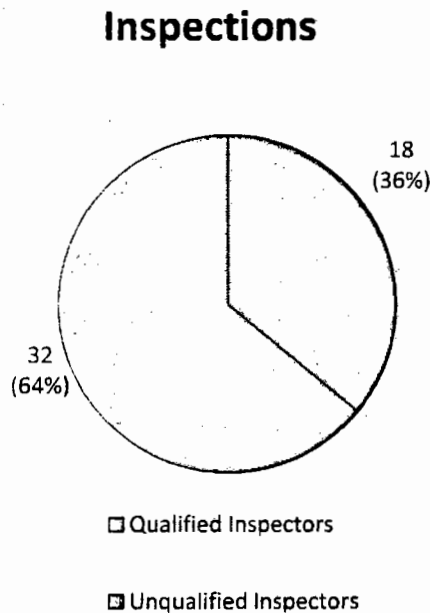
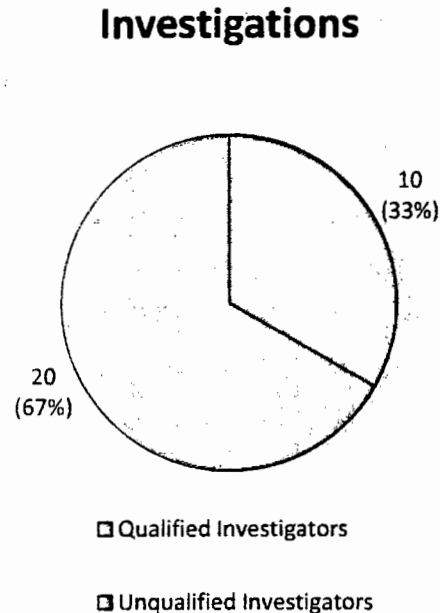


Figure 2. Investigations Personnel



The USCG established an Investigations National Center of Expertise (INCOE) to provide crucial, time-sensitive guidance for a variety of complex investigative issues. Specifically, INCOE personnel provide on-scene support for major marine accidents and assist in certifying the qualifications of local office investigators. However, testing of staff qualifications (see Figure 2) revealed that the majority of INCOE personnel did not meet the USCG requirements to be assigned as investigators. In fact, only two of eight (25 percent) of the investigations staff met those requirements.

According to the USCG, there is a shortage in the number of personnel assigned to inspections positions. This shortage will be further compounded when the regulations implementing the *Coast Guard and Maritime Transportation Act of*

² The USCG has different levels of inspectors, including apprentice, journeymen, and advanced journeymen marine inspectors. Testing results include journeymen and advanced journeymen, positions which require previous inspections experience and qualifications to inspect specific vessels.

³ Qualifications were established for inspectors and investigators, with new guidance issued in October 2011.



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2004, as amended, are phased in, which will expand the inspections workload. The Act requires the USCG to inspect approximately an additional 5,200 traditional towing vessels, 1,800 assistance vessels, and other vessels engaged in towing.

Some local USCG office staff maintain that it is difficult to complete inspections and investigations with current resources. Without sufficient qualified staff, the USCG will not be able to complete future inspections and investigations in a timely manner, which may reduce marine safety.

Corrective Actions

The USCG investigations and inspections processes do not ensure that all investigations and Traveling Inspections corrective actions are addressed and implemented. Corrective actions, in the form of safety recommendations, result from both investigations of marine casualties and reports by the USCG's traveling inspectors—very experienced inspectors stationed at headquarters who visit field units to assist with unique inspections issues. The USCG is unable to ensure that all corrective actions are addressed because it does not have complete processes and dedicated resources to track, review, and implement recommendations for all investigations and Traveling Inspections reports.

According to USCG personnel in charge of the corrective action process, no formal, written instructions or policies exist to ensure recommendations are addressed and implemented. Without a complete process, the USCG risks delays in implementing safety improvements and preventing future accidents.

The USCG's Traveling Inspectors also do not have a process for addressing safety recommendations contained in their reports. They visit local offices to provide assistance on complex inspections issues, such as inspections of complex vessels. Following these visits, they issue reports on their determinations, which include safety recommendations for preventing future inspections issues. After Traveling Inspectors issue their reports, however, they do not follow up with the associated local office or track the implementation of their safety recommendations. According to USCG personnel, each office that requests the Traveling Inspectors' assistance is solely responsible for addressing the report's safety recommendations. We notified the USCG about these deficiencies, and it already has taken action by implementing a process to ensure recommendations are tracked and implemented.



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Open Investigations

The absence of dedicated resources has caused a backlog of more than 6,000 open investigations, which include safety recommendations that need to be addressed. However, safety recommendations cannot be addressed until headquarters closes the associated investigations. Therefore, USCG will be unable to address these safety recommendations in a timely manner without dedicated resources.

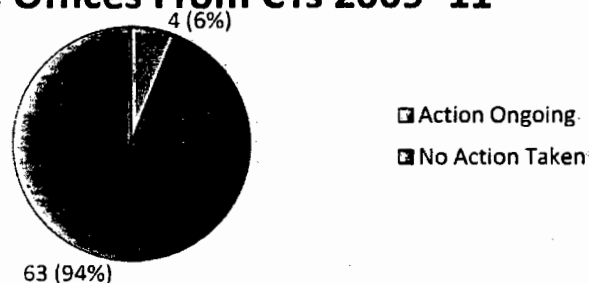
Open Recommendations

USCG policy describes that the purpose of safety recommendations is to propose corrective actions the USCG can implement to prevent unsafe conditions from contributing to future casualties. If corrective actions are not addressed and implemented in a timely manner, preventable marine accidents may occur, resulting in the loss of life or property, injuries, pollution, or unnecessary use of USCG resources.

To assess the USCG's safety recommendations process, testing was conducted to determine whether it had taken any action on safety recommendations from investigations initiated in calendar years (CY) 2009–11. Review of a judgmental sample of 67 local office safety recommendations indicated that the USCG had not initiated implementation on the vast majority of corrective actions (see Figure 3). Of the 63 recommendations upon which no action has been taken, 49 have been awaiting headquarters review for more than a year.

Figure 3. Safety Recommendations by Local Offices From CYs 2009–11

Safety Recommendations by Local Offices From CYs 2009–11*



*Recommendations with action ongoing include those with statuses indicating the USCG is currently addressing them. Recommendations with no action taken include those with statuses indicating they are open pending decisions or investigations, were closed by the USCG without action, and have a status of "N/A."

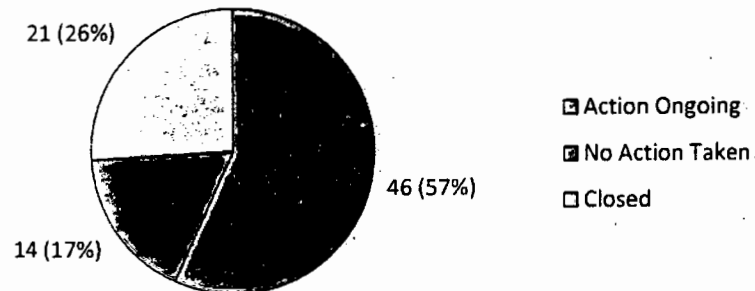


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In contrast, a review of a judgmental sample of 81 safety recommendations that USCG headquarters prepared indicated that it had closed or initiated action on the majority of those recommendations, as summarized in Figure 4. The USCG has done a better job addressing headquarters safety recommendations because the investigations are larger and higher profile.

Figure 4. Safety Recommendations by Headquarters Offices From CYs 2009–11

**Safety Recommendations by
Headquarters Offices From CYs 2009–11***



*Recommendations with action ongoing include those with statuses indicating the USCG is currently addressing them. Recommendations with no action taken include those with statuses indicating the USCG did not concur and those that have no status. Closed recommendations have been completely addressed.

Enforcement

At the local office level, the USCG does not consistently enforce requirements related to reporting marine accidents. According to the *Marine Safety Manual* (MSM), the investigator must provide at least a formal written warning for any violation of marine accident reporting requirements. For more serious offenses, the penalty increases to a NOV, or a Civil Penalty up to \$35,000. Site visits to local offices revealed inconsistencies in how investigators handled enforcement actions. For example, some offices do not always issue written warnings as required, but rather provide verbal warnings that are not documented or tracked. Personnel do this because they believe it is more effective to engage the mariners in a discussion and educate them on reporting requirements. However, the insufficient documentation makes it difficult for USCG to track marine accident history for future enforcement. USCG's MSM indicates that enforcement actions do not include verbal warnings.

Civil Penalties are one tool available to the USCG investigators to ensure compliance with statutes and regulations. For all violations, "it is imperative that



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penalties exceed the benefits of noncompliance.”⁴ For example, the penalty assessed on an individual or company that has spilled oil must be high enough to encourage the entity to take steps to prevent spills. If the penalty assessed does not exceed the economic benefits of noncompliance, there is little incentive for future compliance. For violations of marine casualty reporting requirements, the USCG Commandant’s Instructions on Civil Penalty Procedures specifically indicate that a violation “warrants the initiation of a Civil Penalty and/or other remedial action.”

When the USCG initiates a Civil Penalty, investigators should comply with case development guidance issued by the USCG Hearing Office. The Hearing Office is responsible for reviewing and making the final determinations on Civil Penalty cases. Guidance issued by the Hearing Office stipulates that a Civil Penalty is not a punishment and that the amount recommended by the local office should be only that which is necessary to achieve compliance and deterrence. When investigators assemble a Civil Penalty case, they must provide evidentiary support for each element of the charged violation(s), and may include evidence of factors that influenced the penalty amount they recommended. A Hearing Officer reviews the case to verify allegations; he or she considers local office recommendations, but makes a determination on the appropriate penalty amount. Hearing Officers consider a number of factors in making a determination on the appropriate penalty, including prior violation history, extenuating or mitigating circumstances, and the gravity of the offense.

USCG guidance requires Hearing Officers to provide the local office with feedback to facilitate the submission of better cases in the future. However, USCG field personnel stated that the Hearing Office does not always provide sufficient feedback. Even though the Hearing Office may also provide general training on the Civil Penalty process and the role of the Hearing Officer, USCG personnel indicated it has done so only once. Providing additional feedback and training to investigations personnel may improve the civil penalty process and case development.

When Civil Penalties are used, those penalties are often reduced. Between CYs 2009–11, the Hearing Office reviewed 66 Civil Penalty cases, which included 81 citations alleging violations of marine casualty reporting requirements. Of the 81 citations reviewed, the Hearing Office found 62 (77 percent) to be proven.

USCG should provide more training to investigation personnel on the Civil Penalties process. The Investigating Officer Course at the USCG Training Center

⁴ Civil Penalty Procedures and Administration, Commandant Instruction 16200. 3A, issued October 16, 1992.



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in Yorktown, Virginia, dedicates only 4 hours of a 4-week course to instruction on the Civil Penalty process. The training center has identified enforcement training as a particular area of weakness. It stated that the administrative enforcement case preparation and investigative process is a vital skill set that USCG personnel need to have to ensure that evidence required to support an alleged violation of law or regulations is properly supported. Currently, the USCG has no formal or informal training process for personnel preparing enforcement cases. As result, this training gap has fostered broad inconsistencies in how these cases are prepared and has had a negative effect on the ability of USCG personnel to exercise investigative and enforcement responsibilities. Therefore, personnel have requested that USCG headquarters consider adding a course geared specifically toward enforcement.

Enforcement actions are the USCG's method of ensuring compliance with marine reporting requirements. Without consistent application of the enforcement requirements, there is no effective deterrent to mariners' failure to report accidents. As a result, mariners may not be reporting marine accidents to the USCG, potentially reducing marine safety. At the same time, many USCG offices proactively seek to make mariners aware of reporting requirements through Industry Days, which are educational outreach events covering a variety of topics. According to one USCG official, one local office has even reached out to area hospitals to make them aware of reporting requirements.

Although the USCG has conducted significant outreach, more needs to be done to ensure compliance with accident reporting requirements. It must properly enforce regulations outlined in statute to enhance marine safety.

Conclusion

The USCG has not developed and retained sufficient staff, ensured all corrective actions are addressed and implemented, and needs to enforce requirements related to reporting marine accidents consistently. As a result, it may be delayed in identifying causes of accidents; initiating corrective actions; and providing the findings and lessons learned to mariners, the public, and other government entities. These conditions may also delay the development of new standards, which could prevent future accidents.



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Recommendations

We recommend that the USCG Assistant Commandant for Resources and Chief Financial Officer implement the following recommendations to improve the efficiency and effectiveness of the USCG's marine accident investigations and enforcement of reporting requirements:

Recommendation #1:

Implement an investigations and inspections retention plan to ensure qualified personnel are retained within the inspections and investigations specialties.

Recommendation #2:

Revise and strengthen its personnel management policies by implementing provisions of the *2010 Coast Guard Authorization Act*, which allows promotions by specialty for marine inspectors and investigators to foster retention and continuity.

Recommendation #3:

Develop a complete process with sufficient resources to review, track, and address all recommendations resulting from investigations reports.

Recommendation #4:

Develop a formalized process with sufficient resources to review, track, and address all recommendations resulting from Traveling Inspections reports.

Recommendation #5:

Provide training and guidance to all investigations personnel on all enforcement options.

Recommendation #6:

Develop Civil Penalty enforcement training guidelines for preparing and supporting Civil Penalty cases for all investigations staff. USCG should consider using officers with previous experience in the Hearing Office to complete this task.



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Recommendation #7:

Instruct the Hearing Office to provide feedback in accordance with existing policy.

Management Comments and OIG Analysis

The USCG provided formal comments to our report. A copy of the USCG's response in its entirety is included as Appendix B. The USCG also provided technical comments and suggested revisions to our report in a separate document. We reviewed the technical comments and made changes in the report when appropriate.

The USCG concurred with all seven recommendations, and has formulated plans to implement the recommendations contained in the report. A summary of the responses and our analysis follows.

Response to Recommendation #1: **Concur.** The USCG has already taken action and is pursuing additional measures. It is currently developing a Maritime Prevention Enhancement Plan that will continue and refine improvement efforts, including a consistent focus on retaining prevention professionals. It expects to complete this plan in fiscal year 2014.

OIG Analysis: The USCG's response addresses the intent of our recommendation. The recommendation will remain open and resolved until we can verify, through review of supporting documentation, that the USCG has completed the development of a Maritime Prevention Enhancement Plan that provides a consistent focus on retaining prevention professionals.

Response to Recommendation #2: **Concur.** The USCG anticipates establishing policies which allow for the utilization of Enhanced Status Quo, as authorized in the *Coast Guard Authorization Act of 2010*. The USCG expects to initiate its corrective actions during 2014.

OIG Analysis: The USCG's response addresses the intent of our recommendation. The recommendation will remain open and resolved until we can verify, through review of supporting documentation, that the USCG has established policies which allow for the utilization of Enhanced Status Quo, as authorized in the *Coast Guard Authorization Act of 2010*.

Response to Recommendation #3: **Concur.** The USCG will establish national policy to track all actions on safety recommendations. In the interim, the USCG will develop an aide/tool to assist USCG Headquarters program offices and other



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units in the tracking of safety recommendations for which they are responsible. In the long term, Marine Information for Safety and Law Enforcement (MISLE) and Coast Guard Business Intelligence (CGBI) system functionality will be developed to provide the means to carry out requirements of the national policy. The anticipated implementation date is end of CY 2013 for interim aide tool development and CY 2014 for long-term MISLE/CGBI functionality.

OIG Analysis: The USCG's response addresses the intent of our recommendation. The recommendation will remain open and resolved until we can verify, through review of supporting documentation, that the safety recommendation process has been strengthened based on the interim actions, national policy, and long-term plans.

Response to Recommendation #4: Concur. The USCG has implemented a database and process to track, follow up, and address Traveling Marine Inspector Report recommendations. The USCG considers Recommendation #4 closed as of October 2012.

OIG Analysis: The USCG's actions satisfy the intent of the recommendation and it has provided documentation to support full implementation of the necessary corrective actions. The recommendation is closed.

Response to Recommendation #5: Concur. The USCG is working to develop an Enforcement Course, which will provide education and training on how to properly investigate and document NOV and Civil Penalty enforcement actions. This course will include violation selection and analysis, casework write-up, and documentation in the MISLE database. The anticipated implementation date is fiscal year 2014, pending the availability of training funding.

OIG Analysis: The USCG's response addresses the intent of our recommendation. The recommendation will remain open and resolved until we can verify, through review of supporting documentation, that the enforcement course has been developed and all investigations staff have received the training.

Response to Recommendation #6: Concur. The USCG will ensure the training guidelines for preparing and documenting a Civil Penalty are included in the curriculum developed for the Enforcement Course. Course development includes soliciting recommendations from accomplished performers in the field to include within the curriculum. The anticipated implementation date is fiscal year 2014.



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OIG Analysis: The USCG's response addresses the intent of our recommendation. The recommendation will remain open and resolved until we can verify, through review of supporting documentation, that the enforcement training guide and course has been developed and all investigations staff have received the training.

Response to Recommendation #7: Concur. The USCG's Judge Advocate General will instruct Hearing Officers to provide feedback in accordance with Chapter 2.C of Commandant Instruction MI6200.5A, consistent with their assigned duties. The anticipated implementation date is fiscal year 2014.

OIG Analysis: The USCG's response addresses the intent of our recommendation. The recommendation will remain open and resolved until we can verify, through review of supporting documentation, that the Judge Advocate General has instituted a new instruction requiring feedback to the field on cases reviewed by the Hearing Office.



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Appendix A Objectives, Scope, and Methodology

The Department of Homeland Security (DHS) Office of Inspector General (OIG) was established by the *Homeland Security Act of 2002* (Public Law 107-296) by amendment to the *Inspector General Act of 1978*. This is one of a series of audit, inspection, and special reports prepared as part of our oversight responsibilities to promote economy, efficiency, and effectiveness within the Department.

We conducted this audit to determine whether the USCG has adequate processes for investigating and taking corrective actions following reported marine casualties, and for enforcement of reporting requirements outlined in 46 CFR 4.05-1 and 46 CFR 4.05-10. We conducted site visits to—

Coast Guard Headquarters	Sector Puget Sound – Seattle, WA
Coast Guard Hearing Office – Arlington, VA	MSU Morgan City – Morgan City, LA
Sector Boston – Boston, MA	MSU Chicago – Chicago, IL
Sector Delaware Bay – Philadelphia, PA	Marine Safety Detachment Peoria – Peoria, IL
Sector Houston/Galveston – Houston, TX	INCOE in New Orleans – New Orleans, LA
Sector New Orleans – New Orleans, LA	National Mariners Association – New Orleans, LA
Sector Upper Mississippi River – St. Louis, MO	Three law enforcement agencies – Boston, MA
Sector San Francisco – San Francisco, CA	Two marine industry companies – Boston, MA

We based our site visit selections on marine accident investigation numbers reported in the USCG system, and identified the locations with the largest number of accidents and sites with varying areas of responsibility and waterways. At these site visits, we interviewed employees and officials, made direct observations, and reviewed applicable documents. We also interviewed officials at USCG's headquarters in Washington, DC.

We performed testing to verify whether marine inspectors and marine investigators had the qualifications, training, and experience required by the USCG to conduct investigations. We identified the USCG's current Marine Inspector Performance Qualification Standards and Marine Investigations Standards, and conducted testing of all personnel assigned to either a domestic inspector or investigation position at the time of our visit to determine if staff met the standards for their assigned position.



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We conducted this testing at the six sites we visited: Sector Delaware Bay, Sector Houston/Galveston, Sector Puget Sound, Sector San Francisco, Marine Safety Unit Chicago, and the National Center of Expertise.

We performed testing to determine if USCG was reviewing, addressing, and tracking corrective actions identified in investigation reports. We reviewed a judgmental sample of corrective actions identified by the field and corrective actions identified by USCG headquarters from CYs 2009–11. We also performed testing to determine if the field was enforcing accident reporting requirements and if the Hearing Office was upholding field enforcement actions. We reviewed all enforcement actions from CYs 2009–11.

We conducted this performance audit between January and December 2012 pursuant to the *Inspector General Act of 1978*, as amended, and according to generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based upon our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based upon our audit objectives.



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Appendix B
Management Comments to the Draft Report

U.S. Department of
Homeland Security

United States
Coast Guard



Commandant
United States Coast Guard

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Phone: (202) 372-3533
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7501

APR 23 2013

MEMORANDUM

From: *S. P. Metruck*
S. P. Metruck, RDML
COMDT (CG-8)

Reply to: Audit Manager
Attn of: Mark Kulwicki
(202) 372-3533

To: A. L. Richards
Assistant Inspector General for Audits
Department of Homeland Security (DHS)

Subj: DHS OIG DRAFT REPORT: "MARINE ACCIDENT REPORTING,
INVESTIGATIONS, AND ENFORCEMENT IN THE UNITED STATES COAST
GUARD"

Ref: (a) OIG Project No. 12-027-AUD-USCG, dated March 21, 2013

1. This memorandum transmits the Coast Guard's response to the findings and recommendations identified in reference (a).
2. The Coast Guard concurs with the report's recommendations.
3. If you have any questions, my point of contact is Mr. Mark Kulwicki who can be reached at 202-372-3533.

#

Enclosure: (1) USCG Response



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Department of Homeland Security

UNITED STATES COAST GUARD RESPONSE ON DHS OIG DRAFT REPORT OIG
PROJECT NO. 12-027-AUD-USCG – MARINE ACCIDENT REPORTING,
INVESTIGATIONS, AND ENFORCEMENT IN THE UNITED STATES COAST
GUARD

RECOMMENDATION AND USCG RESPONSE UPDATES

Recommendation #1: *Implement an investigations and inspections retention plan to ensure qualified personnel are retained within the inspections and investigations specialties.*

USCG Response: Concur with the intent of this recommendation - keeping in mind the Coast Guard has already taken action and has the intention of pursuing additional measures. The Coast Guard implemented a plan to improve competency and capacity in marine inspections and investigations - including specific measures to retain personnel in these fields. The Coast Guard Marine Safety Enhancement Plan (MSEP) issued in 2009 and other action taken since then improve retention in inspection and investigations billets by: establishing apprentice, journeyman and master journeyman tours; providing for back-to-back field tours for officers assigned as inspectors and investigators; requiring investigators to first be qualified inspectors; increasing the number of civilian inspector and investigators in the workforce; and enhancing the inspections and investigations training facilities and curriculum. The Coast Guard also initiated a prevention curriculum at the U.S. Coast Guard Academy to bring new officers into the program, and issued career guides that assist personnel in planning their careers, as well as showing junior officers that repeated tours in inspections and investigation may lead to positions of progressively greater responsibility within the program.

The Coast Guard is currently developing a Maritime Prevention Enhancement Plan (MPEP) that will continue and refine our improvement efforts, including a consistent focus on retaining prevention professionals.

Note that the Coast Guard has closed out the recommendations associated with OIG Report: *Revisions to the Marine Safety Performance Plan and Annual Update Supplement will Facilitate Improved Management* (OIG-11-22).

Recommendation #2: *Revise and strengthen its personnel management policies by implementing provisions of the 2010 Coast Guard Authorization Act, which allows promotions by specialty for marine inspectors and investigators to foster retention and continuity.*

USCG Response: Concur. The Coast Guard anticipates establishing policies which allow for the utilization of Enhanced Status Quo (ESQ), as authorized in the *Coast Guard Authorization Act of 2010*.

In order to utilize ESQ, several actions are being taken:

- (a) Identify each position with a talent need. The initial designation has been completed, and the positions are under continual review. This approach establishes the requirements which each talent area, or specialty, will be evaluated to determine the annual need for ESQ.
- (b) Identify the existing talent available. Approximately 3,900 active duty and 550 reserve officers were assigned officer specialty codes in the summer of 2012. This list requires validation from the officer corps, which will begin when the Officer Specialty Management System policy is published.

Enclosure (1)



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(c) Establish a means for new officers to earn a specialty designation. Policy and procedures for assigning officer specialty codes are pending approval. Specialty Program Managers have established and documented criteria for earning officer specialty codes.

(d) Promulgate Policies. Currently, the Officer Specialty Management System Manual is pending approval. The specific selection modification policy is under development.

Once these initiatives are fully implemented, then the Commandant will determine which specialties, if any, to apply the retention capability permitted by ESQ on an annual basis.

As provided in the *Coast Guard Authorization Act of 2010*, ESQ is not specific to the Marine Accident Investigation/Marine Inspector workforce. Needs within this workforce must be evaluated against all workforce requirements of the Coast Guard.

The anticipated implementation date is dependent upon successfully validating assignment of specialty codes for individual officers. OPM will begin sampling data during Promotion Year 2014 to build confidence in data accuracy. Once a reasonable confidence level is achieved, implementation will proceed.

Recommendation #3: *Develop a complete process with sufficient resources to review, track, and address all recommendations resulting from investigations reports.*

USCG Response: Concur. The Coast Guard will establish national policy to track all actions on safety recommendations. In the interim, the Coast Guard will develop an aide/tool to assist USCG Headquarters program offices and/or other units in the tracking of safety recommendations for which they are responsible. In the long-term, Marine Information for Safety and Law Enforcement (MISLE) and Coast Guard Business Intelligence (CGBI) system functionality will be developed to provide the means to carry out requirements of the national policy. The anticipated implementation date is end of calendar year 2013 for interim aide/tool development and calendar year 2014 for long term functionality in MISLE/CGBI.

Recommendation #4: *Develop a formalized process with sufficient resources to review, track, and address all recommendations resulting from Traveling Inspections reports.*

USCG Response: Concur. The Coast Guard has implemented a database and process to track, follow-up, and address Traveling Marine Inspector Report recommendations. The Coast Guard considers Recommendation #4 closed as of October 2012.

Recommendation #5: *Provide training and guidance to all investigations personnel on all enforcement options.*

USCG Response: Concur. The Coast Guard is working to develop an Enforcement Course which would provide education and training on how to properly investigate and document all Notice of Violation and Civil Penalty enforcement actions. This course would include violation selection and analysis, case work write-up, and documentation in MISLE database. The anticipated implementation date is fiscal year 2014, pending availability of training funding.

Recommendation #6: *Develop Civil Penalty enforcement training guidelines for preparing and supporting Civil Penalty cases for all investigations staff. USCG should consider using officers with previous experience in the Hearing Office to complete this task.*



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USCG Response: Concur. The Coast Guard will ensure the training guidelines for preparing and documenting a Civil Penalty are included in the curriculum developed for the Enforcement Course. Development of the course includes soliciting recommendations from accomplished performers in the field to include within the curriculum. The anticipated implementation date is fiscal year 2014.

Recommendation #7: *Instruct the Hearing Office to provide feedback in accordance with existing policy.*

USCG Response: Concur. The Coast Guard's Judge Advocate General will instruct Hearing Officers to provide feedback in accordance with Chapter 2.C of COMDTINST M16200.5A, consistent with their assigned duties. The anticipated implementation date is fiscal year 2014.



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Department of Homeland Security

Appendix C
Major Contributors to This Report

Brooke Bebow, Audit Director
Stephanie Christian, Audit Manager
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Dianne Leyva, Program Analyst
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Carolyn Floyd, Auditor
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Department of Homeland Security

Appendix D
Report Distribution

Department of Homeland Security

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11-0958-12

Please read the instructions before completing this form. For additional forms or assistance in completing this form, contact your agency's Paperwork Clearance Officer. Send two copies of this form, the collection instrument to be reviewed, the Supporting Statement, and any additional documentation to: Office of Information and Regulatory Affairs, Office of Management and Budget, Docket Library, Room 10102, 725 17th Street NW Washington, DC 20503.	
1. Agency/Subagency originating request Dept. of Homeland Security/US Coast Guard	2. OMB control number a. <u>1 6 2 5 - 0 0 0 1</u> b. None
3. Type of information collection (check one) a. ☐ New collection b. ☒ Revision of a currently approved collection c. ☐ Extension of a currently approved collection d. ☐ Reinstatement, without change, of a previously approved collection for which approval has expired e. ☐ Reinstatement, with change, of a previously approved collection for which approval has expired f. ☐ Existing collection in use without an OMB control number For b-f, note item A2 of Supporting Statement instructions	4. Type of review requested (check one) a. ☒ Regular submission b. ☐ Emergency - Approval requested by: <u> </u> / <u> </u> / <u> </u> c. ☐ Delegated 5. Small entities. Will this information collection have a significant economic impact on a substantial number of small entities? <u> </u> Yes ☒ No 6. Requested expiration date a. ☒ Three years from approval date b. Other Specify: <u> </u> / <u> </u> / <u> </u>
7. Title Marine Casualty Information & Periodic Chemical Drug and Alcohol Testing of Commercial Vessel Personnel	
8. Agency form number(s) (if applicable) CG-2692, CG-2692A, CG2692B	
9. Keywords Alcohol testing, Chemical drug testing, Marine casualty, Marine safety, Vessel	
10. Abstract Marine casualty information is needed for CG investigations of commercial vessel casualties involving death, vessel damage, etc., as mandated by Congress. Chemical testing info. is needed to improve CG detection/reduction of drug use by mariners.	
11. Affected public (Mark primary with "P" and all others that apply with "X") a. ☒ Individuals or households b. ☒ Business or other for-profit c. ☐ Not-for-profit institutions d. ☐ Farms e. ☒ Federal Government f. ☐ State, Local or Tribal Gov't	12. Obligation to respond (Mark primary with "P" and all others that apply with "X") a. ☐ Voluntary b. ☐ Required to obtain or retain benefits c. ☒ Mandatory
13. Annual reporting and recordkeeping hour burden a. Number of respondents <u>30,947</u> b. Total annual responses <u>178,847</u> 1. Percentage of these responses collected electronically <u>10</u> % c. Total annual hours requested <u>15,753</u> d. Current OMB inventory <u>19,876</u> e. Difference <u>- 3,123</u> f. Explanation of difference 1. Program change 2. Adjustment <u>- 3,123</u>	14. Annual reporting and recordkeeping cost burden (in thousands of dollars) a. Total annualized capital/startup costs <u>0</u> b. Total annual costs (O&M) <u>0</u> c. Total annualized cost requested <u>0</u> d. Current OMB inventory <u>0</u> e. Difference f. Explanation of difference 1. Program change 2. Adjustment
15. Purpose of information collection (Mark primary with "P" and all others that apply with "X") a. ☐ Application for benefits b. ☒ Program evaluation c. ☐ General purpose statistics d. ☐ Audit e. ☒ Program planning or management f. ☐ Research g. ☒ Regulatory or compliance	16. Frequency of recordkeeping or reporting (check all that apply) a. ☒ Recordkeeping b. ☐ Third party disclosure c. ☒ Reporting 1. ☒ On occasion 2. ☐ Weekly 3. ☐ Monthly 4. ☐ Quarterly 5. ☐ Semi-annually 6. ☐ Annually 7. ☐ Biennially 8. ☐ Other (describe)
17. Statistical methods Does this information collection employ statistical methods? Yes ☐ No ☒	18. Agency contact (person who can best answer questions regarding the content of this submission) Name: <u>Mr. David Du Pont</u> Phone: <u>202-372-1497</u>

**Supporting Statement
for
Marine Casualty Information &
Periodic Chemical Drug and Alcohol Testing
of Commercial Vessel Personnel**

A. Justification.**1) Circumstances that make the collection necessary.*****I. Marine Casualty Information***

Title 46 USC 6101 authorizes the Coast Guard to prescribe regulations for the reporting of marine casualties involving death, serious injury, material loss of property, material damage affecting the seaworthiness of a vessel, or significant harm to the environment. It also requires that information on the use of alcohol be included in a marine casualty report. These reporting requirements permit the Coast Guard to initiate the immediate investigation of marine casualties as required by 46 USC 6301, in order to: (a) determine the causes of casualties, and, (b) whether existing safety standards are adequate or whether new laws or regulations need to be developed. The overall goal of investigations therefore is to identify pertinent safety lessons and to initiate appropriate steps for reducing the likelihood of similar accidents in the future. Regulations implementing reporting requirements and investigative procedures are contained in 46 CFR Part 4. The table below identifies which part of the CFR corresponds to the subject.

**Table 1
Marine Casualty Information: CFR, Subject and Affected Population**

46 CFR	Subject and Affected Population
4.05-10	Written report of marine casualty. Owners, agents, masters, operators, or persons in charge are required to submit a written report with details about the casualty (CG-2692, supplemented as necessary by CG-2692A and CG-2692B).
4.05-12	Alcohol or drug use by individuals directly involved in casualties. On form CG-2692 the marine employer is required to identify those individuals for whom evidence of intoxication has been obtained; and specifies the method used to determine whether there is any evidence of alcohol or drug use by individuals directly involved in the casualty.
4.06-5(b)	Refusal to provide blood, breath or urine specimens for chemical tests. The marine employer is required to document such refusal on the form CG-2692B and in the logbook if the vessel involved is required to have one.
4.06-60 (a) - (d)	Submission of reports and test results. - The marine employer is required to complete and submit form CG-2692B after a serious marine incident occurs. - The marine employer is also required to submit the report of chemical test results for each person listed in the CG-2692B.¹

1. The regulation specifies that all chemical testing results be submitted to the Coast Guard. In The Department of Transportation's (DOT) Paperwork Reduction Act submission titled *Procedures for Transportation Drug and Alcohol Testing Program*, OMB # 2105-0529, DOT has taken the responsibility of the burden posed by reporting the result of drug tests. The Coast Guard is the only transportation mode that requires alcohol testing results; therefore, only the burden of reporting alcohol testing results is accounted in this submission.

II. Periodic Chemical Testing

Title 46 USC 7503 requires the Coast Guard to deny the issuance of licenses, certificates of registry, and merchant mariner's documents (seaman's papers) to users of dangerous drugs. Similarly, 46 USC 7704

requires the Coast Guard to revoke such papers when a holder of the same has been shown to be a drug user. Congress has shown increased interest in this problem by enacting 46 USC 2302 and 18 USC Chapter 17A, which prohibit an individual from operating a vessel while intoxicated by any drug or alcohol. Until 1988, the primary means of detecting drug use has been through examination of criminal conviction records of applicants and holders of seaman's papers. This results in a narrowly focused method. It does not identify drug users in a timely manner.

With advances in the reliability and accessibility of chemical testing methods, the Coast Guard developed drug and alcohol testing requirements that provide meaningful enforcement of existing statutory prohibitions. These requirements are part of a DOT-wide initiative for reducing and deterring substance abuse in all modes of commercial transportation and are consistent with regulations issued by other regulatory agencies.

Coast Guard regulations implementing chemical testing requirements are contained in 46 CFR Part 16. DOT implemented its own drug and alcohol testing requirements, contained in 49 CFR Part 40, some of which overlapped with the Coast Guard's regulatory requirements in this area. Therefore the burdens associated with the overlapping regulatory requirements that were calculated in the previous Collection of Information renewal have now been moved over to DOT. The details associated with this burden can be found in DOT Collection of Information titled *Procedures for Transportation Drug and Alcohol Testing Program*, OMB # 2105-0529, which expires on October 31, 2006.

The table below identifies the parts of the CFR that the Coast Guard is now responsible for, and shows the populations that correspond to the applicable area of regulation.

Table 2
Periodic Chemical Testing: CFR, Subject and Affected Population

46 CFR	Subject and Affected Population
16.201 (c)	Positive drug/alcohol test report. Employers are required to report positive results to the OCMI..
16.207	Foreign Laws Exemption Program. Employers of U.S. citizens operating in foreign waters may, under certain circumstances, request exemption from these drug-testing requirements.
16.220	Periodic testing requirements. All applicants for original issuance or a renewal of a license, a certificate of registry, or a merchant mariner's document, are required to provide results of a chemical test or evidence of participation in a random testing program.
16.250 (c) and (d)	Reasonable cause testing requirement. When the marine employer requires testing of an individual based upon a reasonable suspicion of drug or alcohol use, the individual must be informed of that fact and directed to provide a urine specimen. This fact shall be entered in the vessel's official logbook, if one is required. If an individual involved in a SMI refuses to provide a urine specimen when directed to do so by the employer, this fact shall be entered in the vessel's official logbook if one is required.
16.401(a) and (b)	Employee assistance program education and training. - All employers are required to provide an Employee Assistance Program. - In the program, the displaying and distribution of informational material is required. - The documentation of training given to crewmembers and the employer's supervisor personnel is required. - The documentation that supervisory personnel received 60 minutes of training is also required.

III. Strategic Goals

This information collection supports the following strategic goals:

Department of Homeland Security

- Prevention
- Protection

Coast Guard

- Maritime Safety
- Maritime Stewardship

Marine Safety, Security and Stewardship Directorate (CG-5)

- Reduce crewmember deaths and injuries on U.S. commercial vessels
- Reduce the risk of major loss of life on passenger vessels
- Reduce the amount of oil discharged into the marine environment
- Reduce the amount of chemicals entering the environment

2) Purpose of the information collection.

I. Marine Casualty Information

Receipt of a marine casualty report (CG-2692) is often the only way in which the Coast Guard becomes aware of a marine accident. It is therefore a necessary first step that provides the Coast Guard with the opportunity to determine the extent to which a casualty will be investigated. In the short term, the information provided in the report may also trigger: (a) corrective safety actions addressing immediate hazards or defective conditions; (b) further investigations of mariners' conduct or professional competence; and/or, (c) civil or criminal enforcement actions by the Coast Guard, other Federal agencies, or state and local authorities.

Form CG-2692B in particular will be utilized for reporting chemical testing following serious marine incidents. The two-page form will capture elementary information on the incident category, names of individuals directly involved, whether urine, blood, or breath samples were obtained, and where the samples have been sent for analysis. The Coast Guard can use this critical information to: (a) initiate administrative action against a commercial mariner's right to continue holding seaman's papers, (b) initiate civil or criminal penalty action when an individual has been found to be operating a vessel while intoxicated, and, (c) assess the impact of drug or alcohol use in serious marine incidents.

In the long term, information contained in the report becomes part of a comprehensive marine casualty database at Coast Guard Headquarters. This database is utilized extensively by the Coast Guard for: (a) identifying specific safety problems and analyzing longer-term trends, (b) publishing casualty summaries and annual statistics for public use, (c) supporting the need for additional safety oversight or regulation, (d) measuring the effectiveness of existing safety regulatory programs, and, (e) better focusing of limited Coast Guard marine safety resources. This database is also continually in use by other Federal and state government agencies, marine industry researchers, international groups or foreign government representatives involved in marine safety issues, and the public.

II. Periodic Chemical Testing

Reasonable cause testing requirements outlined in 46 CFR 16 are designed for marine employers to identify users of dangerous drugs and/or alcohol.

3) Considerations of the use of improved information technology to reduce the burden.

All forms used for this collection can be found on the Coast Guard's Marine Safety, Security and Environmental Protection Web site at— <http://www.uscg.mil/hq/g-m/moa/repor.htm>. Currently, all reporting requirements for this collection are submitted in written form. Electronic reporting of marine casualties is under consideration.

I. Marine Casualty Information

Marine casualty reports are currently submitted to the Coast Guard in writing on the existing "Report of Marine Accident, Injury, or Death" (Form CG-2692). If more than two barges are involved in the same

accident, a "Barge Addendum" is also used (Form CG-2692A). Form CG-2692B is used for reporting drug and alcohol testing following a serious marine incident and was also designed for independent submission for those few serious marine incidents that do not meet the marine casualty criteria.

II. Periodic Chemical Testing

Use of facsimile equipment is authorized to transmit marine employer records when required. Options for electronic reporting are under review for the future.

4) Efforts to identify duplication. Why similar information available cannot be used.

< There is no duplication of this information at the Federal level. The Coast Guard is the only Federal agency that collects this information from the marine industry and the public.>

5) Methods used to minimize the burden to small businesses if involved.

< *I. Marine Casualty Information*

Forms CG-2692, CG-2692A and CG-2692B are all designed for filling out with the minimal information necessary for fulfilling the regulatory reporting requirement and for identifying causal and contributing factors. The Coast Guard retains the responsibility to determine the extent to which the marine casualty should be investigated. Accordingly, the initial burden on small entities is small.>

II. Periodic Chemical Testing

To lessen the burden on small businesses, the Coast Guard delayed the scheduled implementation of the regulatory requirements so as to provide additional time to allow small businesses to explore contracting options, obtain necessary equipment and training, learn from the experiences of larger entities, and to organize themselves into a consortium to reduce costs.

6) Consequences to the Federal program if collection were not conducted or conducted less frequently.

< *I. Marine Casualty Information*

Information is collected only upon occurrence of a reportable marine casualty.> Less frequent collection of such information would directly conflict with a well-established statutory mandate, would lead to inconsistencies with data already collected, and would severely diminish the capability to identify specific safety hazards and accurately analyze unsafe trends in the commercial marine industry. This in turn would have a highly negative impact on the Coast Guard's continuing efforts to reduce the incidence of marine casualties.

II. Periodic Chemical Testing

Less frequent collection will reduce marine employers' capability to identify drug users and take enforcement action concerning drug or alcohol use by commercial mariners. This reduced capability would have obvious negative consequences on marine safety.

7) Special circumstances that require collection to be conducted in an inconsistent manner.

Information is collected in manner that is consistent with the guidelines.

8) Solicitation of comments.

A 60-day Notice will be published in the *Federal Register* to obtain public comment on this collection.

9) Provide any payment or gift to respondents.

No payments or gifts of any kind are provided to respondents.

10) Assurances of confidentiality provided to respondents.

I. Marine Casualty Information

< Information collected during the investigation of marine casualties and serious marine incidents is a matter of public record in accordance with 46 USC 6302. > 6301 (6) - need for new laws or regs?

II. Periodic Chemical Testing

The majority of information collected as part of periodic, pre-employment, random, or reasonable cause testing will normally remain confidential. However, when positive test results are used to initiate follow-up enforcement action, that information will become part of the public record during any subsequent administrative, civil, or criminal proceedings.

11) Additional justification for any questions of a sensitive nature.

I. Marine Casualty Information

Routine collection of marine casualty information does not involve questions of a sensitive nature. Chemical testing following serious marine incidents also does not involve sensitive questions. < In 1989 the U.S. Supreme Court upheld the Federal Railroad Administration's (FRA) requirements for drug and alcohol testing of involved personnel following major accidents as a permissible search under the Fourth Amendment to the U.S. Constitution. > The Coast Guard's requirements for similar testing following serious marine incidents are consistent with that of the FRA.

II. Periodic Chemical Testing

Concerns have been expressed regarding chemical testing as an invasion of privacy and an unreasonable method of search of an individual's person. These concerns are related primarily to random urinalysis, and to a lesser degree with periodic, pre-employment, and reasonable cause testing requirements. These questions have been the subject of a lawsuit and have been resolved with the court finding that the public's right to safety overrides an individual's right to privacy.

12) Estimate of annual hour and cost burden.

Annualized Hour and Cost Burden:

- The number of respondents is 30,947.
- The number of responses for this collection is 178,847.
- The total annual reporting and recordkeeping burden is 15,753 hours.
- The total annual cost burden is \$456,847.

A wage rate of \$29/hour was used for all calculations involving the marine industry and the public. This is the GS-03 out of government rate according to COMDTINST 7310.1K. Detailed calculations, as well as explanations of the assumptions used, can be found in Appendix A of this Supporting Statement. Table 3 below gives the hour and cost burdens associated with the regulatory requirements in this collection of information. Some figures may be rounded.

I. Marine Casualty Information

An incident list from 2006 was downloaded from the MISLE Incident Investigations cube. The list was narrowed to only included cases of reported marine casualty or environmental damage.

Total number of respondents = 4,351

We assume that it takes approximately one (1) hour to complete all parts of the form (CG-2692, with CG-2692A and CG-2692B when necessary). With an hour to fill out the form, at a wage rate of \$29/hour, the total annual cost associated with the requirement is \$126,179, and the burden hours are 4,351.

II. Periodic Chemical Testing

For reporting and recordkeeping calculations for chemical testing, we use the Association of Records Management and Administrators, Inc. (ARMA) methodology required by OMB. As the ARMA methodology was not applicable to all the elements involved in this collection of information, we used the Standard method of calculation for those elements. The annualized cost and burden hours associated with chemical testing are **\$330,668** and **11,402 burden hours** respectively. Again, please see Table 3 below, and Appendix A, for more details on the calculations.

Table 3 below offers a more detailed tabulation of the hour and cost burdens associated with each of the regulatory requirements for information collection. The source of certain cost information is Appendix A.

Table 3
Annual Burden of Collection of Information

Requirement	Respondents	Responses	Burden (Hours)	Cost
46 CFR 4.05-10 & 4.05-12 • Written report of marine casualty.	4,351	4,351	4,351	\$126,179
46 CFR 4.06-5(b) • Employer documentation of refusal to provide blood, breath or urine specimens for chemical tests.	1	1	0.083	\$2.41
46 CFR 4.06-5(b) & 4.06-60 • Post accident determination documentation.	245	245	16	\$464
46 CFR 4.06-60(d) • Positive chemical test report to OCMI.	40	40	10	\$290
46 CFR 16.201(c) • Positive drug/alcohol test report to OCMI.	40	40	10	\$290
46 CFR 16.207 • Exemption from foreign laws.	1	1	0.065	\$1.89
46 CFR 16.220 • Periodic test result report.	8,700	87,000	5,593	\$162,197
46 CFR 16.250(c) & (d) • Reasonable suspicion determination documentation.	79	79	5	\$145
• Refusal-to-test record (from reasonable suspicion).	3	3	0.19	\$5.51
46 CFR 16.401(a) and (b) • Supervisor training documentation.	8,700	17,400	1,119	\$32,451
• Employee training documentation.	8,700	69,600	4,475	\$129,775
• Promulgating the policy requirement.	87	87	174	\$5,046
Total Annual Respondents and Burden (Hours & Cost)	30,947	178,847	15,753	\$456,847

13) Estimate of annualized capital and start-up costs.

There are no annualized capital and start-up costs.

14) Estimates of annualized cost to the Federal Government.

The total annualized cost to the Government is \$139,232.

I. Marine Casualty Information

It is estimated that 1 hour is required for the Coast Guard's processing of each form CG-2692/CG-2692A/CG-2692B, including the auditing at a local field investigation office and the entering of pertinent information including the additional information resulting from the change "significant harm to the environment" into a computerized database at Coast Guard Headquarters. Using an estimated wage rate of \$32/hour for Coast Guard personnel of rank E-4¹ the annual cost, for 4,351 forms, is \$139,232.>

II. Periodic Chemical Testing

Those applying for original issuances, a renewal of a license, a certificate of registry and other similar licenses include the passing of a chemical test for dangerous drugs that has to be submitted to the CG Regional Examination Center. The additional cost to the Federal Government here is minimal, as it would have been calculated under the cost to review an application for such licenses. Moreover, there are no costs to the Federal Government from the requirements for routine drug and alcohol testing by employers, as these are records that have to be retained by employers for inspection when necessary.

15) Reasons for change in the burden.

The change in burden is an ADJUSTMENT due a change in the number of marine casualty reports submitted to the Coast Guard.

16) Plans for tabulation, statistical analysis and publication.

I. Marine Casualty Information

<The Coast Guard publishes annual marine casualty statistics based on information gathered from forms CG-2692/CG-2692A/CG-2692B submitted by the public and the marine industry.>

II. Periodic Chemical Testing

The Coast Guard publishes a Notice on annual basis setting the periodic chemical testing rate for the following year. The Coast Guard uses the aggregate percentage rate of positive results of the conducted periodic chemical tests to determine the following year's periodic chemical testing rate. Personal information is not used nor disclosed.

17) Approval for not explaining the expiration date for OMB approval.

We are not seeking such approval. The OMB Number will appear on appropriate PRA disclosure information.

18) Exception to the certification statement.

There are no exceptions to the certification statement.

B. Collection of Information Employing Statistical Methods.

This information collection does not employ statistical methods.

¹ According to COMDTINST 7310.1K

Appendix A**PRA Cost Indicator Summary: Marine Casualty Info. and Periodic Chem****Using ARMA: Chemical Testing Calculations**

PRA Task	Rule Citation	Times Performed	Record Creation \$1.145	Record Filing \$0.118	Record Storage \$0.0228
Post Accident Determination Documentation ¹	46 CFR 4.06-5 (b), and 4.06-60	245	280.53	28.91	5.59
Foreign Laws Program Exemption ²	46 CFR 16.207	1	1.15	0.12	0.02
Periodic Test Result Report ³	46 CFR 16.220	87,000	99,615.00	10,266.00	1,983.60
Reasonable Suspicion Determination Documentation ⁴	46 CFR 16.250 (c)	79	90.46	9.32	1.80
Refusal-to-Test Record ⁵	46 CFR 16.250 (d)	3	3.44	0.35	0.07
Employee Training Documentation ⁶	46 CFR 16.401 (a) and (b)	69,600	79,692.00	8,212.80	1,586.88
Supervisor Training Documentation ⁷	46 CFR 16.401 (b)	17,400	19,923.00	2,053.20	396.72

ENCLOSURE #8 PAGE #9

- 1 The 'times performed' is the number of times in a year the Coast Guard expects that a drug/alcohol test after a SMI would log entry is only made when the person is a crewmember of a ship that is required to have a logbook (ships that are greater than 1600 gross tons).
- 2 No companies have submitted applications under this program. The burden has been calculated in case any apply.
- 3 For the number of times performed, we assumed 8 new employees and 2 employees would apply for licenses and renewals. The number of firms involved is based on Coast Guard estimates. The total number of times performed is therefore 10,000.
- 4 The times performed was determined by taking the actual 1998 number of "reasonable suspicion" tests that were performed on documented vessels that are greater than 1600 gross tons. Since there were 741 inspected vessels greater than 1600 gross tons overall in 1999, the times performed = $(741/7521) \times 800 = 79$.
- 5 Number of times performed is estimated by the number of times in a year the Coast Guard expects drug/alcohol test after a SMI would be refused. Also, the log entry is only made when the person is crewmember of a ship that is required to have a logbook (ships that are greater than 1600 gross tons).
- 6 For number of times performed, assumed 8 new employees for 8,700 firms. The number of firms involved is a Coast Guard estimate.
- 7 For number of times performed, assumed 2 new supervisors for 8,700 firms. The number of firms involved is a Coast Guard estimate.

Appendix A**PRA Cost Indicator Summary: Marine Casualty Info. and Periodic Che**

(Continued from previous page)

Using Standard Method: Chemical Testing

PRA Task	Rule Citation	Time to Complete Single Task (hours)	Number of Times Performed	Burden
Special Post Accident Documentation ¹	46 CFR 4.06-5(b)	0.083	1	0
Positive Chemical Test Report to OCMI ²	46 CFR 4.06-60(d)	0.250	40	
Promulgate Policy ³	46 CFR 16.401	2	87	
Positive Drug/Alcohol Test Report to OCMI ⁵	46 CFR 16.201(c)	0.250	40	

1. The times performed is the number of times in a year the Coast Guard expects that a drug/alcohol test after SMI would be only made when the person is crewmember of a ship that is required to have a logbook (greater than 1600 gross tons).

2. The number of times performed is estimated from the number of positives reported on CG-2692B post a SMI.

3. The number of times performed is estimated by assuming 1% of existing companies is the number of new companies every year.

87. Number of firms is a Coast Guard estimate.

4. The number of times performed is estimated using the number of licensed personnel who tested positive.

5. The number of times performed is a historical estimate using the number of licensed personnel who tested positive as reported in the past.

Using Standard Method: Marine Casualty Information Collection

Requirement	Rule Citation	Time to complete task (hours)	Number of times performed	Burden
Written Report of Marine Casualty ¹	46 CFR 4.05-10	1	4,351	4

1. The number of times performed is based on a Coast Guard database count of the number of Forms CG-2692 (including attachments) submitted to the Coast Guard in year 2006.

ENCLOSURE #8 PAGE #10

U.S. DEPARTMENT OF HOMELAND SECURITY U.S. COAST GUARD CG-2692 (Rev. 05-04)		REPORT OF MARINE ACCIDENT, INJURY OR DEATH				RCS No. G-MOA MISLE NOTIFICATION NUMBER					
SECTION I. GENERAL INFORMATION											
1. Name of Vessel or Facility		2. Official No.		3. Nationality		4. Call Sign					
5. Type (Towing, Freight, Fish, Drill, etc.)		7. Length		8. Gross Tons		9. Year Built					
10. Propulsion (Steam, diesel, gas, turbine...)		11. Hull Material (Steel, Wood...)		12. Draft (Ft. - in) FWD AFT.		13. If Vessel Classed, By Whom (ABS, LLOYDS, DNV, BV, etc.)					
14. Date (of occurrence)		15. TIME (Local)		16. Location (See Instruction No. 10A)		17. Estimated Loss of Damage TO:					
18. Name, Address & Telephone No. of Operating Co.		VESSEL _____		CARGO _____		OTHER _____					
19. Name of Master or Person in Charge		USCG License YES NO		20. Name of Pilot		USCG License State License YES NO YES NO					
19a. Street Address (City, State, Zip Code)		19b. Telephone Number		20a. Street Address (City, State, Zip Code)		20b. Telephone Number					
21. Casualty Elements (Check as many as needed and explain in Block 44)											
NO. OF PERSONS ON BOARD _____ ☐ DEATH - HOW MANY? _____ ☐ MISSING - HOW MANY? _____ ☐ INJURED - HOW MANY? _____ ☐ HAZARDOUS MATERIAL RELEASED OR INVOLVED (Identify Substance and amount in Block 44) ☐ OIL SPILL - ESTIMATE AMOUNT: _____ ☐ CARGO CONTAINER LOST/DAMAGED ☐ COLLISION (Identify other vessel or object in Block 44) ☐ GROUNDING ☐ WAKE DAMAGE				☐ FLOODING, SWAMPING WITHOUT SINKING ☐ CAPSIZING (with or without sinking) ☐ FOUNDERING OR SINKING ☐ HEAVY WEATHER DAMAGE ☐ FIRE ☐ EXPLOSION ☐ COMMERCIAL DIVING CASUALTY ☐ ICE DAMAGE ☐ DAMAGE TO AIDS TO NAVIGATION ☐ STEERING FAILURE ☐ MACHINERY OR EQUIPMENT FAILURE ☐ ELECTRICAL FAILURE ☐ STRUCTURAL FAILURE				☐ FIREFIGHTING OR EMERGENCY EQUIPMENT FAILED OR INADEQUATE (Describe in Block 44.) ☐ LIFESAVING EQUIPMENT FAILED OR INADEQUATE (Describe in Block 44.) ☐ BLOW OUT (Petroleum exploration/production) ☐ ALCOHOL INVOLVEMENT (Describe in Block 44.) ☐ DRUG INVOLVEMENT (Describe in Block 44.) ☐ OTHER (Specify) _____			
22. Conditions											
A. Sea or River Conditions (wave height, river stage, etc.)		B. WEATHER ☐ CLEAR ☐ RAIN ☐ SNOW ☐ FOG ☐ OTHER (Specify) _____		C. TIME ☐ DAYLIGHT ☐ TWILIGHT ☐ NIGHT		D. VISIBILITY ☐ GOOD ☐ FAIR ☐ POOR					
						E. DISTANCE (miles of visibility) _____					
						F. AIR TEMPERATURE (F) _____					
						G. WIND SPEED & DIRECTION _____					
						H. CURRENT SPEED & DIRECTION _____					
23. Navigation Information											
☐ MOORED, DOCKED OR FIXED		SPEED AND COURSE _____		24. Last Port Where Bound		24a. Time and Date of Departure					
☐ ANCHORED		☐ UNDERWAY OR DRIFTING									
25. FOR TOWING ONLY		25a. NUMBER OF VESSELS TOWED		25b. TOTAL H.P. OF TOWING UNITS		25c. MAXIMUM SIZE OF TOW WITH TOW-BOAT(S)					
		Empty Loaded Total				Length Width					
						25d. (Describe in Block 44)					
						☐ PUSHING AHEAD ☐ TOWING ASTERN ☐ TOWING ALONGSIDE ☐ MORE THAN ONE TOW-BOAT ON TOW					
SECTION II. BARGE INFORMATION											
26. Name		26a. Official Number		26b. Type		26c. Length					
26d. Gross Tons		26e. USCG Certificate of Inspection issued at		26f. Year Built		26g. ☐ SINGLE SKIN ☐ DOUBLE					
26h. Draft FWD AFT		26i. Operating Company		26j. Damage Amount		26k. Describe Damage to Barge					
BARGE _____		CARGO _____		OTHER _____							

PREVIOUS EDITION IS OBSOLETE

SECTION III. PERSONNEL ACCIDENT INFORMATION				
27. Person Involved ☐ MALE or ☐ FEMALE ☐ DEAD ☐ INJURED ☐ MISSING		27a. Name (Last, First, Middle Name) 27b. Address (City, State, Zip Code)		27c. Status ☐ Crew ☐ Passenger ☐ Other
28. Birth Date	29. Telephone No.	30. Job Position		31. (Check here if off duty) ☐
32. Employer - (if different from Block 18, fill in Name, Address, Telephone No.)				
33. Person's Time A. IN THIS INDUSTRY - _____ B. WITH THIS COMPANY - _____ C. IN PRESENT JOB OR POSITION - _____ D. ON PRESENT VESSEL/FACILITY - _____ E. HOURS ON DUTY WHEN ACCIDENT OCCURRED - _____			34. Industry of Employer (Towing, Fishing, Shipping, Crew Supply, Drilling, etc.) 35. Was the Injured Person Incapacitated 72 Hours or More? 36. Date of Death	YEAR(S) _____ MONTH(S) _____
37. Activity of Person at Time of Accident				
38. Specific Location of Accident on Vessel/Facility				
39. Type of Accident (Fall, Caught between, etc.)			40. Resulting Injury (Cut, Bruise, Fracture, Burn, etc.)	
41. Part of Body Injured			42. Equipment Involved in Accident	
43. Specific Object, Part of the Equipment in block 42., or Substance (Chemical, Solvent, etc.) that directly produced the injury.				
SECTION IV. DESCRIPTION OF CASUALTY				
44. Describe how accident occurred, damage, information on alcohol/drug involvement and recommendations for corrective safety measures. (See instructions and attach additional sheets if necessary).				
45. Witness (Name, Address, Telephone No.)				
46. Witness (Name, Address, Telephone No.)				
SECTION V. PERSON MAKING THIS REPORT				47c. Title
47. Name (PRINT) (Last, First, Middle)		47b. Address (City, State, Zip Code)		47d. Telephone No.
47a. Signature				47e. Date
FOR COAST GUARD USE ONLY			REPORTING OFFICE:	
MISLE Incident Investigation Activity Data Entry:			MISLE Incident Investigation Activity Number (if applicable)	
☐ NONE ☐ PRELIMINARY ☐ DATA COLLECTION ☐ INFORMAL ☐ FORMAL				
Serious Marine Incident ☐ Yes ☐ No Major Marine Casualty ☐ Yes ☐ No	INVESTIGATOR (Name)	DATE	APPROVED BY (Name)	DATE

INSTRUCTIONS

FOR COMPLETION OF FORM CG-2692

REPORT OF MARINE ACCIDENT, INJURY OR DEATH

AND FORM CG-2692A, BARGE ADDENDUM

WHEN TO USE THIS FORM

1. This form satisfies the requirements for written reports of accidents found in the Code of Federal Regulations for vessels, Outer Continental Shelf (OCS) facilities, mobile offshore drilling units (MODUs), and diving. The kinds of accidents that must be reported are described in the following instructions.

VESSELS

2. A vessel accident must be reported if it occurs upon the navigable waters of the U.S., its territories or possessions; or whenever an accident involves a U.S. vessel; wherever the accident may occur. (Public vessels and recreational vessels are excepted from these reporting requirements.) The accident must also involve one of the following (ref. 46 CFR 4.05-1):

A. All accidental groundings and any intentional grounding which also meets any of the other reporting criteria or creates a hazard to navigation, the environment, or the safety of the vessel;

B. Loss of main propulsion or primary steering, or an associated component or control system, the loss of which causes a reduction of the maneuvering capabilities of the vessel. Loss means that systems, component parts, subsystems, or control systems do not perform the specified or required function;

C. An occurrence materially and adversely affecting the vessel's seaworthiness or fitness for service or route including but not limited to fire, flooding, failure or damage to fixed fire extinguishing systems, lifesaving equipment or bilge pumping systems;

D. Loss of life;

E. An injury that requires professional medical treatment (beyond first aid) and, if a crewmember on a commercial vessel, that renders the individual unfit to perform routine duties.

F. An occurrence not meeting any of the above criteria but resulting in damage to property in excess of \$25,000. Damage cost includes the cost of labor and material to restore the property to the condition which existed prior to the casualty, but it does not include the cost of salvage, cleaning, gas freeing, drydocking or demurrage.

MOBILE OFFSHORE DRILLING UNITS

3. MODUs are vessels and are required to report an accident that results in any of the events listed by Instruction 2-A through 2-F for vessels. (Ref. 46 CFR 4.05-1, 46 CFR 109.411)

OCS FACILITIES

4. All OCS facilities (except mobile offshore drilling units) engaged in mineral exploration, development or production activities on the Outer Continental Shelf of the U.S. are required by 33 CFR 146.30 to report accidents resulting in:

A. Death;

B. Injury to 5 or more persons in a single incident;

C. Injury causing any person to be incapacitated for more than 72 hours;

D. Damage affecting the usefulness of primary lifesaving or firefighting equipment;

E. Damage to the facility in excess of \$25,000 resulting from a collision by a vessel;

F. Damage to a floating OCS facility in excess of \$25,000.

5. Foreign vessels engaged in mineral exploration, development or production on the U. S. Outer Continental Shelf, other than vessels already required to report by Instructions 2 and 3 above, are required by 33 CFR 146.303 to report casualties that result in any of the following:

A. Death;

B. Injury to 5 or more persons in a single incident;

C. Injury causing any person to be incapacitated for more than 72 hours.

DIVING

6. Diving casualties include injury or death that occurs while using underwater breathing apparatus while diving from a vessel or OCS facility.

A. COMMERCIAL DIVING. A dive is considered commercial if it is for commercial purposes from a vessel required to have a Coast Guard certificate of inspection, from an OCS facility or in its related safety zone or in a related activity, at a deepwater port or in its safety zone. Casualties that occur during commercial dives are covered by 46 CFR 197.486 if they result in:

1. Loss of life;

2. Injury causing incapacitation over 72 hours;

3. Injury requiring hospitalization over 24 hours.

In addition to the information requested on this form, also provide the name of the diving supervisor and, if applicable, a detailed report on gas embolism or decompression sickness as required by 46 CFR 197.410(a)(9).

Exempt from the commercial category are dives for:

1. Marine science research by educational institutions;
2. Research in diving equipment and technology;
3. Search and Rescue controlled by a government agency.

B. ALL OTHER DIVING. Diving accidents not covered by Instruction (6-A) but involving vessels subject to Instruction (2), VESSELS, must be reported if they result in death or injury causing incapacitation over 72 hours. (Ref. 46 CFR 4.03-1(c)).

HAZARDOUS MATERIALS

7. When an accident involves hazardous materials, public and environmental health and safety require immediate action. As soon as any person in charge of a vessel or facility has knowledge of a release or discharge of oil or a hazardous substance, that person is required to immediately notify the U. S. Department of Homeland Security's National Response Center (telephone toll-free 800-424-8802 - in the Washington, D.C. area call 202-426-2675). Anyone else knowing of a pollution incident is encouraged to use the toll-free telephone number to report it. If etiologic (disease causing) agents are involved, call the U.S. Public Health Service's Center for Disease Control in Atlanta, GA. (telephone 404-633-5313). (Ref. 42 USC 9603; 33 CFR 153; 49 CFR 171.15)

COMPLETION OF THIS FORM

8. This form should be filled out as completely and accurately as possible. Please type or print clearly. Fill in all blanks that apply to the kind of accident that has occurred. If a question is not applicable, the abbreviation "NA" should be entered in that space. If an answer is unknown and cannot be obtained, the abbreviation "UNK" should be entered in that space. If "NONE" is the correct response, then enter it in that space.

9. Once completed, deliver or mail this form as soon as possible to the Coast Guard Marine Safety, Marine Inspection or Activities Office nearest the location of the casualty or, if at sea, nearest the arrival port.

NOTICE: The information collected on this form is routinely available for public inspection. It is needed by the Coast Guard to carry out its responsibility to investigate marine casualties, to identify hazardous conditions or situations and to conduct statistical analysis. The information is used to determine whether new or revised safety initiatives are necessary for the protection of life or property in the marine environment.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB control number.

The Coast Guard estimates that the average burden for this report is 1 hour. You may submit any comments concerning the accuracy of this burden estimate or any suggestions for reducing the burden to: Commandant (G-MOA), U.S. Coast Guard, Washington, DC 20593-0001 or Office of Management and Budget, Paperwork Reduction Project (1625-0001), Washington, DC 20503

10. Amplifying information for completing the form:

A. Block 16 - "LOCATION" - Latitude and longitude to the nearest tenth of a minute should always be entered except in those rivers and waterways where a mile marker system is commonly used. In these cases, the mile number to the nearest tenth of a mile should be entered. If the latitude and longitude, or mile number, are unknown, reference to a known landmark or object (buoy, light, etc.) with distance and bearing to the object is permissible. Always identify the body of water or waterway referred to.

B. Tug or towboat with tow - Tugs or towboats with tows under their control should complete all applicable portions of the CG-2692. SECTION II should be completed if a barge causes or sustains damage or meets any other reporting criteria. If additional barges require reporting, the "Barge Addendum," CG-2692A, may be used to provide the information for the additional barges.

C. Moored/Anchored Barge - If a barge suffers a casualty while moored or anchored, or breaks away from its moorage, and causes or sustains reportable damages or meets any other reporting criteria, enter the location of its moorage in Block (1) of the CG-2692 and complete the form except for Blocks (2) through (13). The details will be entered in SECTION II for one barge and on the "Barge Addendum" CG-2692A, for additional barges.

D. SECTION III - Personnel Accident Information - SECTION III must be completed for a death or injury. In addition, applicable portions of SECTIONS I, II and IV must be completed. If more than one death or injury occurs in a single incident, complete one CG-2692 for one of the persons injured or killed, and attach additional CG-2692's, filling out Blocks (1) and (2) and SECTION III for each additional person.

E. BLOCK 44 - Describe the sequence of events which led up to this casualty. Include your opinion of the primary cause and any contributing causes of the casualty. Briefly describe damage to your vessel, its cargo, and other vessels/property. Include any recommendations you may have for preventing similar casualties. **ALCOHOL AND DRUG INFORMATION.** Provide the following information with regard to each person determined to be directly involved in the casualty: name, position aboard the vessel, whether or not the person was under the influence of alcohol or drugs at the time of the casualty, and the method used to make this determination. If toxicological testing is conducted the results should be included; if results are not available in a timely manner, provide the results of the toxicological test as soon as practical and indicate that this is the case in block 44 of the casualty form.

U.S. DEPARTMENT OF HOMELAND SECURITY U.S. COAST GUARD CG-2692A (Rev. 06-04)	BARGE ADDENDUM	REPORTS CONTROL SYMBOL G-MOA
NOTE: This form may be used to report data for barges causing or sustaining damage in the accident described on form CG-2692. This form may only be used in addition to form CG-2692, never alone.		
NAME OF VESSEL (Use Same Name as Block 1., of CG-2692)		DATE OF ACCIDENT
FOR BARGE CAUSING OR SUSTAINING DAMAGES		
26. Name	26a. Official Number	26b. Type
26c. Length	26d. Gross Tons	
26f. Year Built	26g. ☐ SINGLE SKIN ☐ DOUBLE SKIN	26h. Draft FWD AFT
		26i. Operating Company
26j. Damage Amount		26k. Describe Damage to Barge
DAMAGE TO BARGE _____ CARGO _____		
26e. USCG Certificate of Inspection issued at:		
FOR BARGE CAUSING OR SUSTAINING DAMAGES		
26. Name	26a. Official Number	26b. Type
26c. Length	26d. Gross Tons	
26f. Year Built	26g. ☐ SINGLE SKIN ☐ DOUBLE SKIN	26h. Draft FWD AFT
		26i. Operating Company
26j. Damage Amount		26k. Describe Damage to Barge
DAMAGE TO BARGE _____ CARGO _____		
26e. USCG Certificate of Inspection issued at:		
FOR BARGE CAUSING OR SUSTAINING DAMAGES		
26. Name	26a. Official Number	26b. Type
26c. Length	26d. Gross Tons	
26f. Year Built	26g. ☐ SINGLE SKIN ☐ DOUBLE SKIN	26h. Draft FWD AFT
		26i. Operating Company
26j. Damage Amount		26k. Describe Damage to Barge
DAMAGE TO BARGE _____ CARGO _____		
26e. USCG Certificate of Inspection issued at:		
FOR BARGE CAUSING OR SUSTAINING DAMAGES		
26. Name	26a. Official Number	26b. Type
26c. Length	26d. Gross Tons	
26f. Year Built	26g. ☐ SINGLE SKIN ☐ DOUBLE SKIN	26h. Draft FWD AFT
		26i. Operating Company
26j. Damage Amount		26k. Describe Damage to Barge
DAMAGE TO BARGE _____ CARGO _____		
26e. USCG Certificate of Inspection issued at:		
FOR BARGE CAUSING OR SUSTAINING DAMAGES		
26. Name	26a. Official Number	26b. Type
26c. Length	26d. Gross Tons	
26f. Year Built	26g. ☐ SINGLE SKIN ☐ DOUBLE SKIN	26h. Draft FWD AFT
		26i. Operating Company
26j. Damage Amount		26k. Describe Damage to Barge
DAMAGE TO BARGE _____ CARGO _____		
26e. USCG Certificate of Inspection issued at:		
SIGNATURE (of person making this report)		
PREVIOUS EDITION MAY BE USED		

FOR BARGE CAUSING OR SUSTAINING DAMAGES					26e. USCG Certificate of Inspection issued at:
26. Name	26a. Official Number	26b. Type	26c. Length	26d. Gross Tons	
26f. Year Built	26g. ☐ SINGLE SKIN ☐ DOUBLE SKIN	26h. Draft FWD AFT	26i. Operating Company		
26j. Damage Amount		26k. Describe Damage to Barge			
DAMAGE TO BARGE _____ CARGO _____					

FOR BARGE CAUSING OR SUSTAINING DAMAGES					26e. USCG Certificate of Inspection issued at:
26. Name	26a. Official Number	26b. Type	26c. Length	26d. Gross Tons	
26f. Year Built	26g. ☐ SINGLE SKIN ☐ DOUBLE SKIN	26h. Draft FWD AFT	26i. Operating Company		
26j. Damage Amount		26k. Describe Damage to Barge			
DAMAGE TO BARGE _____ CARGO _____					

FOR BARGE CAUSING OR SUSTAINING DAMAGES					26e. USCG Certificate of Inspection issued at:
26. Name	26a. Official Number	26b. Type	26c. Length	26d. Gross Tons	
26f. Year Built	26g. ☐ SINGLE SKIN ☐ DOUBLE SKIN	26h. Draft FWD AFT	26i. Operating Company		
26j. Damage Amount		26k. Describe Damage to Barge			
DAMAGE TO BARGE _____ CARGO _____					

FOR BARGE CAUSING OR SUSTAINING DAMAGES					26e. USCG Certificate of Inspection issued at:
26. Name	26a. Official Number	26b. Type	26c. Length	26d. Gross Tons	
26f. Year Built	26g. ☐ SINGLE SKIN ☐ DOUBLE SKIN	26h. Draft FWD AFT	26i. Operating Company		
26j. Damage Amount		26k. Describe Damage to Barge			
DAMAGE TO BARGE _____ CARGO _____					

FOR BARGE CAUSING OR SUSTAINING DAMAGES					26e. USCG Certificate of Inspection issued at:
26. Name	26a. Official Number	26b. Type	26c. Length	26d. Gross Tons	
26f. Year Built	26g. ☐ SINGLE SKIN ☐ DOUBLE SKIN	26h. Draft FWD AFT	26i. Operating Company		
26j. Damage Amount		26k. Describe Damage to Barge			
DAMAGE TO BARGE _____ CARGO _____					

INSTRUCTIONS

FOR COMPLETION OF FORM CG-2692

REPORT OF MARINE ACCIDENT, INJURY OR DEATH

AND FORM CG-2692A, BARGE ADDENDUM

WHEN TO USE THIS FORM

1. This form satisfies the requirements for written reports of accidents found in the Code of Federal Regulations for vessels, Outer Continental Shelf (OCS) facilities, mobile offshore drilling units (MODUs), and diving. The kinds of accidents that must be reported are described in the following instructions.

VESSELS

2. A vessel accident must be reported if it occurs upon the navigable waters of the U.S., its territories or possessions; or whenever an accident involves a U.S. vessel; wherever the accident may occur. (Public vessels and recreational vessels are excepted from these reporting requirements.) The accident must also involve one of the following (ref. 46 CFR 4.05-1):

A. All accidental groundings and any intentional grounding which also meets any of the other reporting criteria or creates a hazard to navigation, the environment, or the safety of the vessel;

B. Loss of main propulsion or primary steering, or an associated component or control system, the loss of which causes a reduction of the maneuvering capabilities of the vessel. Loss means that systems, component parts, subsystems, or control systems do not perform the specified or required function;

C. An occurrence materially and adversely affecting the vessel's seaworthiness or fitness for service or route including but not limited to fire, flooding, failure or damage to fixed fire extinguishing systems, lifesaving equipment or bilge pumping systems;

D. Loss of life;

E. An injury that requires professional medical treatment (beyond first aid) and, if a crewmember on a commercial vessel, that renders the individual unfit to perform routine duties.

F. An occurrence not meeting any of the above criteria but resulting in damage to property in excess of \$25,000. Damage cost includes the cost of labor and material to restore the property to the condition which existed prior to the casualty, but it does not include the cost of salvage, cleaning, gas freeing, drydocking or demurrage.

MOBILE OFFSHORE DRILLING UNITS

3. MODUs are vessels and are required to report an accident that results in any of the events listed by Instruction 2-A through 2-F for vessels. (Ref. 46 CFR 4.05-1, 46 CFR 109.411)

OCS FACILITIES

4. All OCS facilities (except mobile offshore drilling units) engaged in mineral exploration, development or production activities on the Outer Continental Shelf of the U.S. are required by 33 CFR 146.30 to report accidents resulting in:

A. Death;

B. Injury to 5 or more persons in a single incident;

C. Injury causing any person to be incapacitated for more than 72 hours;

D. Damage affecting the usefulness of primary lifesaving or firefighting equipment;

E. Damage to the facility in excess of \$25,000 resulting from a collision by a vessel;

F. Damage to a floating OCS facility in excess of \$25,000.

5. Foreign vessels engaged in mineral exploration, development or production on the U. S. Outer Continental Shelf, other than vessels already required to report by Instructions 2 and 3 above, are required by 33 CFR 146.303 to report casualties that result in any of the following:

A. Death;

B. Injury to 5 or more persons in a single incident;

C. Injury causing any person to be incapacitated for more than 72 hours.

DIVING

6. Diving casualties include injury or death that occurs while using underwater breathing apparatus while diving from a vessel or OCS facility.

A. **COMMERCIAL DIVING.** A dive is considered commercial if it is for commercial purposes from a vessel required to have a Coast Guard certificate of inspection, from an OCS facility or in its related safety zone or in a related activity, at a deepwater port or in its safety zone. Casualties that occur during commercial dives are covered by 46 CFR 197.486 if they result in:

1. Loss of life;

2. Injury causing incapacitation over 72 hours;

3. Injury requiring hospitalization over 24 hours.

In addition to the information requested on this form, also provide the name of the diving supervisor and, if applicable, a detailed report on gas embolism or decompression sickness as required by 46 CFR 197.410(a)(9).

Exempt from the commercial category are dives for:

1. Marine science research by educational institutions;
2. Research in diving equipment and technology;
3. Search and Rescue controlled by a government agency.

B. ALL OTHER DIVING. Diving accidents not covered by Instruction (6-A) but involving vessels subject to Instruction (2), VESSELS, must be reported if they result in death or injury causing incapacitation over 72 hours. (Ref. 46 CFR 4.03-1(c)).

HAZARDOUS MATERIALS

7. When an accident involves hazardous materials, public and environmental health and safety require immediate action. As soon as any person in charge of a vessel or facility has knowledge of a release or discharge of oil or a hazardous substance, that person is required to immediately notify the U. S. Department of Homeland Security's National Response Center (telephone toll-free 800-424-8802 - in the Washington, D.C. area call 202-426-2675). Anyone else knowing of a pollution incident is encouraged to use the toll-free telephone number to report it. If etiologic (disease causing) agents are involved, call the U.S. Public Health Service's Center for Disease Control in Atlanta, GA. (telephone 404-633-5313). (Ref. 42 USC 9603; 33 CFR 153; 49 CFR 171.15)

COMPLETION OF THIS FORM

8. This form should be filled out as completely and accurately as possible. Please type or print clearly. Fill in all blanks that apply to the kind of accident that has occurred. If a question is not applicable, the abbreviation "NA" should be entered in that space. If an answer is unknown and cannot be obtained, the abbreviation "UNK" should be entered in that space. If "NONE" is the correct response, then enter it in that space.

9. Once completed, deliver or mail this form as soon as possible to the Coast Guard Marine Safety, Marine Inspection or Activities Office nearest the location of the casualty or, if at sea, nearest the arrival port.

NOTICE: The information collected on this form is routinely available for public inspection. It is needed by the Coast Guard to carry out its responsibility to investigate marine casualties, to identify hazardous conditions or situations and to conduct statistical analysis. The information is used to determine whether new or revised safety initiatives are necessary for the protection of life or property in the marine environment.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB control number.

The Coast Guard estimates that the average burden for this report is 1 hour. You may submit any comments concerning the accuracy of this burden estimate or any suggestions for reducing the burden to: Commandant (G-MOA), U.S. Coast Guard, Washington, DC 20593-0001 or Office of Management and Budget, Paperwork Reduction Project (1625-0001), Washington, DC 20503

10. Amplifying information for completing the form:

A. Block 16 - "LOCATION" - Latitude and longitude to the nearest tenth of a minute should always be entered except in those rivers and waterways where a mile marker system is commonly used. In these cases, the mile number to the nearest tenth of a mile should be entered. If the latitude and longitude, or mile number, are unknown, reference to a known landmark or object (buoy, light, etc.) with distance and bearing to the object is permissible. Always identify the body of water or waterway referred to.

B. Tug or towboat with tow - Tugs or towboats with tows under their control should complete all applicable portions of the CG-2692. SECTION II should be completed if a barge causes or sustains damage or meets any other reporting criteria. If additional barges require reporting, the "Barge Addendum," CG-2692A, may be used to provide the information for the additional barges.

C. Moored/Anchored Barge - If a barge suffers a casualty while moored or anchored, or breaks away from its moorage, and causes or sustains reportable damages or meets any other reporting criteria, enter the location of its moorage in Block (1) of the CG-2692 and complete the form except for Blocks (2) through (13). The details will be entered in SECTION II for one barge and on the "Barge Addendum" CG-2692A, for additional barges.

D. SECTION III - Personnel Accident Information - SECTION III must be completed for a death or injury. In addition, applicable portions of SECTIONS I, II and IV must be completed. If more than one death or injury occurs in a single incident, complete one CG-2692 for one of the persons injured or killed, and attach additional CG-2692's, filling out Blocks (1) and (2) and SECTION III for each additional person.

E. BLOCK 44 - Describe the sequence of events which led up to this casualty. Include your opinion of the primary cause and any contributing causes of the casualty. Briefly describe damage to your vessel, its cargo, and other vessels/property. Include any recommendations you may have for preventing similar casualties. **ALCOHOL AND DRUG INFORMATION.** Provide the following information with regard to each person determined to be directly involved in the casualty: name, position aboard the vessel, whether or not the person was under the influence of alcohol or drugs at the time of the casualty, and the method used to make this determination. If toxicological testing is conducted the results should be included; if results are not available in a timely manner, provide the results of the toxicological test as soon as practical and indicate that this is the case in block 44 of the casualty form.

INSTRUCTIONS FOR COMPLETION OF FORM CG-2692B REPORT OF REQUIRED CHEMICAL DRUG AND ALCOHOL TESTING FOLLOWING A SERIOUS MARINE INCIDENT

NOTE: When this form is being submitted along with a REPORT OF MARINE ACCIDENT, INJURY OR DEATH (Form CG-2692), Blocks 3-10 and Blocks 12-14 on Form CG-2692B need not be completed.

An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a valid OMB control number. The Coast Guard estimates that the average burden for this report is .5 hours. You may submit any comments concerning the accuracy of this burden estimate or any suggestions for reducing the burden to: Commandant (G-PCA-1), U.S. Coast Guard, 2100 2nd St. SW, Washington D.C. 20593-0001 or Office of Management and Budget, Paperwork Reduction Project (1625-0001), Washington, DC 20503.

WHEN TO USE THIS FORM

1. This form satisfies the requirements in the Code of Federal Regulations for written reports of chemical drug and alcohol testing of individuals directly involved in serious marine incidents. Alcohol tests are to be conducted not later than 2 hours (unless there are casualty directly related safety concerns) and drug test specimens collected not later than 32 hours after a Serious Marine Incident. Public vessels and recreational vessels are excepted from these reporting requirements.

SERIOUS MARINE INCIDENTS

2. The term "serious marine incident" includes the following events involving a vessel in commercial service:

- A. Any marine casualty or accident that occurs upon the navigable waters of the U.S., its territories or possessions, or that involves a U.S. vessel anywhere, and that results in any of the following:
 - 1. One or more deaths;
 - 2. Any injury to a crewmember, passenger, or other person which requires professional medical treatment beyond first aid; and, in the case of a person employed on board a vessel in commercial service, which renders the individual unfit to perform routine vessel duties;
 - 3. Damage to property, as defined in 46 CFR 4.05-1(f), in excess of \$100,000;
 - 4. Actual or constructive total loss of any vessel subject to inspection under 46 U.S.C. 3301; or
 - 5. Actual or constructive total loss of any self-propelled vessel, not subject to inspection under 46 U.S.C. 3301, of 100 gross tons or more.
- B. A discharge of oil of 10,000 gallons or more into the navigable waters of the United States, as defined in 33 U.S.C. 1321, whether or not resulting from a marine casualty.
- C. A discharge of a reportable quantity of a hazardous substance into the navigable waters of the United States, whether or not resulting from a marine casualty.
- D. A release of a reportable quantity of a hazardous substance into the environment of the United States, whether or not resulting from a marine casualty.

INDIVIDUAL DIRECTLY INVOLVED IN A SERIOUS MARINE INCIDENT

3. Term "individual directly involved in a serious marine incident" is an individual whose order, action or failure to act is determined to be, or cannot be ruled out as, a causative factor in the events leading to or causing a serious marine incident.

COMPLETION OF THIS FORM

4. This form should be filled out as completely and accurately as possible. Please type or print clearly. Fill in all blanks that apply to the kind of incident that has occurred. If a question is not applicable, the abbreviation "NA" should be entered in that space. If an answer is unknown and cannot be obtained, the abbreviation "UNK" should be entered in that space. If "NONE" is the correct response, then enter it in that space.

5. When this form has been completed, deliver or mail it as soon as practicable to the Coast Guard Marine Safety or Marine Inspection Office nearest to the location of the incident or, if at sea, nearest to the port of first arrival.

6. Upon receipt of a report of chemical test results, the marine employer shall submit a copy of the test results for each person listed in block 15(a) of this form to the Coast Guard Officer in Charge, Marine Inspection where the CG-2692B was submitted. (Ref. 46 CFR 4.06-80(d)).

7. Amplifying information for completing the form:

A. Block 11—"TYPE OF SERIOUS MARINE INCIDENT"

Check each appropriate box. If box a, b, c, d, or e is checked, or append this form to the required form CG-2692, "REPORT OF MARINE ACCIDENT, INJURY OR DEATH", and submit both forms as indicated in 5. above.

B. Block 16c—"ALCOHOL TEST BREATH SPECIMEN PROVIDED?"

When breath test results are available alcohol concentration shall be expressed numerically in percent by weight (i.e., .04, .10 etc...).

C. Block 22—"REMARKS" Describe the duties of each individual listed in 15a, at the time of incident (i.e., master, pilot, chief engineer...). If an individual refuses to provide the required specimens, if specimens are not timely obtained, or not obtained, describe the circumstances completely.

NOTICE: The information collected on this form is routinely available for public inspection. It is needed by the Coast Guard to carry out its responsibility to investigate marine casualties, to identify hazardous conditions or situations and to conduct statistical analysis. The information is used to determine whether new or revised safety initiatives are necessary for the protection of life or property in the marine environment.

22. REMARKS (Continued)

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GCMA REPORT #R-429-I, Rev. 2 (Series)
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INVESTIGATIONS: ENFORCEMENT OF EXISTING PERSONAL INJURY REPORTING REQUIREMENTS

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INTRODUCTION

The Gulf Coast Mariners Association assigns our highest priority to our efforts to improve existing accident reporting requirements to more accurately report and properly record the personal injuries that happen to "lower-level" mariners on the job.

Item #2 in our 2007 Legislative Priorities⁽¹⁾ is to standardize logbook entries to include the reporting of personal injuries in vessel logbooks by the officer in charge of the watch at the time when the accident occurs. ⁽¹⁾*GCMA Report #R-333, Rev. 3, Mar. 14, 2007. GCMA Regulatory and Legislative Agenda - 2007.]*

Item #3 in our 2007 Legislative Priorities is more

sweeping and calls upon Congress to make certain basic changes in personal injury reporting, specifically:

ITEM #3. Require the Coast Guard to adequately protect mariners and offshore workers by enforcing the Congressional Intent of Occupational Safety and Health Act of 1970. Remove the data collection responsibility for health and safety issues from the Coast Guard and place it with the Department of Labor (e.g., replace forms CG-2692 with OSHA 300 series). Impose steep penalties for failing to report and track every "accident, injury, illness, and death" to a seaman, passenger, or other person on a vessel. Permanently separate personal injury and illness reporting from vessel and equipment casualties.

Existing Coast Guard Regulations

Coast Guard regulations at 46 CFR 4.05-10(a) state in part that "The owner, agent, master, operator, or person in charge shall, within five days, file a written report of any marine casualty required to be reported under §4.05-1. Such casualties include:

- Loss of life.
- Any injury that requires professional medical treatment (i.e., treatment beyond first aid).
- Any injury that leaves a person unfit to perform his or her duties.

GCMA attorney Mark Ross, Esq., investigated parish and county courthouse records in south Louisiana and Texas, checked his findings with local Coast Guard marine safety offices, and determined that one major offshore company had failed to file forty-four (44) written reports of personal injury in violation of Coast Guard regulations between 1992 and 1999. Subsequent discussions with other Coast Guard officials indicated that the number of violations for this one company alone might approach 150 – including both mariners working on their supply boats and oilfield workers on their drilling rigs.

Other evidence gathered from a number of our members while investigating other accidents indicates that these violations were not restricted to one errant employer. There are indications are that other marine employers may have failed to file reports of accidents and injuries. Our attempts to probe this matter repeatedly were obstructed by Coast Guard officials. Violations of the reporting regulation are punishable by a civil penalty – a policy the Coast Guard has failed to follow.

Our Association was appalled to discover that all attempts to encourage cognizant Coast Guard officers to take meaningful action on our findings, such as to impose civil penalties on the offenders, brought about no results. Consequently, GCMA attorney Mark Ross followed a different path and filed suit in Federal District Court under the False Claims Act. Unfortunately, this case was subsequently dismissed on a technicality.

Failure to report instances of serious personal injury and disability under the existing regulations seriously distort Coast Guard statistics maintained by the Coast Guard Office of Investigations and Analysis to the point that they cannot not accurately convey the dangers that our "lower-level" mariners face on the job.

PERSONAL INJURY REPORTING IN THE OFFSHORE OIL INDUSTRY.

On April 25, 2001, the Coast Guard supplied statistics to the National Offshore Safety Advisory Committee (NOSAC) purportedly covering 400 accidents involving offshore supply vessels that took place between 1992 and 2000. These statistics record 37 deaths and 144 injuries. While "deaths" are harder to cover up, the 144 reported injuries do not reflect the 44 injuries that Attorney Mark Ross uncovered reflecting those the injuries reported by a single offshore employer (ENSCO). Each of these cases was serious enough for the injured party to seek an attorney and bring the case to court! Had these cases been included, they would have reflected a significant percentage of the total reported offshore injuries.

Since ENSCO employs not only mariners but oilfield workers on the outer continental shelf, the Coast Guard's lack of concern with monitoring reportable accidents is more widespread than if it affected mariners alone.

[GCMA Comment: In our original report we suggested that Congress should explore "accident reporting" on the entire outer continental shelf and review proposed regulations in Docket # USCG-1998-3868 that would revise the workplace safety regulations on the outer continental shelf. Industry, through NOSAC, has attempted to weaken the proposed new regulations and thereby reduce the level of protection for our mariners as well as oilfield workers.]

PERSONAL INJURY REPORTING IN THE TOWING INDUSTRY

A Coast Guard internal report of towing vessel industry personnel clearly shows that the Coast Guard does not have a grasp on this important sector of the maritime industry that employs our "lower-level" mariners.

In this instance, the accuracy of Coast Guard's count of the number of towing vessels remains in question as well as the size of the work force manning those vessels. However, the Coast Guard exposure data clearly shows that the towing industry is a very dangerous place to work.

In a memorandum dated May 12, 1994,⁽¹⁾ a program analyst in the Coast Guard's Inspection and Documentation Division reported that the death rate (i.e., the number of deaths per 100,000 workers per year) in the towing industry was far higher than had been previously reported because the number of workers in the industry was grossly exaggerated. Instead of using the American Waterways Operators (AWO) estimate of 130,000 to 140,000, the Bureau of Labor Statistics estimated the work force in the towing sector as being closer to only 37,300. This indicated a much more serious fatality rate for the towing industry than previously acknowledged. In this fiasco, it appeared that the Coast Guard depended upon an industry trade group for the statistics it blindly accepted and that they had no valid figure that listed either the exact number of persons or towing vessels in the industry. ⁽¹⁾*GCMA Report #R-351, Rev.1. Oct. 24, 2006, How Safe is the Towing Industry, contains a*

reprint of the original Coast Guard document. This document was presented to the Towing Safety Advisory Committee in November 1994 and subsequently forgotten.]

By pointing out these dangers to our "lower-level" mariners who work on OSVs and on uninspected towing vessels, we hope to encourage industry's employers to take active steps to focus on improving safety in their operations. Recognizing the hazards of the workplace, particularly on unregulated and uninspected towing vessels,⁽¹⁾ we hoped our report would encourage employers to provide adequate life insurance coverage for their employees and thereby attract and retain trained mariners. Unfortunately, this has not happened in the six years following our issuance of the report.

In contrast to the lack of attention employers give this issue, many union contracts provide such coverage. Workboat companies avoid the cost of insuring their employees but are willing to turn to their corporate lawyers to contest every claim a mariner makes for an accidental injury or his estate makes if the injury is fatal. ⁽¹⁾*The Coast Guard will not even tell GCMA whether their proposed workplace regulatory improvements for vessels working on the outer continental shelf include uninspected towing vessels. Section 415 of the Coast Guard and Maritime Transportation Act of 2004 that requires the Coast Guard to inspect towing vessels may finally answer this question for us.]*

Proposed regulatory changes in Docket #USCG-1998-3868 will provide enhanced workplace safety for both mariners and oilfield workers on the outer continental shelf. Unfortunately, this rulemaking has been stalled in the process for the last nine years allowing existing substandard workplace safety conditions to continue.

GCMA determined through its investigation that one of the major problems of accident reporting lies within the internal structure of a number of companies. While masters and persons in charge often report accidents through company channels, and even do so on form CG-2692, some companies fail to follow through and forward these reports to the Coast Guard as they are supposed to. Other companies supply "look-alike" accident report forms on their vessels and edit them in company offices to protect their own interests. While fatalities and serious accidents are usually reported, often the Coast Guard is never informed of other less significant accidents and personal injuries that also are required to be reported. Consequently, GCMA points out that the accident data the Coast Guard uses does not present an accurate picture of how dangerous working offshore or in the towing industry really is. Consequently, GCMA requested that the Coast Guard modify their accident reporting procedures in this petition dated September 7, 2001.

COAST GUARD OFFICE OF INVESTIGATIONS & ANALYSIS DERAIS GCMA ACCIDENT REPORTING PETITION

Executive Secretary
Marine Safety Council (G-LRA 3406)
United States Coast Guard
2100 Second Street, SW
Washington, DC 20593-0001

SUBJECT: Petition to Initiate Rulemaking Action

Dear Sir or Madam,

The Gulf Coast Mariners Association, pursuant to 33 CFR 1.05-20(a), respectfully and formally requests that you initiate rulemaking to expand the listing of persons that are authorized or required to fill out accident reports by 46 CFR 4.05-10(a).

We specifically request that the injured party in addition to the "The owner, agent, master, operator, or person in charge" be authorized to submit a report of his/her injury as long as it meets existing criteria in the regulation.

The criteria of 46 CFR §4.05-1(a)(6) is "An injury that requires professional medical treatment (treatment beyond first aid) and, if the person is engaged or employed aboard a vessel in commercial service, that renders the individual unfit to perform his or her routine duties." We suggest that such a report be sent on form CG-2692 directly to the Coast Guard and not through the mariner's employer.

We also request that a notice similar to that required by 46 CFR §28.165 but reflecting the proposed regulation be required to be posted on every commercial vessel on which a "lower-level" mariner works. In doing so, we specifically direct your attention to the requirements of 46 U.S. Code §10603 that are required to be posted aboard uninspected fishing vessels.

We ask that you carefully review our attached Report #R-292 as supporting information for this petition.
s/ Richard A. Block, Secretary, GCMA

Following three years of fruitless correspondence with Coast Guard Headquarters, we received this reply from W.D. Rabe, Chief, Investigations Division dated July 16, 2004 that stated in part:

"The current regulation, specifically 46 CFR 4.05-1, does not set limitations as to who may submit a report of marine casualty. An injured party is not prohibited from making a report to the Coast Guard. In fact, our Investigating Officers often receive reports directly from mariners and conduct an investigation based on their report.

"I have determined the appropriate action in this instance is to release a policy letter to ensure that proper emphasis is given to any casualty report submitted to the Coast Guard regardless of source."

On June 30, 2005, in response to a GCMA follow-up request, we were told that the following passage would appear in the Marine Safety Manual, Part A, Chapter 5 instead of a policy letter:

"All incidents reported to the Coast Guard, regardless of source, will be investigated, however, the OCMI/COTP must determine on a case by case basis what investigative actions are appropriate for a specific case based on the likely value to marine safety, available resources, and risks in a given port. This policy does not limit or change OCMI/COTP authority or responsibility to determine appropriate actions. For example, a minor collision (damage of less than \$25,000) of a towboat and a moored casino vessel may highlight significant safety concerns that would demand a formal investigation, or the OCMI/COTP may decide to conduct an informal investigation of three deaths from a fishing vessel if the added cost and complexity of a formal investigation would not bring appreciable benefit. In such

cases, the usual process of investigating, determining causal factors, reporting, entering information in MISLE, and recordkeeping must be followed."

[GCMA Comment: The Coast Guard avoided the issue by missing our point that the existing accident reporting regulation at 46 CFR §4.05-1 as worded does not encourage any mariner who is NOT an owner, agent, master, or person-in-charge to file his own accident report and presenting his version of the accident or injury to the Coast Guard for consideration.]

[GCMA Comment: The Marine Safety Manual and/or Policy Letters are obscure documents most mariners never see. Although accident report form CG-2692 is more common, most employers prevent mariners from completing them and submitting them directly to the Coast Guard. GCMA maintains that such practices obscure the real cause of many accidents by preventing mariners from reporting the true causes of accidents and injuries.]

GCMA notes that industry trade associations have taken advantage of skewed accident statistics to the detriment of our mariners. The American Waterways Operators' (AWO) distorted work force estimate mentioned in **Example 2** (above) skewed the estimate of the number of deaths per 100,000 persons so that the towing industry appeared to be three to eight-times safer to work in than it really was in comparison to other U.S. industries.

In another example, the former President of the Offshore Marine Service Association (OMSA) fed this statement⁽¹⁾ to the public record:

- "Only five injuries are identified in a seven-year period that might have been prevented or diminished in severity by proposed workplace safety and health requirements." OR
- "...that OMSA operators had far fewer lost time injuries than any other sector of the U.S. marine transportation industry." OR
- "OMSA vessel operators have an exemplary injury safety record that has been improving for the past seven years." [⁽¹⁾Source: OMSA Letter dated 2/26/00 submitted to USCG Docket #1998-3868 as item #38. This letter spearheaded industry opposition to proposed new workplace safety standards on OSVs for outer continental shelf activities.]

**MARINERS ASSOCIATION COMPLAINTS
SILENCED AT COAST GUARD ADVISORY
COMMITTEE MEETING**

Mrs. Penny Adams, past President of GCMA, attempted to bring the matter that employers were not reporting accidents to the attention of the National Offshore Safety Advisory Committee (NOSAC) at their meeting in Washington on April 19, 2001. However, the Committee's Executive Director, Coast Guard Captain Peter Richardson (G-MSO) prevented her from disclosing our Association's data during the public portion of the meeting. This was the most blatant attempt on the part of a Coast Guard officer to

muzzle our lower-level mariners and to suppress information that revealed problems that affect our mariners' lives and livelihood.

**GCMA FILED SUIT AGAINST ENSCO
FOR FAILING TO REPORT
PERSONAL INJURY ACCIDENTS**

[Source: GCMA Press Release, March 12, 2001. Contact: Mark Ross, Esq., GCMA Counsel, (337) 266-2345.]

The Gulf Coast Mariners Association has filed suit in federal court against ENSCO Marine Company and ENSCO Offshore Company, two large offshore supply vessel and offshore drilling companies operating in the Gulf of Mexico. The GCMA's complaint asserts that ENSCO violated federal law by consistently failing to report accidents involving their offshore employees to the U.S. Coast Guard. The lawsuit was originally filed on August 30, 2000, but has remained under seal until today in compliance with federal law.

The suit was brought under the False Claims Act, a federal whistleblower statute, and was filed in U.S. District Court in Lafayette, Louisiana. GCMA contends that federal law requires ENSCO to report all employee accidents requiring a doctor's care. In particular, ENSCO must file an accident report (known as a CG-2692) with the Coast Guard within five days of any such accident. GCMA alleges that for many years, ENSCO systematically failed to report such employee accidents to the Coast Guard except in cases involving fatalities.

GCMA's investigation of ENSCO's compliance with the law followed requests under the Freedom of Information Act, seeking copies of ENSCO's Form CG-2692 reports for employee accidents that were the subject of other lawsuits brought against the company. Out of 44 accidents resulting in lawsuits in various federal and state courts, the U.S. Coast Guard only had one CG-2692 on file for ENSCO.

"Our investigation shows that the U.S. Coast Guard's marine safety data base, which the Coast Guard uses to track accidents and make inspection decisions in the Gulf of Mexico, is effectively rendered useless by ENSCO's refusal to report all relevant accidents," said GCMA President Penny Adams. "The safety aspects of offshore work are not as rosy as the Coast Guard portrays them."

GCMA's complaint also alleges that ENSCO failed to produce copies of the employee accident reports during the discovery process in prior lawsuits. A court transcript included with the GCMA's complaint shows that an ENSCO attorney denied that any accident reports existed in conjunction with a particular plaintiff's injury. GCMA subsequently determined that the accident report did exist, but that ENSCO had failed to provide the report to the plaintiff's counsel or to the Coast Guard.

"Following that revelation, we asked the Coast Guard to write to ENSCO and demand an explanation of why the Company had failed to file accident reports," said Richard Block, a GCMA board member. "Our members often ask us to notify the Coast Guard about boat companies that break the law."

Following the Coast Guard's inquiries, ENSCO's safety manager responded that ENSCO accident reporting to the Coast Guard had "fallen through the cracks" during a change

in the ENSCO safety group in the preceding few months. However, GCMA's lawsuit alleges that ENSCO's failure to report reaches back much further and covers at least a five-year period between 1993 and 1998. "We doubt that these reports had just fallen through the cracks for the five years," said Block, adding that "the failure to file these reports suggests a broader undermining of federal safety regulations."

The GCMA's lawsuit charges that ENSCO violated the False Claims Act by providing the Coast Guard with a false explanation of the company's failure to report accidents.

The GCMA's lawsuit is in the early stages of litigation and no trial date has yet been scheduled. One of the Association's first goals is to determine how many accident reports are maintained in ENSCO's records but have never been filed with the U.S. Coast Guard. "Proper reporting of accidents is a critical component of the Coast Guard's safety strategy," said Block. "When companies fail to file the proper reports, mariners and regulators have no ability to assess safety concerns at sea. Our suit is aimed at holding ENSCO accountable to this important standard. We will also assess the compliance of other companies on these counts."

The GCMA's lawsuit seeks the proper filing of all accident reports by ENSCO, modification of ENSCO's reporting requirements, and imposition of civil penalties. Federal law provides that ENSCO can be fined up to \$25,000 for each failure to report an accident. The False Claims Act also provides for treble damages and additional penalties of \$5,000 to \$10,000.

The GCMA is an association of "lower-level" mariners employed on tugs, towboats, offshore supply vessels, and small passenger vessels throughout the United States. The Association represents mariners on issues important to their profession and advocates for mariners and their families before the Coast Guard and other government agencies.

THE COAST GUARD CUTS AND RUNS

Although GCMA's case against ENSCO's failure to report injuries never went to court, GCMA continued to press the issue because it affected every single one of our merchant mariners.

GCMA reported the matter to the Department of Transportation's Inspector General's Office (OIG). However, we had to submit a number of FOIA requests to obtain any information as to whether the matter was even investigated. A heavily redacted document from the OIG office finally stated in part: "On April 23, 2001, DOT OIG contacted ■ and inquired into any civil penalties the USCG might have filed against ENSCO. ■ advised to (his/her) knowledge the USCG imposed no civil remedial files on ENSCO. ■ advised since (he/she) began working with ENSCO, they seem to be complying with USCG safety requirements. In addition, ENSCO hired two new personnel, a Safety Advisor, and a Case Management Coordinator to help ensure that ENSCO complied with USCG requirements."

[GCMA Comment: COMDTINST 16200.3A, Table 5-A gives the Civil Penalty ranges for "failure of a marine employer to report a marine casualty in writing to the

OCMI as required by 46 CFR §4.05-10(a) as between \$500 and \$1,000. This civil penalty for failing to report an injury is considerably less than the criminal penalty for filing a false report. There were a total of 44 separate incidents reported.]

The Coast Guard Investigations Department at Marine Safety Office in Morgan City in 2001 was clearly out of its league in attempting to deal with a major drilling contractor. Consequently, they took the easy route out that indicated that enforcing personal injury reporting regulations clearly was not high on their agenda. They issued ENSCO the following weak-kneed OCMI Letter of Warning dated February 16, 2001 and swept the matter out the door:

"Based on the results of a Coast Guard investigation concerning the non-reporting of injuries during the period of 1993 through 1998 that occurred on various ENSCO vessels, the Coast Guard determined you were in violation of federal regulation 46 CFR §4.05-1 & 5.

"This violation can result in a \$25,000.00 penalty for each incident. The Coast Guard has initiated casualty cases for the unreported injuries; and noted that there were an additional five reportable injuries but Coast Guard policy did not require initiation of a casualty case. In consideration of the nature of this violation, and it does not appear to be the standard policy (since other injuries were reported by ENSCO during the time period) I am issuing this Letter of Warning to you rather than initiating civil penalty action. However, I urge your cooperation in preventing future occurrences of this kind.

"This matter will not be pursued further unless you wish to contest this Letter of Warning...."

[GCMA Comment: Nobody in their right mind would contest this toothless letter that was addressed to the Company and rather than any specific person in authority at that company.]

[GCMA Comment: The Coast Guard reinforced its local investigations office in Morgan City by assigning a retired Coast Guard officer with legal training to its staff.]

CONGRESSIONAL OVERSIGHT OF COAST GUARD INVESTIGATIONS

On March 1, 2003 the Coast Guard was transferred from the Department of Transportation to the Department of Homeland Security.

On December 16, 2005 the Chairmen and Ranking Members of the Committee on Transportation and Infrastructure of the House of Representatives and the Committee on Commerce, Science, and Transportation of the U.S. Senate requested the Department of Homeland Security's Office of Inspector General to "conduct a study of the Coast Guard's marine casualty investigation program and to report to these Committees the findings and recommendations of that study not later than June 30, 2007."

The request continues: "The Committees expect that the study and report shall examine the extent to which marine casualty investigations and reports result in information and

recommendations that prevent similar casualties; minimize the effect of similar casualties, given that it has occurred; and maximize lives saved in similar casualties, given that the vessel has become uninhabitable.

"The Committees also suggest that the study include the following to promote the safety of all who work on or travel by water and to protect the marine environment:

- the adequacy of resources devoted to marine casualty investigations considering caseload and duty assignment practices;
- training and experience of marine casualty investigators;
- investigation standards and methods, including a comparison of the formal and informal investigation processes;
- the use of best investigation practices considering transportation investigation practices used by other Federal agencies and foreign governments, including the British Marine Accident Investigation Branch programs;
- usefulness of the marine casualty data base for marine casualty prevention programs;
- the extent to which mariner casualty data and information have been used to improve *survivability and* habitability of vessels involved in marine casualties.
- any changes to current statutes that would clarify Coast Guard responsibilities for marine casualty investigations and report, and
- the extent to which the Coast Guard has reduced the frequency of formal investigations, or changed the types of incidents for which it has carried out a formal investigation process, in the past five years.

MASTER MARINER #39 REPORTS ON SHORTCOMINGS IN PERSONAL INJURY REPORTING

[*Editorial Note: Emphasis by underlining is ours.*]

REF: Your letter of March 20, 2007

Dear Capt. Block:

In response to your inquiry concerning our litigation related experience at the American Admiralty Bureau (AAB), I'd like to first address my experience as a working licensed master and pilot.

As you know I hold an unlimited tonnage Master's license for U.S. inland waters endorsed as First Class Pilot and Towboat Master, as well as Master of Auxiliary Sail (limited tonnage). Before working for the American Admiralty Bureau I worked for three companies that operated vessels of 1,600 gross register tons or over as relief master, pilot, or mate. I also worked as master of a fire and rescue boat for the State of Louisiana, and for several companies operating smaller craft and charter yachts.

My initial sea duty was with the U.S. Navy and Coast Guard. During the 12 years or so that I was involved in the full time operation of vessels, I never experienced a reportable accident. Consequently, like most GCMA members and other licensed officers, I never had to deal with a CG-2692 form personally. Thus I was unaware that the completion of this form was a problem until I began to see the form in litigation. I believe my experience indicates why the use of and abuse of the form has not become an issue for

licensed officers generally. Only a minority experience reportable accidents, so the rest of us are blissfully unaware of widespread industry abuses of the form and the related regulations.

I first became aware of the problems with the form in a litigation context not at the American Admiralty Bureau but at the first insurance defense admiralty law firm at which I worked as an investigator and paralegal. I do not wish to name the firm since client confidentiality is involved, nor can I name companies or cases. As you know many legal settlements involve confidentiality agreements applicable to both sides. So my observations at the first law firm I worked for must be highly generalized as the underlying specific information is derived from privileged information. Additionally the firm no longer exists so verification would be impossible even if legal privilege could be broken.

As soon as I began investigating personal injuries and collisions as a law firm investigator, I noticed that many companies had not filed CG-2692 forms. The non-filers followed a pattern. If the case involved a major collision or the injured seaman was removed by ambulance or MEDIVAC helicopter, a CG-2692 form was filed. In most cases of personal injury where the crewman was not immediately MEDIVACED from the vessel no CG 2692 form was ever filed. I brought these facts to the attention of the firm's managing partner and the firm began a policy of insuring that a CG-2692 form was filed by each client, even if it was filed late. However, the firm's lawyers prepared the form, never the master or a company manager.

The firm's lawyers became experts at completing the form with the "who, what and where" of the accidents but virtually none of the why or any other details that might lead to an answer as to why an accident occurred. It was this initial law-firm experience that led me to be on the look out for 2692 forms as a part of every "discovery package" received for examination at the American Admiralty Bureau, Ltd. (AAB) when I became Chief Forensic Examiner there.

During my tenure at the AAB, I examined over 1,000 cases of collision, allision, and personal injury. I immediately observed the same pattern that I observed at the law firm. More than half the cases arrived with no CG-2692 form. But I also observed something new. Of those which came with no CG-2692 form the overwhelming majority came with no Coast Guard signatures in the "Coast Guard only block". At first I thought that this simply meant that the responding party sent their copy of what they submitted to the Coast Guard. We would then submit a "Freedom of Information Act inquiry" to the Coast Guard for the investigative file. In the majority of such cases the Coast Guard would respond that they had no such case in their system. Subsequent deposition testimony would often reveal that we were furnished a lawyer-prepared 2692 form specifically designed to respond to our request for production. They would always have some excuse for their failure to file with the Coast Guard. Our technical experts acting as expert witnesses would always point out that such failure to file deprived the injured seaman of a free and neutral investigation that necessitated some of the expert expense cost of litigation that they now had to pay to make their case. Judges were receptive to this concept generally in terms of damage awards, but neither the courts nor the lawyers who hired the AAB ever reported these events to the

Coast Guard. Lawyers place little value on Coast Guard investigative findings since they are inadmissible in court since the intent of such investigations has nothing to do with liability.

At the AAB we gradually educated client lawyers to the fact that while the Coast Guard's reports per se were inadmissible, they often led to other evidence that was. Additionally a competent expert would insist on examining any existing Coast Guard file and can mention parts of the content in his fully admissible expert report, providing a side door of admissibility. We did not report these instances of non-compliance to the Coast Guard based on client instructions. Once settlement discussions would begin, our client lawyers generally didn't want to do anything that might inflame the other side. The National Federation of Paralegal Association (NFPA) Code of Ethics and the National Forensic Center's (NFC) Code of Ethics that the AAB adhered to both made all support services in litigation totally subservient to the lawyer who hired the service. Adversarial codes of ethics in tort situations place a premium on adversarial efforts to "make the client whole" and not on acting as enforcer of regulations.

Based on my combined experience at both an insurance defense admiralty law firm and the somewhat more plaintiff seaman orientated American Admiralty Bureau, I believe that on average only about twenty percent of litigated reportable marine accidents are ever reported to the Coast Guard by means of the CG 2692 form or any other means. Unfortunately, with the AAB as was the case with the law firm, client confidentiality precludes discussion of specific cases. In furtherance of this confidentiality all AAB case files and materials were forwarded to the commissioning attorney upon the close of the case. There is no AAB case archive. Additionally many of the business records of the AAB were destroyed in Hurricane Katrina.

I hope the above and foregoing provides some insight into the extent of the problem of non-compliance with Coast Guard accident reporting and the reasons behind it. Obviously the reason for non compliance is liability avoidance. The reason the problem stays hidden from the Coast Guard is a combination of the tendency for court cases to settle and the usual requirements for confidentiality of settlement agreements. Most of the cases I observed involved companies operating work vessels of 1,600 gross registered tons or less. My experience with American registered unlimited tonnage operations is that the presence of the union's patrol men and shop stewards drives accident reporting requirement compliance to near the 100% mark. However as you know the AGT fleet is the smallest sector of the American Merchant Marine in terms of vessel numbers and numbers of mariners. I believe that a comparison of Coast Guard accident reports filed with the total of maritime accident litigations filed in the U.S. court systems would reveal only a portion of the problem. Such a study would reveal only the difference between reported cases and those that resulted in the filing of litigation. The many reportable cases that settled on notice, or went unchallenged by the injured seaman or don't involve a probable contestant such as unintentional groundings will not show up in the court filings. So when I estimate that only about 20% of cases are reported, I'm speaking of only those cases that are eventually litigated.

Again, the problem is not so acute in the any gross tons (AGT) (unlimited tonnage) fleet where the unions monitor accident reporting compliance. The unions are the only mariner voice that the Coast Guard usually hears and they aren't complaining because their members are enjoying a high compliance rate thanks to the union's efforts. These I believe are the reasons for the high rate of non compliance and the general lack of awareness of the high rate of non compliance.

The above and foregoing of course, represent my personal opinion and not that of any organization or employer that I have ever served. The very same reasons that tend to hide the problem from the Coast Guard make it impossible for me to support my opinion with specific examples, or statistics. But for what it is worth the above and foregoing is my litigation experienced-based generalized opinion on the general state of industry compliance with accident reporting requirements.

Very Truly Yours,
Master Mariner #39

CONCLUSION

If you are a mariner and are injured or become seriously on the job, we recommend that you immediately notify the Master of **(and read this carefully)** "an injury that requires professional medical treatment (treatment beyond first aid) and, if the person is engaged or employed on board a vessel in commercial service, that renders the individual unfit to perform his or her routine duties..."

Even if it is just a cut, scrape, slip, trip, fall, strain or other minor injury, ask the Master of the vessel to make a logbook entry. Ask him to also report the injury or illness to the company and then check to see that he has done so. If you require more than first aid (i.e., a trip to the doctor's office or a medical clinic, or hospital) be sure that the company reports it to the Coast Guard on CG-2692.

Be alert to the fact that most companies prefer to take care of this at the office rather than to allow the Master to fill out a form and submit it directly to the Coast Guard. However, if you doubt whether the Company reported your injury or illness to the Coast Guard, ask for a copy of the form they submitted to the Coast Guard. However, if they won't give you a copy or they never filled one out for you, ask for a blank copy and mail it directly to the Coast Guard. If the injury or illness is serious, immediately contact a maritime attorney of your choice, and discuss the extent of your injuries with him/her and seek advice. You will find a list of maritime attorneys on the GCMA website.

We also suggest that you read the following GCMA Reports because there is no reason for you to learn about the unscrupulous actions of some employers, even well-known large corporations, "the hard way."

- GCMA Report # R-333, Rev. 3, Jun. 21, 2006. Don't Count On Corporate Compassion or Coast Guard Concern – True Stories of Our Lost, Injured, and Cheated Mariners.
- GCMA Report # R-370, (Series), Jun. 16, 2003. 12 Hour Rule Violation: The Verret Case.
- GCMA Report # R-412, April 25, 2005. Towboat Engineer's Death Points to Need for Changes in the Law.

Explanation.

- **Our initial petition bears Docket #USCG-2002-12580-1.** The petition was submitted over a year earlier in our letter dated Sept. 7, 2001. It was mishandled by the Executive Secretary of the Marine Safety Council. (1 page)
- **Docket #USCG-2002-12580-2.** The Coast Guard assigned us a Docket number on June 28, 2002. (1 page)
- **Docket #USCG-2002-12580-3.** Sept. 3, 2002. Our Association reviewed the docket postings on the internet and reiterated our request that GCMA Report #R-292 be added to the docket and reviewed as supporting evidence. (5 pages).
- **Docket #USCG-2002-12580-4.** Feb. 1, 2005. (32 numbered pages). After reviewing the final Coast Guard response, and being unable to locate or obtain a copy of the Policy Letter promised in Paragraph 3 of that letter, we asked that the full background of our complaint be added to that docket for future reference. We apologize for any duplications found therein, but our goal was to establish a complete record available to the public. Policy Letters were organized and incorporated into a major policy document, Volume 5 of the Marine Safety Manual (COMDTINST M16000.10 A) in April 2008. In reviewing that document we could find no reference to the material that the "Policy Letter" mentioned by the Chief of the Investigations Department mentioned in that document. Consequently, we determined that our Association had been misled.



Docket Folder Summary

USCG-2002-12580

Petition for Rulemaking

Docket ID: USCG-2002-12580 Agency: USCG

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Gulf Coast Mariners Association	Public Submission	Block, Secretary, Richard	Gulf Coast Mariners Association	USCG-2002-12580-0004	02/11/2005	
Coast Guard's Reply to Petitioner	Supporting & Related Material		USCG	USCG-2002-12580-0002	08/07/2002	
Petition for Rulemaking	Supporting & Related Material		USCG	USCG-2002-12580-0001	08/07/2002	

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Gulf Coast Mariners Association



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183258

September 7, 2001

Executive Secretary
Marine Safety Council (G-LRA 3406)
United States Coast Guard
2100 Second Street, SW
Washington, DC 20593-0001

SUBJECT: Petition to Initiate Rulemaking Action

Dear Sir or Madam,

The Gulf Coast Mariners Association, pursuant to 33 CFR 1.05-20(a), respectfully and formally requests that you initiate rulemaking to expand the listing of persons that are authorized or required to fill out accident reports by 46 CFR 4.05-10(a).

We specifically request that the injured party in addition to the "The owner, agent, master, operator, or person in charge" be authorized to submit a report of his/her injury as long as it meets existing criteria in the regulation.

The criteria of 46 CFR 4.05-1(a)(6) is "An injury that requires professional medical treatment (treatment beyond first aid) and, if the person is engaged or employed aboard a vessel in commercial service, that renders the individual unfit to perform his or her routine duties;..." We suggest that such a report be sent on form CG-2692 directly to the Coast Guard and not through the mariner's employer.

We also request that a notice similar to that required by 46 CFR 28.165 but reflecting the proposed regulation be required to be posted on every commercial vessel on which a "lower-level" mariner works. In doing so, we specifically direct your attention to the requirements of 46 USC 10603 that are required to be posted aboard uninspected fishing vessels.

We ask that you carefully review our attached Report #R-292 as supporting information for this petition.

Very truly yours,

Richard A. Block
Master #830614
Secretary, Gulf Coast Mariners Association

COPY

Date: 9/12/01 Follow up #: 3
To date, we have received no answer to this letter. When writing to any government agency, we expect the courtesy of a written response.

PLEASE ANSWER
OUR LETTER

U.S. Department
of Transportation

United States
Coast Guard



United States Coast Guard
Commandant

2100 2nd Street, SW
Washington, DC 20593-0001
Staff Symbol: G-LRA
Phone: 202-267-1534
FAX: 202-267-6234

183263

16704
June 28, 2002

Gulf Coast Mariners Association
Attn: Richard A. Block
P.O. Box 3589
Houma, LA 70360-3589

USCG-02-12580-2

Dear Sir:

Your petition requesting that the "injured party in addition to the owner, agent, master, operator, or person in charge be authorized to submit a report of his/her injury as long as it meets existing criteria in the regulation" has been forwarded to Assistant Commandant for Marine Safety and Environmental Protection for consideration. A more thorough response to the petition will be forthcoming from that office after their review is completed.

Your petition for rulemaking has been assigned a Department of Transportation Docket Management System docket number; that number is USCG 2002-12580. A copy of your petition, along with the Coast Guard's response when made, and other documents made part of the docket, will be placed in the docket at the Department of Transportation's Docket Management Facility. The docket is available for public review between 9 a.m. and 5 p.m., Monday through Friday, except Federal Holidays, in room PL-401, 400 Seventh Street SW, Washington, DC and electronically through the Internet site at <http://dms.dot.gov>.

Sincerely,

LATICIA ARGENTI
Commander, U.S. Coast Guard
Executive Secretary
Marine Safety Council

Copy: G-MOA



GULF COAST MARINERS ASSOCIATION

P. O. Box 3589 • Houma, Louisiana 70361-3589

Phone: (985) 537-4885 • Fax: (985) 537-4860

E-mail: info@gulfcoastmariners.org Website: www.gulfcoastmariners.org

September 3, 2002

U.S. Department of Transportation
Docket Management Facility
Room PL-401
400 Seventh Street, SW
Washington, DC 20590

VIA FAX TO: (202) 493-2251

Docket #USCG-2002-12580 Accident Reporting

Dear Sir or Madam,

USCG-2002-12580-3

This docket was opened recently based upon our petition to the Executive Secretary of the Marine Safety Council filed a year ago. In that letter, we asked that GCMA Report #R-292 be reviewed as supporting evidence. However, in reviewing the docket on the internet we did not find this report.

We are sending a copy of this report by fax and ask that you include it in this docket. (4 pages).

Very truly yours,

Richard A. Block

Master #1014425

Secretary, Gulf Coast Mariners Association

02 SEP -3 AM 9:40
DEPT OF TRANSPORTATION

Gulf Coast Mariners Association



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www.gulfcoastmariners.org

GCMA REPORT #R-292, Rev. 1
DATE: July 16, 2006

[Publication History: Originally issued on September 7, 2001. This report also replaces GCMA Report #R-277.]

ENFORCEMENT OF EXISTING ACCIDENT AND INJURY REPORTING REQUIREMENTS

The Gulf Coast Mariners Association assigns a very high priority to our efforts to improve existing accident reporting requirements to more accurately report and properly record the personal injuries that happen to "lower-level" mariners on the job.

Coast Guard regulations at 46 CFR 4.05-10(a) state in part that "The owner, agent, master, operator, or person in charge shall, within five days, file a written report of any marine casualty required to be reported under §4.05-1. Such casualties include:

- § Loss of life.
- § Any injury that requires professional medical treatment (i.e., treatment beyond first aid).
- § Any injury that leaves a person unfit to perform his or her duties.

GCMA attorney Mark Ross, Esq., investigated parish and county courthouse records in south Louisiana and Texas, checked his findings with local Coast Guard marine safety offices, and determined that one major offshore company had failed to file forty-four (44) written reports of personal injury in violation of Coast Guard regulations between 1992 and 1999. Subsequent discussions with other Coast Guard officials indicated that the number of violations for this one company alone might approach 150 – including both mariners working on their supply boats and oilfield workers on their drilling rigs.

Other evidence gathered from a number of our members while investigating other accidents indicates that these violations were not restricted to one errant employer. There are indications are that other marine employers may have failed to file reports of accidents and injuries. Our attempts to probe this matter repeatedly were obstructed by Coast Guard officials. Violations of the reporting regulation are punishable by a civil penalty – a policy the Coast Guard has failed to follow.

Our Association was appalled to discover that all attempts to encourage cognizant Coast Guard officers to take meaningful action on our findings, such as to impose civil penalties on the offenders, brought about no results. Consequently, GCMA attorney Mark Ross followed a

different path and filed suit in Federal District Court under the False Claims Act. Unfortunately, this case was subsequently dismissed on a technicality.

Failure to report instances of serious personal injury and disability under the existing regulations seriously distorted Coast Guard statistics maintained by the Coast Guard Office of Investigations and Analysis to the point that they could not accurately convey the dangers that our "lower-level" mariners face on the job.

Example #1: The Offshore Oil Industry.

On April 25, 2001, the Coast Guard supplied statistics to the National Offshore Safety Advisory Committee (NOSAC) purportedly covering 400 accidents involving offshore supply vessels that took place between 1992 and 2000. These statistics record 37 deaths and 144 injuries. While "deaths" are harder to cover up, the 144 reported injuries do not reflect the 44 injuries that Attorney Mark Ross uncovered reflecting those the injuries reported by a single offshore employer (ENSCO). Each of these cases was serious enough for the injured party to seek an attorney and bring the case to court! Had these cases been included, they would have reflected a significant percentage of the total reported offshore injuries.

Since ENSCO employs not only mariners but oilfield workers on the outer continental shelf, the Coast Guard's lack of concern with monitoring reportable accidents is more widespread than if it affected mariners alone.

[GCMA Comment: Congress should explore "accident reporting" on the entire outer continental shelf and review proposed regulations in Docket # USCG-1998-3868 that would revise the workplace safety regulations on the outer continental shelf. Industry, through NOSAC, has attempted to weaken the proposed new regulations and thereby reduce the level of protection for our mariners as well as oilfield workers.]

Example #2: The Towing Industry

A Coast Guard internal report of towing vessel industry personnel clearly shows that the Coast Guard does not have a grasp on this important sector of the maritime industry that employs our "lower-level" mariners.

In this instance, the accuracy of Coast Guard's count of the number of towing vessels remains in question as well as the size of the work force manning those vessels. However, the Coast Guard exposure data clearly shows that the towing industry is a very dangerous place to work.

In a memorandum dated May 12, 1994,⁽¹⁾ a program analyst in the Coast Guard's Inspection and Documentation Division reported that the death rate (i.e., the number of deaths per 100,000 workers per year) in the towing industry was far higher than had been previously reported because the number of workers in the industry was grossly exaggerated. Instead of using the American Waterways Operators (AWO) estimate of 130,000 to 140,000, the Bureau of Labor Statistics estimated the work force in the towing sector as being closer to only 37,300. This indicated a much more serious fatality rate for the towing industry than previously acknowledged. In this fiasco, it appeared that the Coast Guard depended upon an industry trade group for the statistics it blindly accepted and that they had no valid figure that listed either the exact number of persons or towing

vessels in the industry. [⁽¹⁾GCMA Report #R-351 How Safe is the Towing Industry contain a reprint of the Coast Guard document. This document was presented to the Towing Safety Advisory Committee in November 1994.]

By pointing out these dangers to our "lower-level" mariners who work on OSVs and on uninspected towing vessels, we hope to encourage industry's employers to take active steps to focus on improving safety in their operations. Recognizing the hazards of the workplace, particularly on unregulated and uninspected towing vessels,⁽¹⁾ we hoped our report would encourage employers to provide adequate life insurance coverage for their employees and thereby attract and retain trained mariners. Unfortunately, this does not appear to have happened in the five years following our issuance of the report. In contrast to the lack of attention employers give this issue, many union contracts provide such coverage. Companies avoid the cost of insuring their employees but turn to corporate lawyers to contest every claim a mariner makes for an accidental injury or his estate makes if the injury is fatal. [⁽¹⁾*The Coast Guard will not even tell GCMA whether their proposed workplace regulatory improvements for vessels working on the outer continental shelf include uninspected towing vessels. Section 415 of the Coast Guard and Maritime Transportation Act of 2004 that requires the Coast Guard to inspect towing vessels may answer this question for us.*

Proposed regulatory changes in Docket #USCG-1998-3868 will provide enhanced workplace safety for both mariners and oilfield workers on the outer continental shelf. Unfortunately, this rulemaking has been stalled in the process for the last eight years allowing existing substandard workplace safety conditions to continue.]

GCMA determined through its investigation that one of the major problems of accident reporting lies within the internal structure of a number of companies. While masters and persons in charge often report accidents through company channels, and even do so on Form CG-2692, some companies fail to follow through and forward these reports to the Coast Guard as they are supposed to. While fatalities and serious accidents are usually reported, often the Coast Guard is never informed of other less significant accidents and personal injuries that also are required to be reported. Consequently, GCMA has pointed out that the accident data the Coast Guard uses does not present an accurate picture of how dangerous working offshore really is. Consequently, GCMA requested that the Coast Guard modify their accident reporting procedures in this petition dated September 7, 2001.

Executive Secretary
Marine Safety Council (G-LRA 3406)
United States Coast Guard
2100 Second Street, SW
Washington, DC 20593-0001

SUBJECT: Petition to Initiate Rulemaking Action

Dear Sir or Madam,

The Gulf Coast Mariners Association, pursuant to 33 CFR 1.05-20(a), respectfully and formally requests that you initiate rulemaking to expand the listing of persons that are authorized or required to fill out accident reports by 46 CFR 4.05-10(a).

We specifically request that the injured party in addition to the "The owner, agent, master, operator, or person in charge" be authorized to submit a report of his/her injury as long as it meets existing criteria in the regulation.

The criteria of 46 CFR §4.05-1(a)(6) is "An injury that requires professional medical treatment (treatment beyond first aid) and, if the person is engaged or employed aboard a vessel in commercial service, that renders the individual unfit to perform his or her routine duties." We suggest that such a report be sent on form CG-2692 directly to the Coast Guard and not through the mariner's employer.

We also request that a notice similar to that required by 46 CFR §28.165 but reflecting the proposed regulation be required to be posted on every commercial vessel on which a "lower-level" mariner works. In doing so, we specifically direct your attention to the requirements of 46 U.S. Code §10603 that are required to be posted aboard uninspected fishing vessels.

We ask that you carefully review our attached Report #R-292 as supporting information for this petition.
s/ Richard A. Block, Secretary, GCMA

Following three years of correspondence with Coast Guard Headquarters, we received this reply from W.D. Rabe, Chief, Investigations Division dated July 16, 2004 that stated in part:

"The current regulation, specifically 46 CFR 4.05-1, does not set limitations as to who may submit a report of marine casualty. An injured party is not prohibited from making a report to the Coast Guard. In fact, our Investigating Officers often receive reports directly from mariners and conduct an investigation based on their report.

"I have determined the appropriate action in this instance is to release a policy letter to ensure that proper emphasis is given to any casualty report submitted to the Coast Guard regardless of source."

On June 30, 2005, in response to a GCMA follow-up request, we were told that the following passage would appear in the Marine Safety Manual, Part A, Chapter 5 instead of a policy letter:

"All incidents reported to the Coast Guard, regardless of source, will be investigated, however, the OCMI/COTP must determine on a case by case basis what investigative actions are appropriate for a specific case based on the likely value to marine safety, available resources, and risks in a given port. This policy does not limit or change OCMI/COTP authority or responsibility to determine appropriate actions. For example, a minor collision (damage of less than \$25,000) of a towboat and a moored casino vessel may highlight significant safety concerns that would demand a formal investigation, or the OCMI/COTP may decide to conduct an informal investigation of three deaths from a fishing vessel if the added cost and complexity of a formal investigation would not bring appreciable benefit. In such cases, the usual process of investigating, determining causal factors, reporting, entering information in MISLE, and recordkeeping must be followed."

[GCMA Comment: The Coast Guard avoided the issue by missing our point that the existing accident reporting regulation at 46 CFR §4.05-1 as worded does not encourage any mariner who is NOT an owner, agent,

master, or person-in-charge to file his own accident report and presenting his version of the accident or injury to the Coast Guard for consideration. The Marine Safety Manual and/or Policy Letters are obscure documents most mariners never see. Although accident report form CG-2692 is more common, most employers prevent mariners from completing them and submitting them directly to the Coast Guard. GCMA maintains that such practices obscure the real cause of many accidents by preventing mariners from reporting the true causes of accidents and injuries.]

GCMA notes that industry trade associations have taken advantage of skewed accident statistics to the detriment of our mariners. The American Waterways Operators' (AWO) distorted work force estimate mentioned in **Example 2** (above) skewed the estimate of the number of deaths per 100,000 persons so that the towing industry appeared to be three to eight-times safer to work in than it really was in comparison to other U.S. industries.

In another example, the former President of the Offshore Marine Service Association (OMSA) fed this statement⁽¹⁾ to the public record:

§ "Only five injuries are identified in a seven-year period that might have been prevented or diminished in severity by proposed workplace safety and health requirements." OR

§ "...that OMSA operators had far fewer lost time injuries than any other sector of the U.S. marine transportation industry." OR

§ "OMSA vessel operators have an exemplary injury safety record that has been improving for the past seven years." [⁽¹⁾Source: OMSA Letter dated 2/26/00 submitted to USCG Docket #1998-3868 as item #38. This letter spearheaded industry opposition to proposed new workplace safety standards on OSVs for outer continental shelf activities.]

Mariners silenced. The past President of GCMA, Mrs. Penny Adams, attempted to bring the matter that employers were not reporting accidents to the attention of the National Offshore Safety Advisory Committee (NOSAC) at their meeting in Washington on April 19, 2001. However, the Committee's Executive Director, USCG Captain Peter Richardson (G-MSO) prevented her from disclosing our Association's data during the public portion of the meeting. This was a blatant attempt on the part of Coast Guard to muzzle lower-level mariners and to suppress information that reveals problems that affect our mariners lives and livelihood.

GCMA FILED SUIT AGAINST ENSCO FOR FAILING TO REPORT ACCIDENTS

[Source: GCMA Press Release, March 12, 200. Contact: Mark Ross, Esq., GCMA Counsel, (337) 266-2345.]

The Gulf Coast Mariners Association has filed suit in federal court against ENSCO Marine Company and ENSCO Offshore Company, two large offshore supply vessel and offshore drilling companies operating in the Gulf of Mexico. The GCMA's complaint asserts that ENSCO violated federal

law by consistently failing to report accidents involving their offshore employees to the U.S. Coast Guard. The lawsuit was originally filed on August 30, 2000, but has remained under seal until today in compliance with federal law.

The suit was brought under the False Claims Act, a federal whistleblower statute, and was filed in U.S. District Court in Lafayette, Louisiana. GCMA contends that federal law requires ENSCO to report all employee accidents requiring a doctor's care. In particular, ENSCO must file an accident report (known as a CG-2692) with the Coast Guard within five days of any such accident. GCMA alleges that for many years, ENSCO systematically failed to report such employee accidents to the Coast Guard except in cases involving fatalities.

GCMA's investigation of ENSCO's compliance with the law followed requests under the Freedom of Information Act, seeking copies of ENSCO's Form CG-2692 reports for employee accidents that were the subject of other lawsuits brought against the company. Out of 44 accidents resulting in lawsuits in various federal and state courts, the U.S. Coast Guard only had one CG-2692 on file for ENSCO.

"Our investigation shows that the U.S. Coast Guard's marine safety data base, which the Coast Guard uses to track accidents and make inspection decisions in the Gulf of Mexico, is effectively rendered useless by ENSCO's refusal to report all relevant accidents," said GCMA President Penny Adams. "The safety aspects of offshore work are not as rosy as the Coast Guard portrays them."

GCMA's complaint also alleges that ENSCO failed to produce copies of the employee accident reports during the discovery process in prior lawsuits. A court transcript included with the GCMA's complaint shows that an ENSCO attorney denied that any accident reports existed in conjunction with a particular plaintiff's injury. GCMA subsequently determined that the accident report did exist, but that ENSCO had failed to provide the report to the plaintiff's counsel or to the Coast Guard.

"Following that revelation, we asked the Coast Guard to write to ENSCO and demand an explanation of why the Company had failed to file accident reports," said Richard Block, a GCMA board member. "Our members often ask us to notify the Coast Guard about boat companies that break the law."

Following the Coast Guard's inquiries, ENSCO's safety manager responded that ENSCO accident reporting to the Coast Guard had "fallen through the cracks" during a change in the ENSCO safety group in the preceding few months. However, GCMA's lawsuit alleges that ENSCO's failure to report reaches back much further and covers at least a five-year period between 1993 and 1998. "We doubt that these reports had just fallen through the cracks for the five years," said Block, adding that "the failure to file these reports suggests a broader undermining of federal safety regulations."

The GCMA's lawsuit charges that ENSCO violated the False Claims Act by providing the Coast Guard with a false explanation of the company's failure to report accidents.

The GCMA's lawsuit is in the early stages of litigation and no trial date has yet been scheduled. One of the Association's first goals is to determine how many accident reports are maintained in ENSCO's records but have never been filed with the U.S. Coast Guard. "Proper reporting of accidents is a critical component of the Coast Guard's safety strategy," said

Block. "When companies fail to file the proper reports, mariners and regulators have no ability to assess safety concerns at sea. Our suit is aimed at holding ENSCO accountable to this important standard. We will also assess the compliance of other companies on these counts."

The GCMA's lawsuit seeks the proper filing of all accident reports by ENSCO, modification of ENSCO's reporting requirements, and imposition of civil penalties. Federal law provides that ENSCO can be fined up to \$25,000 for each failure to report an accident. The False Claims Act also provides for treble damages and additional penalties of \$5,000 to \$10,000.

The GCMA is an association of mariners employed in the Gulf region. The Association represents mariners on issues important to their profession and advocates for mariners and their families before the Coast Guard and other government agencies.

A copy of the complaint is available upon request from GCMA.

THE COAST GUARD CUTS AND RUNS

Although the matter of the failure to report injuries never went to court, GCMA pressed the issue because it affects every single merchant mariner.

GCMA reported the matter to the Department of Transportation's Inspector General's Office (OIG). However, we had to submit a number of FOIA requests to obtain any information as to whether the matter was even investigated. A heavily redacted document from the OIG office stated in part: "On April 23, 2001, DOT OIG contacted ■ and inquired into any civil penalties the USCG might have filed against ENSCO. ■ advised to (his/her) knowledge the USCG imposed no civil remedial files on ENSCO. ■ advised since (he/she) began working with ENSCO, they seem to be complying with USCG safety requirements. In addition, ENSCO hired two new personnel, a Safety Advisor, and a Case Management Coordinator to help ensure that ENSCO complied with USCG requirements.

[GCMA Comment: COMDTINST 16200.3A, Table 5-A gives the Civil Penalty ranges for "failure of a marine employer to report a marine casualty in writing to the OCMi as required by 46 CFR §4.05-10(a) as between \$500 and \$1,000. This civil penalty for failing to report an injury is considerably less than the criminal penalty for filing a false report. There were a total of 44 separate incidents reported.]

The Coast Guard Investigations Department at Marine Safety Office in Morgan City was clearly out of its league in attempting to deal with a major drilling contractor. Consequently, they took the easy route out and indicated

clearly that enforcing "accident reporting" regulations clearly was not high on their agenda. They issued ENSCO the following OCMi Letter of Warning dated February 16, 2001 and swept the matter out the door:

"Based on the results of a Coast Guard investigation concerning the non-reporting of injuries during the period of 1993 through 1998 that occurred on various ENSCO vessels, the Coast Guard determined you were in violation of federal regulation 46 CFR §4.05-1 & 5.

"This violation can result in a \$25,000.00 penalty for each incident. The Coast Guard has initiated casualty cases for the unreported injuries; and noted that there were an additional five reportable injuries but Coast Guard policy did not require initiation of a casualty case. In consideration of the nature of this violation, and it does not appear to be the standard policy (since other injuries were reported by ENSCO during the time period) I am issuing this Letter of Warning to you rather than initiating civil penalty action. However, I urge your cooperation in preventing future occurrences of this kind.

"This matter will not be pursued further unless you wish to contest this Letter of Warning...."

[GCMA Comment: Nobody in their right mind would contest this toothless letter that was addressed to the Company and rather than any specific person in authority at that company.]

CONCLUSION

If you are a mariner and are injured on the job, we recommend that you immediately notify the Master of (**and read this carefully**) "an injury that requires professional medical treatment (treatment beyond first aid) and, if the person is engaged or employed on board a vessel in commercial service, that renders the individual unfit to perform his or her routine duties..."

Even if it is just a cut, scrape, slip, trip, fall, strain or other minor injury, ask the Master to make a logbook entry. Ask him to also report it to the company and check to see that he has done so. If you require more than first aid (i.e., a trip to the doctor's office or a medical clinic, or hospital) be sure that the company reports it to the Coast Guard on CG-2692. Most companies prefer to take care of this at the office rather than to allow the Master to fill out a form and submit it directly to the Coast Guard. However, if you doubt whether the Company reported your injury, ask for a copy of the form they submitted to the Coast Guard. However, if they won't give you a copy or they never filled one out for you, ask for a blank copy and mail it directly to the Coast Guard. If the injury is serious, immediately contact a maritime attorney of your choice, and discuss the extent of your injuries with him/her and seek advice.



GULF COAST MARINERS ASSOCIATION

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February 1, 2005

U.S. Department of Transportation
Docket Management Facility
Nassif Building
400 Seventh Street, SW. Room PL-401
Washington, DC 20590

< DOCKET #USCG-2002-12580 - 4 >

Dear Sir or Madam,

Please enter the attached pages numbered (1) through (32) in the lower right hand corner into Docket #USCG-2002-12580.

Very truly yours,

Richard A. Block

Master #1014425, Issue #8

Secretary, Gulf Coast Mariners Association

2005 FEB 11 PM 1:06
U.S. DEPARTMENT OF
TRANSPORTATION
PL-401

U.S. Department of
Homeland Security

United States
Coast Guard



Commandant
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315009

16704
Docket 2002-12580

JUL 16 2004

Gulf Coast Mariners Association
ATTN: Mr. Richard A. Block
P. O. Box 3589
Houma, LA 70360-3589

Dear Sir:

I have carefully reviewed your petition for rulemaking requesting that an injured party involved in a reportable marine casualty be authorized to submit a report of his/her injury and have determined that no rulemaking is necessary.

The current regulation, specifically 46 CFR 4.05-1, does not set limitations as to who may submit a report of marine casualty. An injured party is not prohibited from making a report to the Coast Guard. In fact, our Investigating Officers often receive reports directly from mariners and conduct an investigation based on their report.

I have determined that the appropriate action in this instance is to release a Policy Letter to ensure that proper emphasis is given to any casualty report submitted to the Coast Guard regardless of the source.

Please feel free to contact LCDR Kelly Post of my staff at the number above if we can be of any other assistance in this matter.

Sincerely,

W. D. RABE
U.S. Coast Guard
Chief, Investigations Division
By direction of the Commandant

Copy: Commandant (G-LRA)



GULF COAST MARINERS ASSOCIATION

P. O. Box 3589 • Houma, Louisiana 70361-3589

Phone: (985) 879-3866 • Fax: (985) 879-3911

E-mail: info@gulfcoastmariners.org Website: www.gulfcoastmariners.org

August 1, 2004

ATTN: Mr. W.D. Rabe (G-MOA)
Chief, Investigations Division
U.S. Coast Guard Headquarters
2100 Second Street, SW
Washington, DC 20593-0001

Subject: Accident Reporting, 46 CFR 4.05-1.
Reference: Docket #2002-12580
Our Files #:GCM-60 & #GCM-81 (U.S. DOL)

VIA United Parcel Service Courier

Dear Mr. Rabe,

Thank you for your letter of July 16, 2004 in response to our petition for rulemaking filed on September 7, 2001. The purpose of this letter and its enclosures is to ask you to reconsider and clarify the regulation itself in light of the additional information contained herein.

Discussion: While I can see that existing 46 CFR 4.05-1 does not specifically prohibit a mariner who is not an "...owner, agent, master, operator, or person-in-charge" from reporting a marine casualty including a personal injury received while working aboard a vessel, we believe it is important to clarify in this regulation that an "injured party" can submit a report that will be considered by the cognizant authorities and, if the matter warrants, be investigated.

If a mariner and his attorney have convenient primary access to any document it would be a federal regulation rather than a (proposed) agency policy letter. This is why we believe the regulation itself needs to be clarified. Perhaps the clarification could read "...owner, agent, master, operator, person-in-charge, and/or injured party."

While the release of a "Policy Letter" might be an appropriate way to inform knowledgeable Coast Guard personnel (passively) to accept accident reports submitted by injured parties, we believe the regulation needs to be more pro-active so that mariners can have the Coast Guard consider their input on the cause of the accident/injury from the outset. A policy letter would be useful in stressing to Coast Guard personnel that the mariner's version of his/her accident or injury be given equal consideration with a version submitted by "the company" in that our mariners often (either correctly or incorrectly) believe that the Coast Guard is biased in favor of the employer. After all, accident reports look at safety issues rather than assigning blame or liability in these accidents. (46 USC §6308)

We believe that maintaining meaningful accident statistics is one of the Coast Guard's weak points. This view is reinforced in Report CG-D-13-95 (August 1994). More recently, our views were reinforced during the last Towing Safety Advisory Committee meeting in Washington, when it appeared that everybody on the TSAC Committee was in agreement that the Coast Guard's accident and injury "self-reporting" system – and especially filling out the CG-2692 accident report forms was not taken very

seriously in that it allows the person completing the form to put his or her personal interpretation ("spin") on reporting the accident.

Many times accident reports are left to be completed by "the front office" which either puts their best possible corporate face on the report to serve its purposes or simply neglects to file the report. In addition, the Coast Guard often does not investigate many accidents or injuries beyond the CG-2692 stage or "data collection."

As you know, the requirements of 46 CFR 4.05-1 lumps both personal injuries and vessel accidents together on a single form. We believe this procedure needs to be changed - and needed to be changed when we first brought the matter up in 2001.

Personal injuries requiring more than first aid. In regard to personal injuries on the job, the mariners who are injured often depend upon others to accurately fill out the CG-2692 forms that describe their accident. When you are hurt and on the way to the hospital, you could care less about who completes form CG-2692 as long as you receive the necessary medical treatment. In addition, some employers delay treatment of their employee's injuries to have drug tests performed to see if they can find a way to escape paying for the treatment. Often, no CG-2692 forms are ever filed within 5 days or are filed months after the fact by people in the "front office" who know nothing about the facts of the accident/injury.

Our Association's attorney, Mark Ross, Esq., found that one company (ENSCO) failed to report 44 personal injury accidents that eventually found their way to state and Federal court. The Coast Guard office in Morgan City was queried and had no record of these accidents and at the time (several years ago) was neither particularly helpful nor forthcoming. After the matter was brought to Federal court, the Coast Guard gave the company a "slap on the wrist" and did not penalize them in any manner other than to tell them to be more careful in the future. We believe all our mariners deserve a higher standard of care and superintendence from the Coast Guard than they received in the ENSCO matter. In fact, we believe the Coast Guard should require the same standard of personal injury record keeping as OSHA uses in maintaining its records of industrial accidents.⁽¹⁾ [Enclosure D]. ⁽¹⁾ i.e., utilizing OSHA Forms 300 & 301.]

A review of Civil Penalty actions from 1985-2004 shows hundreds of cases where casualty reports (both "immediate" and CG-2692 reports) are delinquent. And these are only the reports that the Coast Guard knows about. Our attorney has proven that there are countless other personal injury reports that are never turned in.

Vessel accident reporting. We assumed until recently that most vessel accidents were routinely reported to the Coast Guard. However, the discussion of filing CG-2692 forms at the last TSAC meeting raised some doubts. Many mariners tell us about accidents they know about as never reported to the Coast Guard. If we don't have any concrete evidence, we classify that as a rumor. Currently GCMA has over 400 accident cases either on file or that we are actively considering. In a few vessel casualty cases we do receive a "no information" notation from the FOIA people at G-CIM at USCG Headquarters when we ask for an accident report or results of an investigation. We are preparing to look into this matter in greater depth.

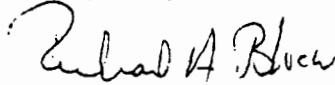
On September 19, 2001 we wrote the attached letter [Enclosure A] to Captain Sarubbi in the Office of Compliance in regard to the ENSCO matter previously discussed. Perhaps you did not see that letter. In any event, we respectfully submit this as additional information for your consideration.

Our disgust with the current personal injury reporting system manifested itself during 2002 with correspondence to both the Department of Labor and the Department of Transportation. Our complaint of February 2, 2002 is particularly noteworthy in describing the denial of reasonable protection of our mariners in contrast to the accident reporting procedures provided industrial workers under the OSH Act. We respectfully submit [Enclosure C] as additional information for your re-consideration in revising the existing regulation.

It is almost three years since we filed our original rulemaking petition. On September 3, 2002 we received a letter from the Vice Commandant [Enclosure B] that mentions this Docket number inclusively.

While we realize the Coast Guard has been busy on other more pressing matters since the events of "9/11," our attorneys continue to process cases where our injured mariners were in a most cavalier manner by their employers. I hope that you will understand when I tell you that we have lost confidence in the ability of the Coast Guard to make even the most minor reforms in its accident and injury reporting system. Consequently, we have taken steps to approach Congress directly on this matter. Nevertheless, we hope that you will reconsider your proposed action and consider providing more comprehensive accident and injury reporting procedures that will better protect our mariners.

Very truly yours,

A handwritten signature in dark ink, appearing to read "Richard A. Block". The signature is fluid and cursive, with the first name "Richard" being more prominent.

Richard A. Block
Master #1014425, Issue #8
Secretary, Gulf Coast Mariners Association

Gulf Coast Mariners Association



Mailing Address: P.O. Box 3589 • Houma, Louisiana 70360-3589

Telephone: (504) 580-4100

Fax: (504) 580-1509

e-mail: gcma@gs.verio.net

September 19, 2001

ATTN: J. Sarubbi (G-MOC)
Office of Compliance
United States Coast Guard Headquarters
2100 Second Street, SW
Washington, DC 20593-0001

VIA FAX TO: 202/267-0506

Subject: Adequately enforcing existing Coast Guard Regulations that require reporting of all injuries that occur on any vessel that require medical attention beyond first aid.

References: 46 CFR 4.05-1: GCMA Report #R-292

Dear Captain Sarubbi,

During the past year, our Association representing over 1,450 "lower-level" mariners working in the the Eighth District, discovered that a major offshore vessel operator had failed to report 44 workplace injuries as required by Coast Guard regulations. This matter is detailed in GCMA Report #R-292 (ENCLOSURE #1).

Our Association works through three principal Federal Advisory Committees, NOSAC, TSAC, and MERPAC. At the last NOSAC meeting, our President, Mrs. Penny Adams, attempted to bring this matter to the attention of NOSAC. She was prevented from doing this by Captain Peter Richardson. He indicated that this matter could not be discussed because it was "...in litigation." Our Attorney advised us that Captain Richardson's ruling simply did not make sense. In any event, the matter is no longer in litigation.

On August 3, 2001, after being advised that Agenda items needed to be routed through the Executive Secretary of the Marine Safety Council (G-LRA/3406) we asked that this item be placed on the MERPAC/TSAC Meeting Agenda for the September 26/27 meeting. To this date, we have received no response to our letter.

As the meeting date approaches, I spoke with Mr. Gerry Miente (G-MSO) who informed me that advisory committees do not discuss "enforcement" matters. Frankly, as much as I would like to believe Gerry, I never heard of any such prohibition applying to a federal advisory committee. He opined that these matters are generally handled at the local MSO or District level. I stated that MSO Morgan City knew of all these missing reports and had done absolutely nothing about it although they had ample opportunity to do so. In addition, our Association kept the Eighth District Headquarters (then commanded by RADM Paul Pluta) fully informed.

U.S. Department
of Transportation

United States
Coast Guard



Commandant
United States Coast Guard
2100 Second Street, S.W.
Washington, DC 20593

Staff Symbol: G-LRA
Phone: (202) 267-1634
FAX: (202) 267-8234

16704
SEP 3 2002

Gulf Coast Mariners Association
Attn: Richard Block
P. O. Box 3589
Houma, LA 70361-3589

Dear Sir:

* { This letter responds to your correspondence (undated) received on June 17, 2002. The issues contained in that letter, and its enclosures, regard your requests for rulemaking action and lack of response by the Coast Guard. The Coast Guard considers your concerns seriously and I deeply regret that we were unable to place your petitions for rulemaking into the public docket in a timely manner. As you will see in the comments below, this situation has been corrected.

The Executive Secretary to the Marine Safety Council has forwarded your requests to the appropriate office that has substantive purview over the issues raised. As of this date, each of your requests, and the Coast Guard's response, for rulemaking have been placed in the public docket filed with the Department of Transportation Docket Management System. The following numbers have been assigned to your petitions: USCG 02-12578 through USCG 02-12581.

You will receive a separate correspondence from the Executive Secretary to the Marine Safety Council stating which office is reviewing your various petitions. Again, I appreciate you bringing these matters to my attention and the Coast Guard will work to ensure that future petitions are handled in a timely manner.

Sincerely,

A handwritten signature in cursive script, appearing to read "T.J. Barrett".

T.J. BARRETT
Vice Admiral, U.S. Coast Guard
Acting Commandant



GULF COAST MARINERS ASSOCIATION

P. O. Box 3589 • Houma, Louisiana 70361-3589

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E-mail: info@gulfcoastmariners.org Website: www.gulfcoastmariners.org

September 30, 2002

John J. Flynn, III
Special Assistant to the Secretary
U.S. Department of Labor
200 Constitution Avenue, NW
Suite S2018
Washington, DC 20210

VIA FAX TO: 202.693.6145

Subject: Petition for Improved Recordkeeping and Accident Reporting for Lower-Level Mariners.

Action: Addendum to our August 8, 2002 petition [new ENCLOSURES #4 & #5]

Dear John,

The enclosed letter [ENCLOSURE #4] from the OSHA Office of Public Affairs (FOIA) that replies to our letter of February 2, 2002 (to the DOT Inspector General) [ENCLOSURE #5] when coupled with the Coast Guard's reply of August 1, 2002 [ENCLOSURE #3] reinforces our belief that no discussions were held on the matter of "recordkeeping" of occupational injuries and illnesses aboard inspected vessels since the USCG/OSHA Memorandum of Understanding was signed on March 8, 1993. As you know, our mariners work both on inspected offshore supply vessels as well as on uninspected towing vessels.

We estimate that our petition affects approximately 45,000 lower-level mariners serving on 5,200 uninspected towing vessels and 1,700 inspected offshore supply vessels.

Very truly yours,

Richard A. Block
Master #1014425
Secretary, Gulf Coast Mariners Association

U.S. Department
of Transportation
United States
Coast Guard



Commandant
U.S. Coast Guard

2100 2nd St., S.W.
Washington, DC 20593
Staff Symbol: G-MSO-2
Phone: (202) 267-1181
FAX: (202) 267-4570

5720
FOIA No. 02-1459

AUG - 1 2002

Mr. Richard Block
Gulf Coast Mariners Association
P.O. Box 3589
Houma, Louisiana 70360-3589

Dear Mr. Block:

This letter is in response to your Freedom of Information Act (FOIA) request of February 2, 2002. Your FOIA request to Mr. Roger P. Williams, Counsel to the Inspector General, U.S. Department of Transportation was forwarded to the Coast Guard on June 10, 2002 for response to your FOIA Request #2. In this request you have asked for "copies of the minutes of all meetings and all documents related to any and all agreements reached that have resolved the Memorandum of Understanding (MOU) recordkeeping issue subsequent to March 8, 1983".

3 { A member of my staff has searched our records and has not found any minutes of meetings relating to the MOU between the Coast Guard and the Occupational Safety and Health Administration (OSHA), subsequent to March 8, 1983. However, we did find a document relating to the MOU between the Coast Guard and OSHA. A copy of this document is enclosed.

If you have any questions concerning this matter, you may contact me at (202) 267-1181, or Mr. Jim Magill of my staff at (202) 267-1082. Please reference this letter and FOIA control number 02-1459.

Sincerely,

M. A. PRESCOTT

Commander, U. S. Coast Guard
Chief, Vessel and Facility Operating
Standards Division
By direction

Encls: (1) COMMANDANT NOTICE 16613, dated 18 November 1980, cancelled 16 May 1981

U.S. Department of Labor

Occupational Safety and Health Administration
Washington, D.C. 20210

Reply to the Attention of:



September 12, 2002

Mr. Richard A. Block
Secretary, Gulf Coast Mariners Association
P.O. Box 3589
Houma, Louisiana 70360-3589

Dear Mr. Block:

A portion of your Freedom of Information Act (FOIA) request dated February 2, 2002, has been referred to our agency, the Occupational Safety and Health Administration (OSHA), for a direct response. Your request was received by this office on July 17, 2002. You requested records concerning discussions between the Coast Guard and OSHA.

 { A search of our agency files in Washington, DC, was conducted for documents responsive to your request; however, no records were located.

I do not consider this a denial under the FOIA; however if you do not agree, you have the right to appeal this response. If you wish to appeal, you may do so through the Solicitor of Labor under 29 C.F.R. §70.22. The appeal must be filed within 90 days from the date the response was received. The letter should state in writing the grounds for appeal, including any supporting statements or arguments. To facilitate processing, the appeal should include copies of the initial request and the response of the disclosure officer. Address the appeal to Solicitor of Labor, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20210. The appeal and the envelope must be marked "FOIA APPEAL."

If we can be of further service, please contact Sue Izumi of my staff at (202) 693-1999.

Sincerely,


Bonnie Friedman, Director
Office of Public Affairs

Gulf Coast Mariners Association



Mailing Address: P.O. Box 3589 • Houma, Louisiana 70360-3589
Toll Free Phone: (800) 979-GCMA(4262)
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e-mail: gcma@gs.verio.net

February 2, 2002

ATTN: Mr. Roger P. Williams
Counsel to the Inspector General
U.S. Department of Transportation
400 Seventh Street, SW
Washington, DC 20590

SUBJECT: Non-Reporting of Work-Related Accidents and Injuries.
FILE #: GCM-64; JCMA0202.1J

THIS LETTER CONTAINS TWO FREEDOM OF INFORMATION ACT REQUESTS

Dear Mr. Williams,

Thank you for your letter of January 16, 2002 in response to our letters concerning ENSCO Marine Company, Inc. and its non-reporting of personal injuries. [ENCLOSURE #1].

Although your office "...opened an investigation based upon the False Claims Act lawsuit filed on behalf of...(GCMA)...in October 2000" our attorney informs me that neither your office nor the United States Attorney's Office in Lafayette, LA, ever told him of this investigation. Therefore, we respectfully request a copy of your findings in this investigation under the Freedom of Information Act. [FOIA Request #1]

The fact that the United States Attorney declined to take action did not and will not dissuade us from asserting and protecting the rights of "lower-level" mariners (i.e., maritime transportation workers) working on vessels of less than 1,600 gross tons who suffer at the hands of their maritime employers.

Our correspondence of last October 4th and November 14th did not and this letter will not and speak further to the GCMA False Claims Act lawsuit. Our concern expressed herein is with DOT's oversight of the administration of 46 CFR 4.05-1(a)(6), "Notice of Marine Casualty" regulations involving reporting injuries that require treatment beyond first aid. After all, not reporting at least 45 personal injuries and perhaps as many as 150 personal injuries is more than a slight oversight as we previously pointed out.

Our Association makes a point of attending and contributing our expertise to three federal advisory committees. We strongly object to being misled and subsequently being prevented from

discussing a crucial mariner health and welfare issue in an open forum where marine personnel issues are aired. Furthermore, we believe a Letter of Warning as pointed out in Captain Brusseau's letter of November 5th [ENCLOSURE #2] is totally inadequate relative to the egregious nature and extent of this violation. This is especially true in light of the fact that a number of ENSCO workers have come forward to our attorney in Lafayette alleging mistreatment by their employer in handling on-the-job injuries sustained in the workplace. We are further offended by not even able to obtain a copy of the Letter of Warning mentioned in Captain Brusseau's letter over 2½ months after our request! [ENCLOSURE #3].

ENSCO is a large corporation with vast financial resources. We firmly believe they have both a legal and moral obligation to treat employees on the job in a fair and equitable manner. They have not always done so in the past and now find themselves as parties to a major class action lawsuit. [ENCLOSURE #4]. We intend to see that they treat their maritime transportation employees fairly when injured in the workplace.

On January 9, 2002, the United States Supreme Court decided CHAO, SECRETARY OF LABOR v. MALLARD BAY DRILLING, INC. [ENCLOSURE #5]. Although the case dealt primarily with uninspected vessels, the Syllabus states in part: "With respect to inspected vessels, the parties do not dispute that OSHA's regulations have been pre-empted because the Coast Guard has exercised its broad statutory authority over workers' occupational health and safety, 46 USC §3306. Indeed, OSHA and the Coast Guard signed a Memorandum of Understanding (MOU) over all working conditions on inspected vessels, including those not addressed by specific regulations..."

We respectfully disagree with this statement relative to the Coast Guard's existing accident reporting procedures in 46 CFR 4.05-1.

The MOU deals with inspected offshore supply vessels like those operated by ENSCO. The penultimate paragraph of this MOU signed on March 8, 1983 states: "RECORDKEEPING: OSHA and the Coast Guard will continue to discuss the extent of their respective jurisdictions to require owners of inspected vessels to keep records concerning occupational injuries and illnesses. This MOU does not resolve any issues concerning recordkeeping obligations." (Emphasis ours.) [ENCLOSURE #6].

Presumably, "discussions" have been going on between the Coast Guard and OSHA for the past eighteen years.⁽¹⁾ It does not appear that these discussions reached fruition because existing 29 CFR §1904.2(b) does not appear to exempt the "transportation" industry from OSHA accident reporting requirements spelled out in detail in OSHA regulations at 29 CFR Part 1904. [ENCLOSURE #7]. [FOIA REQUEST #2: We respectfully request copies of the minutes of all meetings and all documents related to any and all agreements reached that may have resolved the MOU's "recordkeeping" issue subsequent to March 8, 1983.]

I have reviewed 29 CFR Part 1904 in its entirety as noted by the markings in the enclosure. In comparing its text with the text of the existing Coast Guard accident reporting requirements in 46 CFR 4.05-1 and 4.05-5 I can plainly see that our maritime workers, like other American workers, would be much better served by the OSHA accident reporting regulations than by those supposedly "enforced" by the U.S. Coast Guard. Since the MOU cited in the Supreme Court decision plainly states that the matter of recordkeeping for occupational injuries is not resolved, I will approach the Department of Labor on behalf of our mariners on this and related matters.

I truly regret that the Department of Transportation and the U.S. Coast Guard have let us down in their unwillingness to stand up and protect the interests of our nation's "lower-level" merchant mariners. Clearly the interests of employers have taken precedence over those of mariners on

uninspected vessels as shown in CHAO v. MALLARD BAY. This only scratches the surface; mariners on inspected vessels have also been deprived of OSH Act protection for over 30 years. Mariners note that the Coast Guard stalled for 20 years in resolving "workplace" issues required by the Outer Continental Shelf Lands Act.⁽¹⁾ [⁽¹⁾Refer to Docket # USCG-1998-3868.]

I am enclosing a copy of our book Mariners Speak Out on Violation of the 12-Hour Work Day. [ENCLOSURE #8]. This is significant area of "workplace safety" the Coast Guard and industry have teamed up to keep from public view. It is an area I encourage your office to investigate.

Very truly yours,

Richard A. Block
Master #830614
Secretary, Gulf Coast Mariners Association

Notification of Requirement to Participate in the Survey of Occupational Injuries and Illnesses-2002



U.S. Department of Labor
Bureau of Labor Statistics

Reporting Site:

SAME AS YOUR COMPANY ADDRESS

Your Company Address:

22-063273140-2002

22-063273140-20021 2731 8 P 50 00

— IMPORTANT —

OSHA has issued revised recordkeeping regulations and revised forms which are effective January 2002. These changes include revised definitions of recordable injuries and illnesses and new Log, Summary, and case forms. A copy of the new OSHA recordkeeping forms package is included for your convenience.

Dear Employer:

The U.S. Bureau of Labor Statistics is working with State agencies to survey employers about work-related injuries and illnesses. You have been selected to participate in the mandatory *Survey of Occupational Injuries and Illnesses* for calendar year 2002 (OMB No. 1220-0045, approval expires 10-31-04). In order to obtain complete and accurate information about the safety record of America's work places, our survey must include a sample of all establishments, regardless of size and industry. Thus, some establishments who are normally exempt from keeping the enclosed OSHA records are included in the survey and must keep records for the survey year. This year, we are notifying all survey participants in advance, including those who normally keep OSHA records.

Beginning January 2002, record any work-related injuries and illnesses that occur in your workplace during 2002 according to the revised OSHA recordkeeping regulations. This package contains copies of the new OSHA recording forms and instructions you will need to keep records of any work-related injuries or illnesses which occur during 2002.

This package contains:

1. Our letter and instructions to participating employers and contact information "If you need help"
2. The revised OSHA Forms for Recording Work-Related Injuries and Illnesses containing:
 - *Log of Work-Related Injuries and Illnesses (OSHA Form 300)*
 - *Summary of Work-Related Injuries and Illnesses (OSHA Form 300A)*
 - *Injury and Illness Incident Report (OSHA Form 301)*

PLEASE NOTE: OSHA has revised the recording rules as noted in the enclosed booklet. The OSHA Log form has been revised for 2002 and the case form contains new data elements. There is also a new year-end summary form employers are required to complete which includes information about the employment and hours worked at your establishment. We have provided one copy of each form in the package. You may photocopy these as needed or print additional copies from the recordkeeping page of the OSHA web site (www.osha.gov).

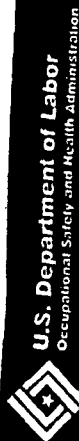
You will be mailed the survey form entitled *Survey of Occupational Injuries and Illnesses* early in 2003. You will then be asked to copy the 2002 year-end summary information and mail the completed *Survey* to us. At that time, we will also ask for details about individual cases of injury or illness. The Bureau of Labor Statistics and the State agency collecting this information will use the information you provide for statistical purposes only. To the full extent permitted by law, the information will be held in confidence and will not be disclosed without the written consent of your establishment.

Your participation in the recordkeeping activity and the Survey is mandatory under Public Law 91-596. If you have questions regarding your responsibilities for this Survey, or if you need help in recording the information we request, call the **phone number listed for your State on the back page**. In addition, OSHA has provided a list of phone numbers by State for questions regarding the new OSHA recordkeeping requirements, which are included in their booklet.

We appreciate your effort to comply with these new reporting requirements. Thank you for helping us collect accurate information and for helping in the effort to make America's work places safer and healthier.

Bureau of Labor Statistics
U.S. Department of Labor

OSHA Forms for Recording Work-Related Injuries and Illnesses



ENCLOSURE #10 PAGE #25

What's Inside..

In this package, you'll find OSHA's Log and the Summary for the next several years.

- ▼ **An Overview Record** — General instructions and definitions of terms for your cases as injuries.
- ▼ **How to Fill Out the Log** — Instructions on how to fill out the Log properly.
- ▼ **Log of Work-Related Injuries and Illnesses** — Several pages (but you may make as many as you need.) The Log is separate from the Summary.
- ▼ **Summary of Work-Related Injuries and Illnesses** — Removable for easy posting at the workplace. Note that you post the Summary, not the Log.
- ▼ **Worksheet to Help You Calculate** — Figuring the average number of injuries and illnesses for your establishment and industry.
- ▼ **OSHA's 301: Injury and Illness Report** — Several copies to provide details about injuries and illnesses. You may make as many copies as you need to use an equivalent form.

Take a few minutes to review the questions, visit us online at www.osha-slc.gov. We'll be happy to help you.

An Overview: Recording Work-Related Injuries and Illnesses

The Occupational Safety and Health (OSH) Act of 1970 requires certain employers to prepare and maintain records of work-related injuries and illnesses. Use these definitions when you classify cases on the Log. OSHA's recordkeeping regulation (see 29 CFR Part 1904) provides more information about the definitions below.

The *Log of Work-Related Injuries and Illnesses* (Form 300) is used to classify work-related injuries and illnesses and to note the extent and severity of each case. When an incident occurs, use the *Log* to record specific details about what happened and how it happened. The *Summary* — a separate form (Form 300A) — shows the totals for the year in each category. At the end of the year, post the *Summary* in a visible location so that your employees are aware of the injuries and illnesses occurring in their workplace.

Employers must keep a *Log* for each establishment or site. If you have more than one establishment, you must keep a separate *Log* and *Summary* for each physical location that is expected to be in operation for one year or longer.

Note that your employees have the right to review your injury and illness records. For more information, see 29 Code of Federal Regulations Part 1904.35, *Employer Involvement*.

Cases listed on the *Log of Work-Related Injuries and Illnesses* are not necessarily eligible for workers' compensation or other insurance benefits. Listing a case on the *Log* does not mean that the employer or worker was at fault or that an OSHA standard was violated.

When is an injury or illness considered work-related?

An injury or illness is considered work-related if an event or exposure in the work environment caused or contributed to the condition or significantly aggravated a preexisting condition. Work-relatedness is

presumed for injuries and illnesses resulting from events or exposures occurring in the workplace, unless an exception specifically applies. See 29 CFR Part 1904.5(b)(2) for the exceptions. The work environment includes the establishment and other locations where one or more employees are working or are present as a condition of their employment. See 29 CFR Part 1904.5(b)(1).

Which work-related injuries and illnesses should you record?

Record those work-related injuries and illnesses that result in:

- ▼ death,
- ▼ loss of consciousness,
- ▼ days away from work,
- ▼ restricted work activity or job transfer, or
- ▼ medical treatment beyond first aid.

You must also record work-related injuries and illnesses that are significant (as defined below) or meet any of the additional criteria listed below.

You must record any significant work-related injury or illness that is diagnosed by a physician or other licensed health care professional. You must record any work-related case involving cancer, chronic irreversible disease, a fractured or cracked bone, or a punctured eardrum. See 29 CFR 1904.7.

What are the additional criteria?

You must record the following conditions when they are work-related:

- ▼ any needlestick injury or cut from a sharp object that is contaminated with another person's blood or other potentially infectious material;
- ▼ any case requiring an employee to be medically removed under the requirements of an OSHA health standard;
- ▼ tuberculosis infection as evidenced by a positive skin test or diagnosis by a physician or other licensed health care professional after exposure to a known case of active tuberculosis.

What is medical treatment?

Medical treatment includes managing and caring for a patient for the purpose of combating disease or disorder. The following are not considered medical treatments and are **NOT** recordable:

- ▼ visits to a doctor or health care professional solely for observation or counseling;
- ▼ diagnostic procedures, including administering prescription medications that are used solely for diagnostic purposes; and
- ▼ any procedure that can be labeled first aid. (See below for more information about first aid.)

What is first aid?

If the incident required only the following types of treatment, consider it first aid. Do NOT record the case if it involves only:

- ▼ using non-prescription medications at non-prescription strength;
- ▼ administering tetanus immunizations;
- ▼ cleaning, flushing, or soaking wounds on the skin surface;
- ▼ using wound coverings, such as bandages, BandAids™, gauze pads, etc., or using SteriStrips™ or butterfly bandages.
- ▼ using hot or cold therapy;
- ▼ using any totally non-rigid means of support, such as elastic bandages, wraps, non-rigid back belts, etc.;
- ▼ using temporary immobilization devices while transporting an accident victim (splints, slings, neck collars, or back boards).
- ▼ drilling a fingernail or toenail to relieve pressure, or draining fluids from blisters;
- ▼ using eye patches;
- ▼ using simple irrigation or a cotton swab to remove foreign bodies not embedded in or adhered to the eye;
- ▼ using irrigation, tweezers, cotton swab or other simple means to remove splinters or foreign material from areas other than the eye;
- ▼ using finger guards;
- ▼ using massages;
- ▼ drinking fluids to relieve heat stress.

How do you decide if the case involved restricted work?

Restricted work activity occurs when, as the result of a work-related injury or illness, an employer or health care professional keeps, or recommends keeping, an employee from doing the routine functions of his or her job or from working the full workday that the employee would have been scheduled to work before the injury or illness occurred.

How do you count the number of days of restricted work activity or the number of days away from work?

Count the number of calendar days the employee was on restricted work activity or was away from work as a result of the recordable injury or illness. Do not count the day on which the injury or illness occurred in this number. Begin counting days from the day after the incident occurs. If a single injury or illness involved both days away from work and days of restricted work activity, enter the total number of days for each. You may stop counting days of restricted work activity or days away from work once the total of either or the combination of both reaches 180 days.

Under what circumstances should you NOT enter the employee's name on the OSHA Form 300?

You must consider the following types of injuries or illnesses to be privacy concern cases:

- ▼ an injury or illness to an intimate body part or to the reproductive system,

- ▼ an injury or illness resulting from a sexual assault,
- ▼ a mental illness,
- ▼ a case of HIV infection, hepatitis, or tuberculosis,
- ▼ a needlestick injury or cut from a sharp object that is contaminated with blood or other potentially infectious material (see 29 CFR Part 1904.8 for definition), and
- ▼ other illnesses, if the employee independently and voluntarily requests that his or her name not be entered on the log.

You must not enter the employee's name on the OSHA 300 Log for these cases. Instead, enter "privacy case" in the space normally used for the employee's name. You must keep a separate, confidential list of the case numbers and employee names for the establishment's privacy concern cases so that you can update the cases and provide information to the government if asked to do so.

If you have a reasonable basis to believe that information describing the privacy concern case may be personally identifiable even though the employee's name has been omitted, you may use discretion in describing the injury or illness on both the OSHA 300 and 301 forms. You must enter enough information to identify the cause of the incident and the general severity of the injury or illness, but you do not need to include details of an intimate or private nature.

Optional

Calculating Injury and Illness Incidence Rates

What is an incidence rate?

An incidence rate is the number of recordable injuries and illnesses occurring among a given number of full-time workers (usually 100 full-time workers) over a given period of time (usually one year). To evaluate your firm's injury and illness experience over time or to compare your firm's experience with that of your industry as a whole, you need to compute your incidence rate. Because a specific number of workers and a specific period of time are involved, these rates can help you identify problems in your workplace and/or progress you may have made in preventing work-related injuries and illnesses.

How do you calculate an incidence rate?

You can compute an occupational injury and illness incidence rate for all recordable cases or for cases that involved days away from work for your firm quickly and easily. The formula requires that you follow instructions in paragraph (a) below for the total recordable cases or those in paragraph (b) for cases that involved days away from work, and for both rates the instructions in paragraph (c).

(a) To find out the total number of recordable injuries and illnesses that occurred during the year, count the number of line entries on your OSHA Form 300, or refer to the OSHA Form 300A and sum the entries for columns (G), (H), (I), and (J).

(b) To find out the number of injuries and illnesses that involved days away from work, count the number of line entries on your OSHA Form 300 that received a check mark in column (H), or refer to the entry for column (H) on the OSHA Form 300A.

(c) The number of hours all employees actually worked during the year. Refer to OSHA Form 300A and optional worksheet to calculate this number.

You can compute the incidence rate for all recordable cases of injuries and illnesses using the following formula:

$$\frac{\text{Total number of injuries and illnesses} \div \text{Number of hours worked by all employees} \times 200,000 \text{ hours}}{\text{Total recordable case rate}}$$

(The 200,000 figure in the formula represents the number of hours 100 employees working 40 hours per week, 50 weeks per year would work, and provides the standard base for calculating incidence rates.)

You can compute the incidence rate for recordable cases involving days away from work, days of restricted work activity or job transfer (DART) using the following formula:

$$\frac{(\text{Number of entries in column H} + \text{Number of entries in column I}) \div \text{Number of hours worked by all employees} \times 200,000 \text{ hours}}{\text{DART incidence rate}}$$

You can use the same formula to calculate incidence rates for other variables such as cases involving restricted work activity (column (I) on Form 300A), cases involving skin disorders (column (M-2) on Form 300A), etc. Just substitute the appropriate total for these cases, from Form 300A, into the formula in place of the total number of injuries and illnesses.

What can I compare my incidence rate to?

The Bureau of Labor Statistics (BLS) conducts a survey of occupational injuries and illnesses each year and publishes incidence rate data by

various classifications (e.g., by industry, by employer size, etc.). You can obtain these published data at www.bls.gov or by calling a BLS Regional Office

Worksheet

Total number of recordable injuries and illnesses in your establishment

÷

X 200,000 =

Hours worked by all your employees

Total number of recordable injuries and illnesses with a checkmark in column H or column I

÷

X 200,000 =

Hours worked by all your employees

Classifying Illnesses

Skin diseases or disorders

Skin diseases or disorders are illnesses involving the worker's skin that are caused by work exposure to chemicals, plants, or other substances.

Examples: Contact dermatitis, eczema, or rash caused by primary irritants and sensitizers or poisonous plants; oil acne; friction blisters, chrome ulcers; inflammation of the skin.

Respiratory conditions

Respiratory conditions are illnesses associated with breathing hazardous biological agents, chemicals, dust, gases, vapors, or fumes at work.

Examples: Silicosis, asbestosis, pneumonitis, pharyngitis, rhinitis or acute congestion; farmer's lung, beryllium disease, tuberculosis, occupational asthma, reactive airways dysfunction syndrome (RADS), chronic obstructive pulmonary disease (COPD), hypersensitivity pneumonitis, toxic inhalation injury, such as metal fume fever, chronic obstructive bronchitis, and other pneumoconioses.

Poisoning

Poisoning includes disorders evidenced by abnormal concentrations of toxic substances in blood, other tissues, other bodily fluids, or the breath that are caused by the ingestion or absorption of toxic substances into the body.

Examples: Poisoning by lead, mercury, cadmium, arsenic, or other metals; poisoning by carbon monoxide, hydrogen sulfide, or other

gases; poisoning by benzene, benzol, carbon tetrachloride, or other organic solvents; poisoning by insecticide sprays, such as parathion or lead arsenate; poisoning by other chemicals, such as formaldehyde.

All other illnesses

All other occupational illnesses.

Examples: Heatstroke, sunstroke, heat exhaustion, heat stress and other effects of environmental heat; freezing, frostbite, and other effects of exposure to low temperatures; decompression sickness; effects of ionizing radiation (isotopes, x-rays, radium); effects of nonionizing radiation (welding flash, ultra-violet rays, lasers); anthrax; bloodborne pathogenic diseases, such as AIDS, HIV, hepatitis B or hepatitis C; brucellosis; malignant or benign tumors; histoplasmosis; coccidioidomycosis.

When must you post the Summary?

You must post the Summary only — not the Log — by February 1 of the year following the year covered by the form and keep it posted until April 30 of that year.

How long must you keep the Log and Summary on file?

You must keep the Log and Summary for 5 years following the year to which they pertain.

Do you have to send these forms to OSHA at the end of the year?

No. You do not have to send the completed forms to OSHA unless specifically asked to do so.

How to Fill Out the Log

The *Log of Work-Related Injuries and Illnesses* is used to classify work-related injuries and illnesses and to note the extent and severity of each case. When an incident occurs, use the *Log* to record specific details about what happened and how it happened.

If your company has more than one establishment or site, you must keep separate records for each physical location that is expected to remain in operation for one year or longer.

We have given you several copies of the *Log* in this package. If you need more than we provided, you may photocopy and use as many as you need.

The *Summary* — a separate form — shows the work-related injury and illness totals for the year in each category. At the end of the year, count the number of incidents in each category and transfer the totals from the *Log* to the *Summary*. Then post the *Summary* in a visible location so that your employees are aware of injuries and illnesses occurring in their workplace.

You don't post the *Log*. You post only the *Summary* at the end of the year.

OSHA's Form 300

Log of Work-Related Injuries and Illnesses

You must record information about every work-related death and about every work-related injury or illness that involves loss of consciousness, restricted work ability or job days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that result in any of the specific recording criteria listed in 29 CFR Part 1904.9 through 1904.12. Please use this form for a single case if you need it. You must complete an Injury and Illness Incident Report (OSHA Form 301) or equivalent form for each injury or illness requiring treatment. If you are not sure whether a case is recordable, call your local OSHA office for help.

IDENTIFY THE PERSON			DESCRIBE THE CASE			DATE
(A) Case no.	(B) Employer's name	(C) Job title (e.g. title)	(D) Date of injury or onset of illness	(E) Where the event occurred (e.g. building, deck, work area)	(F) Describe injury or illness, parts of body affected, and object or substance that directly injured or made person ill (e.g. "You and dog ran to an eight person from neighbor's law")	(G) Date the case was closed
1	Mark Beggs	Welder	5/23	Workshop	fracture, left arm and left leg, fell from ladder	
2	Shane Alexander	Foundry man	7/12	pouring deck	burning from hot metal	
3	Sam Swader	Electrician	8/11	2nd floor staircase	broken left foot, fell over banister	
4	Ralph Bazzelle	Laborer	9/12	on loading dock	Back strain, lifting boxes	
5	Jared Daniels	Machine operator	10/23	production floor	shot in eye	

Be as specific as possible. You can use line items if you need more room.

Revise the log if the injury or illness progresses and the outcome is more serious than you originally recorded for the case. Cross out, erase, or write-out the original entry.

Check category by recording outcome, case, or other helpful

OSHA's Form 300A

Summary of Work-Related Injuries and Illnesses

All establishments covered by Part 1904 must complete this Summary page, even if no work-related injuries or illnesses occurred during the year. Remember to review the Log to verify that the entries are complete and accurate before completing this summary.

Using the Log, count the individual entries you made for each category. Then write the totals below, making sure you've added the entries from every page of the Log. If you had no cases, write "0."

Employees, former employees, and their representatives have the right to review the OSHA Form 300 in its entirety. They also have limited access to the OSHA Form 301 or its equivalent. See 29 CFR Part 1904.35, in OSHA's recordkeeping rule, for further details on the access provisions for these forms.

Number of Cases

Total number of deaths	Total number of cases with days away from work	Total number of cases with job transfer or restriction	Total number of other recordable cases
_____	_____	_____	_____
(G)	(H)	(I)	(J)

Number of Days

Total number of days of job transfer or restriction	Total number of days away from work
_____	_____
(K)	(L)

Injury and Illness Types

Total number of ...
(M)

(1) Injuries	_____	(4) Poisonings	_____
(2) Skin disorders	_____	(5) All other illnesses	_____
(3) Respiratory conditions	_____		

Post this Summary page from February 1 to April 30 of the year following the year covered by the form.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time to review the instructions, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any other aspect of this data collection, contact: US Department of Labor, OSHA Office of Statistics, Room N-3044, 200 Constitution Avenue, NW, Washington, DC 20210. Do not send the completed forms to this office.

Establishment Information

Your establishment name _____

Street _____

City _____

Industry description (e.g., Manufacturing) _____

Standard Industrial Classification _____

Employment Information

Worksheet on the back of this page to e

Annual average number of employees _____

Total hours worked by all employees _____

Sign here

Knowingly falsifying this c

I certify that I have examined knowledge the entries are m

Company signature _____

Date _____

Log of Work-Related Injuries and Illnesses

You must record information about every work-related death and about every work-related injury or illness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria listed in 29 CFR part 1904.8 through 1904.12. Feel free to use two lines for a single case if you need to. You must complete an injury and illness Incident Report (OSHA Form 301) or equivalent form for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call your local OSHA office for help.

Identify the person		Describe the case			Classify the case						
(A) Case no.	(B) Employee's name	(C) Job title (e.g., Welder)	(D) Date of injury or onset of illness	(E) Where the event occurred (e.g., Loading dock north end)	(F) Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill (e.g., Second degree burns on right forearm from acetylene torch)	(G) Using check boxes, indicate whether each of the listed conditions applies to your case					
						Death	Days lost from work	Permanent physical impairment	Medical attention	First aid	Other
			/			☐	☐	☐	☐	☐	☐
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Public reporting burden for this collection of information is estimated to average 18 minutes per response, including time to review the instructions, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any other aspect of this data collection, contact: US Department of Labor, OSHA Office of Statistics, Room 3N-3641, 200 Constitution Avenue, N.W., Washington, DC 20210. Do not send the completed forms to this office.

Page totals ➤

Be sure to transfer these totals to the Summary page (Form 300A) before you file.

Optional

Worksheet to Help You Fill Out the Summary

At the end of the year, OSHA requires you to enter the average number of employees and the total hours worked by your employees on the summary. If you don't have these figures, you can use information on this page to estimate the numbers you will need to enter on the Summary page at the end of the year.

How to figure the average number of employees who worked for your establishment during the year:

- 1 Add the total number of employees your establishment paid in all pay periods during the year. Include all employees: full-time, part-time, temporary, seasonal, salaried, and hourly.

The number of employees paid in all pay periods = ① _____

- 2 Count the number of pay periods your establishment had during the year. Be sure to include any pay periods when you had no employees.

The number of pay periods during the year = ② _____

- 3 Divide the number of employees by the number of pay periods.

$\frac{①}{②} = ③$ _____

- 4 Round the answer to the next highest whole number. Write the rounded number in the blank marked Annual average number of employees.

The number rounded = ④ _____

For example, Acme Construction figured its average employment this way:

For pay period... Acme paid this number of employees...

1	10
2	0
3	15
4	30
5	40
▼	▼
24	20
25	15
26	+10
	830

Number of employees paid = 830 ①

Number of pay periods = 26 ②

$830 \div 26 = 31.92$ ③

31.92 rounds to 32 ④

32 is the annual average number of employees

How to figure the total hours worked by all

Include hours worked by salaried, hourly, part-time, as well as hours worked by other workers subject to your establishment (e.g., temporary help services).

Do not include vacation, sick leave, holidays, or even if employees were paid for it. If your establishment has employees who are paid for their hours, estimate the hours that the employees actually worked.

If this number isn't available, you can use this estimate it.

Optional Worksheet

_____ Find the number of full-time employees for the year

X _____ Multiply by the number of employees in a year.

_____ This is the number of full-time employees

+ _____ Add the number of any other hours worked by other employees (temporary, seasonal)

_____ Round the answer to the nearest whole number. Write the rounded number in the blank marked hours worked by all employees

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

Completed by _____

Title _____

Phone (____) _____ - _____ Date ____/____/____

4) Name of physician or other health care professional _____

7) If treatment was given away from the workplace, where was it given?
Facility _____
Street _____
City _____ State _____ ZIP _____

8) Was employee treated in an emergency room?
☐ Yes
☐ No

9) Was employee hospitalized overnight as an in-patient?
☐ Yes
☐ No

- 10) Case number from the Log _____
- 11) Date of injury or illness ____ / ____ / ____
- 12) Time employee began work _____ AM
- 13) Time of event _____ AM
- 14) What was the employee doing just before the incident? "Tools, equipment, or material the employee was using were carrying roofing materials"; "spraying chlorine fumes"
- 15) What happened? Tell us how the injury occurred. "He fell 20 feet"; "Worker was sprayed with chlorine gas developed sores on wrist over time."
- 16) What was the injury or illness? Tell us the part of body more specific than "hurt," "pain," or "sore." "Eyes tunnel syndrome."
- 17) What object or substance directly harmed the employee? "radial arm saw." If this question does not apply to your case, leave blank.
- 18) If the employee died, when did death occur? D

Public reporting burden for this collection of information is estimated to average 22 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information unless it displays a current valid OMB control number. If you have any comments about this estimate or any other aspect of this data collection, including suggestions for reducing this burden, contact: US Department of Labor, OSHA Office of Management and Administration, Paperwork Project Team, Washington, DC 20540. Do not send the completed form to this office.

If You Need Help...

If you need help deciding whether a case is recordable, or if you have questions about the information in this package, feel free to contact us. We'll gladly answer any questions you have.

▼ Visit us online at www.osha.gov

▼ Call your OSHA Regional office
and ask for the recordkeeping
coordinator

or

▼ Call your State Plan office

Federal Jurisdiction

Region 1 - 617 / 565-9860
Connecticut; Massachusetts; Maine; New
Hampshire; Rhode Island

Region 2 - 212 / 337-2378
New York; New Jersey

Region 3 - 215 / 861-4900
DC; Delaware; Pennsylvania; West Virginia

Region 4 - 404 / 562-2300
Alabama; Florida; Georgia; Mississippi

Region 5 - 312 / 353-2220
Illinois; Ohio; Wisconsin

Region 6 - 214 / 767-4731
Arkansas; Louisiana; Oklahoma; Texas

Region 7 - 816 / 426-5861
Kansas; Missouri; Nebraska

Region 8 - 303 / 844-1600
Colorado; Montana; North Dakota; South
Dakota

Region 9 - 415 / 975-4310

Region 10 - 206 / 553-5930
Idaho

State Plan States

Alaska - 907 / 269-4957

Arizona - 602 / 542-5795

California - 415 / 703-5100

*Connecticut - 860 / 566-4380

Hawaii - 808 / 586-9100

Indiana - 317 / 232-3325

Iowa - 515 / 281-3661

Kentucky - 502 / 564-3070

Maryland - 410 / 767-2371

Michigan - 517 / 322-1851

Minnesota - 651 / 296-2116

Nevada - 702 / 687-3250

*New Jersey - 609 / 292-2313

New Mexico - 505 / 827-4230

*New York - 518 / 457-2574

North Carolina - 919 / 807-2875

ENCLOSURE #10 PAGE #36



U.S. Department of Labor
Occupational Safety and Health Administration

Have questions?

If you need help in filling out the form or have questions about whether you qualify, call us. We'll be happy to help you.

- ▼ Visit us online at: www.osha-slc.gov
- ▼ Call your regional or state office for the phone number listed in the directory.



U.S. Department of Labor
Occupational Safety and Health Administration

An Overview: Recording Work-Related Injuries and Illnesses

The Occupational Safety and Health (OSH) Act of 1970 requires certain employers to prepare and maintain records of work-related injuries and illnesses. Use these definitions when you classify cases on the Log. OSHA's recordkeeping regulation (see 29 CFR Part 1904) provides more information about the definitions below.

The *Log of Work-Related Injuries and Illnesses* (Form 300) is used to classify work-related injuries and illnesses and to note the extent and severity of each case. When an incident occurs, use the *Log* to record specific details about what happened and how it happened. The *Summary* — a separate form (Form 300A) — shows the totals for the year in each category. At the end of the year, post the *Summary* in a visible location so that your employees are aware of the injuries and illnesses occurring in their workplace.

Employers must keep a *Log* for each establishment or site. If you have more than one establishment, you must keep a separate *Log* and *Summary* for each physical location that is expected to be in operation for one year or longer.

Note that your employees have the right to review your injury and illness records. For more information, see 29 Code of Federal Regulations Part 1904.35, *Employee Involvement*.

Cases listed on the *Log of Work-Related Injuries and Illnesses* are not necessarily eligible for workers' compensation or other insurance benefits. Listing a case on the *Log* does not mean that the employer or worker was at fault or that an OSHA standard was violated.

When is an injury or illness considered work-related?

An injury or illness is considered work-related if an event or exposure in the work environment caused or contributed to the condition or significantly aggravated a preexisting condition. Work-relatedness is

presumed for injuries and illnesses resulting from events or exposures occurring in the workplace, unless an exception specifically applies. See 29 CFR Part 1904.5(b)(2) for the exceptions. The work environment includes the establishment and other locations where one or more employees are working or are present as a condition of their employment. See 29 CFR Part 1904.5(b)(1).

Which work-related injuries and illnesses should you record?

Record those work-related injuries and illnesses that result in:

- ▼ death,
- ▼ loss of consciousness,
- ▼ days away from work,
- ▼ restricted work activity or job transfer, or
- ▼ medical treatment beyond first aid.

You must also record work-related injuries and illnesses that are significant (as defined below) or meet any of the additional criteria listed below.

You must record any significant work-related injury or illness that is diagnosed by a physician or other licensed health care professional. You must record any work-related case involving cancer, chronic irreversible disease, a fractured or cracked bone, or a punctured eardrum. See 29 CFR 1904.7.

What are the additional criteria?

You must record the following conditions when they are work-related:

- ▼ any needlestick injury or cut from a sharp object that is contaminated with another person's blood or other potentially infectious material;
- ▼ any case requiring an employee to be medically removed under the requirements of an OSHA health standard;
- ▼ tuberculosis infection as evidenced by a positive skin test or diagnosis by a physician or other licensed health care professional after exposure to a known case of active tuberculosis.

What is medical treatment?

Medical treatment includes managing and caring for a patient for the purpose of combating disease or disorder. The following are not considered medical treatments and are NOT recordable:

- ▼ visits to a doctor or health care professional solely for observation or counseling;
- ▼ diagnostic procedures, including administering prescription medications that are used solely for diagnostic purposes; and
- ▼ any procedure that can be labeled first aid. (See below for more information about first aid.)

OSHA Forms for Recording Work-Related Injuries and Illnesses

What's Inside...

In this package, you'll find OSHA's *Log* and the *Summary of Work-Related Injuries and Illnesses* for the next several years. O

- ▼ **An Overview: Recording** — General instructions for and definitions of terms your cases as injuries or
- ▼ **How to Fill Out the Log** — out the *Log* properly.
- ▼ **Log of Work-Related Injuries and Illnesses** — Several pages (but you may make as many as the *Log* as you need.) No *Log* is separate from the
- ▼ **Summary of Work-Related Injuries and Illnesses** — Removable for easy posting at the establishment. Note that you post the *Summary*, not the *Log*.
- ▼ **Worksheet to Help You Fill Out the Log** — Figuring the average number of employees in your establishment and
- ▼ **OSHA's 301 Injury and Illness Report** — Several copies to provide details about injuries and illnesses. You may make as many copies as you need or use an equivalent form.

Take a few minutes to review the instructions and answer any questions, visit us online at www.osha-slc.gov. We'll be happy to help you.

U.S. Department of
Homeland Security

United States
Coast Guard



Commandant
United States Coast Guard

2100 Second Street, S.W. STOP 7581
Washington, DC 20593-7581
Staff Symbol: CG-5453
Phone: (202) 372-1289
Fax: (202) 372-1822
Email: Rodney.Levy@uscg.mil

5720
FOIA 11-2098
May 3, 2011

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

Dear Mr. Block:

This letter is in response to your Freedom of Information Act (FOIA) request of March 27, 2011, seeking information on each attached activity in the Marine Information for Safety and Law Enforcement (MISLE) database.

Because the cost of providing this information is over \$250.00 you must pay the cost for this information before we process your request. The cost of providing this information is \$9,020.55. When making payment, your check, draft or money order should be made payable to the "Treasury of the United States" and sent to the following address:

Commandant (CG-5453)
U.S. Coast Guard
2100 Second Street, SW STOP 7581
Washington, DC 20593-7581

Payment may be made by credit card on the Internet using the FOIA Request Payment form at <https://www.pay.gov/pavgov/>. Please reference this letter when forwarding payment. Also ensure the FOIA case number (FOIA 11-2098) appears on the front of the check, money order, or electronic payment form.

If you do not respond within thirty days after the date of this letter we will assume that you are no longer interested in obtaining this information.

Sincerely,

A handwritten signature in dark ink, appearing to read "D. Patterson".

D. PATTERSON
Chief, Data Administration Division
U.S. Coast Guard
By direction

Copy: CG-54 FOIA Coordinator



124 North Van Avenue
Houma, Louisiana 70363-5895
Phone: (985) 851-2134
Fax: (985) 879-3911

E-mail: info@nationalmariners.org
Website: www.nationalmariners.org

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

May 16, 2011

ATTN: D. Patterson
Chief, Data Administration Division
U.S. Coast Guard Headquarters
2100 Second Street, SW
Washington, DC 20593-7581

Subject: FOIA 11-2098
Via Fax to: (202) 372-1922

Dear Ms. Patterson,

Thank you for your letter of May 3, 2011. Please cancel this request.

Please mail the entire request to me at the above address.

Very truly yours,

Richard A. Block
Master #1186377, Issue #9
Secretary, National Mariners Association

MEMORANDUM OF UNDERSTANDING
BETWEEN THE
UNITED STATES COAST GUARD
U.S. DEPARTMENT OF TRANSPORTATION
AND THE
OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION
U.S. DEPARTMENT OF LABOR
CONCERNING THEIR AUTHORITY TO
PRESCRIBE AND ENFORCE STANDARDS OR REGULATIONS
AFFECTING THE OCCUPATIONAL SAFETY AND HEALTH OF SEAMEN
ABOARD VESSELS INSPECTED AND CERTIFICATED BY THE
UNITED STATES COAST GUARD

PURPOSE. It is the purpose of this memorandum of understanding (MOU) to set forth clearly the boundaries of the authority of the United States Coast Guard (Coast Guard) of the U.S. Department of Transportation and the Occupational Safety and Health Administration (OSHA) of the U.S. Department of Labor in prescribing and enforcing standards or regulations affecting the occupational safety and health of seamen aboard vessels inspected and certificated by the Coast Guard (hereinafter "inspected vessels"). This MOU is intended to eliminate confusion among members of the public with regard to the relative authorities of the two agencies. Nothing in this MOU pertains to uninspected vessels. The Coast Guard and OSHA agree to work together to fulfill their respective authorities.

AUTHORITY OF THE COAST GUARD. The Coast Guard is the dominant federal agency with the statutory authority to prescribe and enforce standards or regulations affecting the occupational safety and health of seamen aboard inspected vessels. Under the Vessel Inspection Laws of the United States, the Coast Guard has issued comprehensive standards and regulations concerning the working conditions of seamen aboard inspected vessels.

These comprehensive standards and regulations include extensive specific regulations governing the working conditions of seamen aboard inspected vessels as well as ample general authority regulations to cover these seamen with respect to all other working conditions that are not addressed by the specific regulations. These standards and regulations are generally set forth at 46 C.F.R. Chapter I, and in the Coast Guard's Marine Safety Manual and its Navigation and Vessel Inspection Circulars.

AUTHORITY OF OSHA. OSHA has a general statutory authority to assure safe and healthful working conditions for working men and women under the Occupational Safety and Health (OSH) Act of 1970. Section 4(b)(1) of the OSH Act defines the relationship between OSHA and the other federal agencies whose exercise of statutory responsibilities may affect occupational safety and health. Based on OSHA's interpretation of section 4(b)(1), and as a result of the Coast Guard's exercise of its authority, described above,

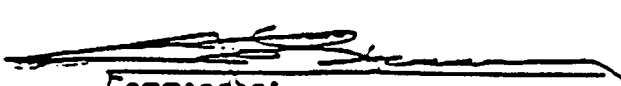
OSHA has concluded that it may not enforce the OSH Act with respect to the working conditions of seamen aboard inspected vessels. Nonetheless, OSHA retains the following responsibilities.

OSHA retains its authority under section 11(c) of the OSH Act, which forbids discrimination in any manner against employees who have exercised any right afforded them under the OSH Act. Pursuant to this provision, OSHA has the authority to require vessel owners to post a notice that informs employees of their right to complain about working conditions to the Coast Guard, OSHA, or the employer and to be free from retaliatory discrimination. OSHA has concluded that its exercise of authority under section 11(c) is not precluded by the scope of section 4(b)(1) of the OSH Act.

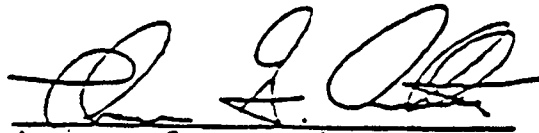
OSHA agrees to refer to the Coast Guard, for its consideration, any complaints, other than section 11(c) discrimination complaints, OSHA receives from seamen working aboard inspected vessels. However, the Coast Guard, consistent with the statement of its authority above, has the sole discretion to determine, under its applicable standards and regulations, whether the events complained of constitute hazardous conditions and the extent of any remedy that may be required.

B { RECORDKEEPING. OSHA and the Coast Guard will continue to discuss the extent of their respective jurisdictions to require owners of inspected vessels to keep records concerning occupational injuries and illnesses. This MOU does not resolve any issues concerning recordkeeping obligations.

EFFECTIVE DATE AND PUBLICATION. This MOU shall take effect upon signature by the parties. It shall be promptly published in the Federal Register.


Commandant
United States Coast Guard
U.S. Department of Transportation

Date: 3-8-93


Assistant Secretary for
Occupational Safety and Health
U.S. Department of Labor

Date: _____

Enclosure #13

Explanation:

We ask our readers to focus upon pages 9-23 that represents the current status of OSHA/USCG Authority Over Vessels found in NMA Report #R-202-B, Revision 1 in this enclosure.

However, since we are asking for Congress to look into this relationship between these two Executive Branch Agencies vis-à-vis our mariners, we would be remiss in not mentioning that there are additional problems between the two agencies that call for resolution. We last addressed these other issues in a "Report to Congress" (NMA Report #R-350, Rev. 6).

Also included in this enclosure is a Coast Guard letter dated Feb. 26, 2010 that comments upon the lack of training given to Marine Inspectors on regulations enforced by other agencies. We believe that the marked portions of this letter are key to a better understanding of the apparent lack of coordination by these two agencies that has negatively impacted our mariners since the OSH Act of 1970.

U.S. Department of
Homeland Security

United States

Coast Guard

J.Hawkins@uscg.mil

Commandant
United States Coast Guard

2100 Second Street, S.W. Stop 7126
Washington, DC 20593-0001
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Fax: (202) 372-1925
Email: Benjamin.

2009-2781

5103

February 26, 2010

National Mariners Association
124 North Van Avenue
Houma, Louisiana 70363-5895
Attn: Richard A. Block

Dear Mr. Block:

Thank you for your reply to our letter of January 16, 2010. We appreciate your commitment in this matters, and, in response to your questions, we offer the following comments:

Regarding your questions pertaining to hearing conservation, the *United States Coast Guard Requirements for Uninspected Towing Vessels* guidebook does not seek to address requirements which may be applicable from other agencies, such as the Public Health Service or the Occupational Safety and Health Administration (OSHA). Guidance on OSHA regulations, including noise regulations contained in Title 29 Code of Federal Regulations (CFR) § 1905.95, is available through their website or any of their regional offices. If you wish to know more about OSHA's enforcement activities and steps they have taken in the past to improve hearing conservation aboard uninspected towing vessels, I recommend you contact them directly.

Concerning your inquiries related to asbestos exposure, the Coast Guard's inspector training program is designed to train inspectors to assess compliance with regulations contained in Titles 33 and 36 of the CFR. As part of that training, Coast Guard inspectors are familiarized with the Navigation and Vessel Inspection Circulars (NVIC). However, we do not prepare our inspectors to enforce OSHA regulations, or any other agency's regulations, on uninspected vessels. Neither the Towing Vessel Center of Expertise nor the Offshore Operations Center of Expertise has been contacted by industry with concerns regarding asbestos; however, our office has forwarded your letters and Gulf Coast Mariner's Report #R-205 to ensure they are aware of the potential concerns.

A copy of MSC 83/25/13 is enclosed per your request.

ENCLOSURE #13 PAGE #2

gbn-Anander, U.S. Coast Guard
Acting Chief, Office of Design and Engineering
Standards By direction

Copy: (1) CG-543
(2) Commanding Officer, TVNCOE Paducah, KY



NMA REPORT #R-202-B, Revision #2

DATE: May 13, 2010

124 North Van Avenue
Houma, LA 70363-5895
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Asserting our right "...to petition the Government for redress of grievances."
Amendment I, U.S. Constitution, Dec. 15, 1791

COAST GUARD & OSHA MISS THE BOAT ON MARITIME WORKPLACE SAFETY AND HEALTH ISSUES

Publication History: NMA Report #R-347, Rev. 1, Nov. 19, 2009, was canceled, renumbered and revised as R-202-B, May 13, 2010.

Reference files #GCM-269 & GCM-278.; **Other NMA related safety and health Reports:** #R-205; #R-349; #R-349-A; #R-350; #R-395; #R-445

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INTRODUCTION TO DOCKET #USCG-1998-3868

In December 1999, the Coast Guard issued a Notice of Proposed Rule Making that proposed to revise the regulations contained in 33 CFR Subchapter N (parts 140 through 147) dealing with Outer Continental Shelf (OCS) activities. This was a major rulemaking project that affected the offshore oil industry. Our Association was particularly interested in Part 142 of the proposed rulemaking because it sought to apply workplace safety and health regulations developed by the U.S. Department of Labor's Occupational Safety and Health Administration (OSHA) to vessels serving on the Outer Continental Shelf.

THE OCCUPATIONAL SAFETY AND HEALTH ACT OF 1970

(a) The Congress finds that personal injuries and illnesses arising out of work situations impose a substantial burden upon, and are a hindrance to, interstate commerce in terms of lost production, wage loss, medical expenses, and disability compensation payments.

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

(1) by encouraging employers and employees in their efforts to reduce the number of occupational safety and health hazards at their places of employment, and to stimulate employers and employees to institute new and to perfect existing programs for providing safe and healthful working conditions;

(2) by providing that employers and employees have separate but dependent responsibilities and rights with respect to achieving safe and healthful working conditions;

(3) by authorizing the Secretary of Labor to set mandatory occupational safety and health standards applicable to businesses affecting interstate commerce, and by creating an Occupational Safety and Health Review Commission for carrying out

adjudicatory functions under this chapter;

(4) by building upon advances already made through employer and employee initiative for providing safe and healthful working conditions;

(5) by providing for research in the field of occupational safety and health, including the psychological factors involved, and by developing innovative methods, techniques, and approaches for dealing with occupational safety and health problems;

(6) by exploring ways to discover latent diseases, establishing causal connections between diseases and work in environmental conditions, and conducting other research relating to health problems, in recognition of the fact that occupational health standards present problems often different from those involved in occupational safety;

(7) by providing medical criteria which will assure insofar as practicable that no employee will suffer diminished health, functional capacity, or life expectancy as a result of his work experience;

(8) by providing for training programs to increase the number and competence of personnel engaged in the field of occupational safety and health;

(9) by providing for the development and promulgation of occupational safety and health standards;

(10) by providing an effective enforcement program which shall include a prohibition against giving advance notice of any inspection and sanctions for any individual violating this prohibition;

(11) by encouraging the States to assume the fullest responsibility for the administration and enforcement of their occupational safety and health laws by providing grants to the States to assist in identifying their needs and responsibilities in the area of occupational safety and health, to develop plans in accordance with the provisions of this chapter, to improve the administration and enforcement of State occupational safety and health laws, and to conduct experimental and demonstration projects in connection therewith;

(12) by providing for appropriate reporting procedures with respect to occupational safety and health which procedures will help achieve the objectives of this chapter and accurately describe the nature of the occupational safety and health problem;

(13) by encouraging joint labor-management efforts to reduce injuries and disease arising out of employment.

ENFORCING OCCUPATIONAL SAFETY AND HEALTH REGULATIONS

The Occupational Safety and Health Administration (OSHA) enforces a variety of regulations that govern safety, health and welfare issues in the workplace – as long as those workplaces are on land. These regulations appear in Title 29 Code of Federal Regulations, Parts 1900 through 1999 (29 CFR §1900-1999). These are very comprehensive safety, health, and welfare regulations.

OSHA regulatory enforcement does not have a seagoing component that can enforce workplace regulations on the water. Whether it is a grain barge on the western rivers, an uninspected towing vessel pushing an uninspected work barge on inland waters, or a supply or towing vessel working on the outer continental shelf, OSHA cannot send its inspectors out to these “workplaces” to inspect vessels or investigate accidents. In addition, OSHA investigators are not familiar with the marine industry in general. Consequently, Congress left the enforcement of occupational safety and health regulations “on the water” to the Coast Guard.

INDUSTRY’S LACK OF ENTHUSIASM FOR NEW REGULATIONS

In the past, “industry” (using a generalization) has had problems with OSHA enforcement. “Enforcement” has a connotation of making a person or corporation do something it would rather not do. Safety has a significant cost factor that industry must pay for and, unless carefully managed, has the ability to reduce “profits.”

The oil drilling industry’s land-based operations had to deal with OSHA since the agency’s inception in 1970. However, there are no OSHA inspectors on the Outer Continental Shelf. Consequently, the proposed new regulations that announced in the Federal Register of December 7, 1999⁽¹⁾ probably were not particularly popular with that sector of the industry. [⁽¹⁾ Proposed 33 CFR Part 142 appears at 64 FR 68457-68467.]

However, boat owners who operated inspected offshore supply vessels were adamantly opposed to the cost of additional “OSHA-type” regulations that would be imposed on their vessels that, under the proposed regulations, were classified as “OCS Units.” These regulations had considerable “cost” to boat operators – and they opposed their classification as “OCS Units” primarily for that reason. Our Association, looking out for the health, safety and welfare of our “limited tonnage” mariners on the OCS, grasped at any straw where the Coast Guard even suggested that it would assist our mariners with workplace safety.

A question that our Association brought up in 1999 was whether uninspected towing vessels that were not specifically listed in the proposed regulations, would be governed by the OSHA-type regulations. We believe it was a reasonable question and, 10 years late, are still awaiting an answer. We are awaiting an answer because the

entire rulemaking package was shelved for 10 years as the Coast Guard's entire Marine Safety mission was downgraded.⁽¹⁾ [⁽¹⁾ Refer to VADM Card's report reprinted in our Report #R-401-E.]

It might be unfair to say that "industry" sabotaged the 1999 Notice of Proposed Rulemaking. It might also be unfair to say that the Coast Guard failed to assign the resources to push the proposed rulemaking through the regulatory rulemaking process because it was unpopular. However, it is clear from Admiral Card's report that something was seriously wrong in "Marine Safety"

Comments about the contents of the proposed rule making were received from many stakeholders during 2000 but the rule was never revised. Our Association alone submitted four out of a total of 109 letters to the Coast Guard Docket.

Recently, the USCG initiated a study to investigate the use of industry standards in the offshore industry and contracted with ABS Group Consulting, Inc. to profile OCS industry standards and their usage. Specifically, their tasking was limited to reviewing and updating existing industry standards that were under consideration by the Coast Guard to be "incorporated by reference" and to determine their utilization, cost and effectiveness.

Although this is a very narrow issue and had not drawn too much attention, it attracted our attention to the fact that the rulemaking was still alive, had not dropped from the radar screen, and could provide a positive impact for our mariners safety and health. We brought up the possibility that its application, in pertinent part, could apply to mariners working in places in addition to the outer continental shelf including rivers and inland waters.

While it is acknowledged that considerable time and effort had been afforded this process by industry during 1999 and 2000, the Coast Guard hired ABS Consulting as a contractor to revisit the most critical pieces of the NPRM by meeting with stakeholders (including our Association to initiate a dialogue.

Coast Guard headquarters personnel and contractors came to a meeting at Sector New Orleans on Nov. 17, 2009 to obtain insights into these issues. Particular areas of interest were as follows;

- industry-wide and company standards to reduce injury, death, property and environmental damage.
- industry-wide and company standards to monitor and control confined space entry, fire suppression and prevention, survival craft, and accommodation spaces.
- cost to implement and maintain industry-wide and company standards including equipment, personnel, record-keeping and training.
- effectiveness of these standards to reduce injury, death, property and environmental damage.

While the idea was to avoid creating new regulations where acceptable industry standards already exist, these standards would be "Incorporated by Reference" in the proposed rulemaking making adherence to these standards a requirement. Regulations prepared by other agencies such as OSHA or the Minerals Management Service are much more substantial than Coast Guard "guidelines" like NVICs and policy letters that can be ignored at will.

Following the meeting, our Association prepared the attached letter to the Coast Guard (CG-5222) and expanded upon the very narrow focus of the meeting. At the earlier MERPAC/TSAC Meeting in Martinsburg in September, we had requested Coast Guard assistance with several of our Association's major issues covered in our Report #R-350, Rev. 5. The text of the letter outlines our concerns in terms spelled out in the Notice of Proposed Rulemaking in 33 CFR Part 142 in that we believe that certain OSHA requirements need to be adopted for the protection of our mariners.

OUR LETTER TO THE COAST GUARD OF NOVEMBER 17, 2009

Ms. Mayte Medina (CG-52)
U.S. Coast Guard Headquarters
2100 Second Street, SW
Washington, DC 20593

Subject: Outer Continental Shelf Activities – Workplace Safety and Health. Proposed New 33 CFR Part 142
Docket #USCG-1998-3868; NPRM 64 FR 68457-68467, Dec. 7, 1999.

Dear Ms. Medina,

Our Association, formerly known as the Gulf Coast Mariners Association, submitted four comments to the NPRM Docket cited above. We followed the progress, or lack of progress of the NPRM for the past 10 years and maintained contact with Mr. Jim Magill, the Project Officer, throughout this period.

We were notified by the ABS Consulting Group that the Economic Analysis of the NPRM performed over 10 years ago was under review. We attended a public meeting in New Orleans on Nov. 17, 2009 with ABS and Coast Guard Economist Mr. Reed Garfield, and offer the following comments on this rulemaking.

In reviewing the docket for its impact on our mariners, aside from comments questioning the economic analysis of the project, our Association independently reviewed comments from major offshore boat companies (e.g., Tidewater, Hornbeck, Seacor et al) that challenged the idea that "vessels" should be defined as "OSC Units" and fall under the proposed Outer Continental Shelf (OCS) regulations. From the outset, our Association, speaking on behalf of mariners working aboard those vessels, believed that our mariners should be protected by Workplace Safety and Health regulations proposed in new 33 CFR Part 142 – not only on the OCS but on all other waters as well.

In the recent public meeting, there appeared to be no question of the Coast Guard's intent to continue to include "vessels" (defined as "OCS Units") in these proposed regulations. However, certain aspects of the offshore boat company letters also appeared to express valid concerns as to whether the items covered by 33 CFR Part 142 really belonged as parts of OCS regulations. We opine that some of the proposed regulations in Part 142 could be included as additions to vessel inspection regulations such as those contained in 46 CFR Subchapter L, Subchapter M, or Subchapter T/K.

We will restrict our comments to 33 CFR Part 142 proposed Workplace Safety and Health regulations. While not discounting their use on the OCS, we opine that use on the OCS alone narrowly restricts their use to a single geographic area. We believe some or all of the proposed regulations in Part 142 of the NPRM could also be made a part of vessel inspection regulations.

Proposed Part 142 appears to contain a thorough and exhaustive review of current OSHA regulations that should be applicable to the OCS. In fact, we believe that the Occupational Safety and Health Act of 1970 calls for the Coast Guard to enforce many of the standards the U.S. Department of Labor enforces on land. While some items in Part 142 may be more applicable to the drilling industry "OCS Units," we believe others should apply to various classes of inspected vessels. We believe further study would be required to determine exactly which of these regulations should apply to which class of vessels. This study should have been initiated at least 30 years ago!

In our letter and its three enclosures to you dated Oct. 7, 2009 and titled "Mariner Health Issues," our Association requested your assistance with three items covered in our Report to Congress #R-350, Rev. 5, namely:

- Issue "Q" Protecting Mariners Hearing. Our Report #R-349 [Enclosure #1];
- Issue "U" Protecting Our Mariners from Asbestos. Our Report #R-445 [Enclosure #2].
- Issue "R" Provide Safe and Adequate Potable Water. Our Report #R-395, Rev. 2. [Enclosure #3]

In reviewing the OCS Docket, we identify "Issue Q" in proposed 33 CFR §§142.235 and 142.240..

In reviewing the OCS Docket, we identify "Issue U" in proposed 33 CFR §§142.181.

In reviewing the OCS Docket, we failed to identify "Issue R" in proposed 33 CFR Part 142. However, while this may not be an OSHA requirement and, as such, did not appear in the NPRM, we note that the Coast Guard incorrectly identified the provision of safe potable water as a regulation enforced by another agency when, in fact, no potable water regulations ever benefited our mariners. However, Congress did assign this task to the Coast Guard in 2004 as per our [Enclosure #3] previously furnished. We believe that this item is applicable to all vessels (not just those) working on the OCS and, in fact, to every vessel inspected under regulations in Title 46 CFR and should be added to OCS and appropriate vessel inspection regulations.

In reviewing the OCS Docket, we did not see where "Hydrogen Sulfide Gas" (H₂S) was recognized as an OCS problem. We encountered this problem in 2003 and, with the help of Mr. Jim Magill, learned that it was covered by the regulations of another agency (the Minerals Management Service). We assert that the problem is significant enough (e.g., potentially lethal) and closely related to "Workplace Health and Welfare" in the tug and barge industry and that it be mentioned in 33 CFR Part 142 if by nothing more than "Incorporation by Reference" to MMS regulations and added to appropriate vessel inspection regulations. We provide [Enclosure #4] that outlines the problem as we viewed it.

In reviewing the OCS Docket, we identified Confined Space Entry as the "need for respiratory protection on vessels working on the OCS" in our letter dated April 1, 2000 (USCG-1998-3868-29.). We noted in the preamble at 64 FR 68430, col. 2, that "While gathering information to evaluate the nature and extent of this problem, the Coast Guard met with a NOSAC working Group at the Coast Guard Eighth District Headquarters in New Orleans,

Louisiana." "The recommendation of the group was that the regulations are necessary for work in confined spaces." The regulations are those proposed in 33 CFR Subpart D – Confined Space Entry. We further cited AWO requirements from the Responsible Carrier Program (RCP) as confirming the importance of this item (in the tug and barge industry). We note the need for training Offshore Competent Persons (proposed in §§142.370-142.375) would be required to avoid a tragedy similar to the one reported on the loss of 3 lives in dangerous enclosed spaces on the EERV Viking Islay, Amethyst Gas Field (UK) on Sept. 23, 2007. [Refer to MAIB Report #12/2008, Our file #M-783, Our Report #R-450 [Enclosure #5].

In reviewing the OCS Docket, proposed 33 CFR §142.155 – §142.160, we submit [Enclosure #6] in support of requiring a suitable fall-arrest system on those vessels where mariners are put at risk. We note that the occurrence was not on the OCS.

We wish to commend Mr. Jim Magill for his work on this regulatory package including his coordination with OSHA representatives in assembling proposed 33 CFR Part 142. I previously stated at a NOSAC meeting that his retirement before the promulgation of the proposed new regulations would be a blow to the offshore industry, the credibility of the Coast Guard, and especially to our mariners who would be denied their promised OSH protections.

Repeated delays that this regulatory project experienced reinforces our long-held belief that the Coast Guard failed to provide our working mariners with a uniform level of workplace safety and health protection that Congress called for in the Occupational Safety and Health Act of 1970. Here we are, 40 years later, with no regulations in place!

Although Mr. Magill finished most of this work years ago and faithfully reported on it at each NOSAC meeting, we do not believe that the upper echelon of the Coast Guard's Marine Safety Directorate devoted enough resources to properly care for our "limited tonnage" mariners – not only on the many OSVs and other vessels on the Outer Continental Shelf but also to those serving on other waters as well. Mariners working on all classes of inspected vessels need many of the same OSH protections as mariners on OSVs and drilling industry workers.

On Oct. 28, 2009, the House of Representatives passed the Coast Guard Authorization Act of 2010. At the time, Congressman Cummings stated: "This authorization will hopefully allow the Coast Guard to shed their tradition of doing more with less." [Enclosure #7]

Our Association views the 10-year delay of this rulemaking package as an example of trying to do more with less – as also occurred in their mismanagement of merchant vessel personnel. The results were sad and unprofessional and cannot be covered up. Congressman Cummings also said: "The Coast Guard deserves recognition as a critical piece of our homeland security strategy; one we hold responsible for the safety of both professional and recreational mariners. We (i.e., Congress) must provide the funding needed to continue to improve on their outstanding history of service."

It appears that Congress does plan to fund new vessel inspectors. I trust that these inspectors will be properly trained and utilized to enforce workplace Safety and Health issues to protect our working mariners in addition to more traditional issues including the accurate and timely reporting and investigation of mariner personal injuries.

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

Enclosures:

Encl. # 1, 2, & 3 provided in our ltr of Oct. 7

Encl #4: H₂S Correspondence & MMS Regulation

Encl #5: NMA Reference Mnl-19-7 and our Report #R-347

Encl. #6: NMA Report #R-450

Encl. #7: Article - Maritime Executive Magazine, Oct. 28, 2009

RESPONSE TO OUR LETTER BY OFFICE OF DESIGN & ENGINEERING STANDARDS

January 8, 2010

Dear Mr. Block:

Thank you for your letter dated October 7, 2009, and your interest in merchant mariner health issues. In response to the issues you have raised, we offer the following comments.

With regard to issue "Q," your letter asks the Coast Guard to consider upgrading the guidance in Coast Guard Navigation and Vessel Inspection Circular (NVIC) 12-82, "Recommendations on Control of Excessive Noise," which applies to Coast Guard inspected vessels, to a formal regulation with force of law. As you are aware, NVIC 12-82 was heavily influenced by the 1981 International Maritime Organization (IMO) Resolution A.468(XII) "Code on Noise Levels On Board Ships." The issue of protection of mariners against excessive noise levels on board ships was raised again in 2007 at the 83^d session of the International Maritime Organization's Maritime

Safety Committee (MSC) in paper MSC 83/25/13 (Austria *et al*). At this session, MSC designated "protection against noise on ships" a high priority item on the work programme of the Sub-Committee on Ship Design and Equipment (DE). The DE subcommittee plans to consider this issue during their next two sessions (22-26 Feb. 2010 and 25-29 Oct. 2010). At these sessions the United States intends to support making A.468(XII) mandatory internationally, in addition to supporting a review and update of A.468(XII) to ensure it reflects current standards in hearing protection. Due to the anticipated revision of Resolution A.468(XII), the Coast Guard does not intend to initiate a rulemaking project regarding noise on Coast Guard inspected vessels until the matter has been considered by IMO. If such a rulemaking is initiated, the Coast Guard will consider all options to ensure mariners are protected, including consideration of existing Occupational Safety and Health Administration (OSHA) regulations.

Also, in Gulf Coast Mariner's Association report #R-349 "Protecting Mariner Hearing," attached to your letter, you ask the Coast Guard to consider creating regulations for uninspected commercial vessels to "provide lower-level mariners with the same hearing protection afforded American industrial workers under the OSHA regulations at 29 CFR 1910.95." These protections already exist. In 2002 the United States Supreme Court concluded in *Chao v. Mallard Bay Drilling, Inc.*, that the Occupational Safety and Health Administration's authority to maintain workplace safety for "uninspected" vessels is not pre-empted by the Coast Guard's authority unless there is a specific Coast Guard regulation covering the matter. Uninspected commercial vessel operators must comply with all applicable OSHA regulations regarding health and safety, to include establishing a hearing conservation program for their employees.

Concerning issue "U," the Coast Guard understands the negative health effects associated with prolonged exposure to asbestos fibers. NVIC 6-87, "Recommended Procedures for Control of Asbestos and Other Respiratory Hazards On Board Merchant Vessels, Outer Continental Shelf (OCS) Facilities and Deepwater Ports," was published to provide marine industry personnel the information necessary to safely work with the material. In 1983 the USCG and OSHA signed a Memorandum of Understanding (MOU) to ensure CG/OSHA responsibilities were clearly delineated regarding enforcement of applicable regulations. A second "memorandum," referred to in Gulf Coast Mariners Association Report #R-445, is actually OSHA Instruction CPL 2-1.20; this instruction further clarifies the responsibilities of both agencies. The Coast Guard believes that, when properly enforced, existing OSHA regulations and the Coast Guard guidance provided in NVIC 6-87 sufficiently protects U.S. merchant mariners from asbestos exposure. The Coast Guard Headquarters Office of Vessel Activities (CG-543) will initiate discussions with OSHA to ensure future reports of asbestos exposure are investigated and adjudicated appropriately under existing regulations. In addition, the Coast Guard Headquarters Office of Operating and Environmental Standards (CG-522) will consider the possibility of "incorporating by reference" existing OSHA asbestos regulations into 46 CFR Part 197 to provide the Coast Guard with additional enforcement options in the future.

With regard to issue "R," 46 U.S.C. 3305 requires the Coast Guard inspection process to ensure vessels subject to inspection have an adequate supply of potable water. To properly address this mandate the Coast Guard published a notice of request for comments in Federal Register docket USCG-2005-20052. The Coast Guard thoroughly considered the several comments received and has opened discussions with the Centers for Disease Control and United States Public Health Service. The Coast Guard is also actively working with the Food and Drug Administration (FDA), which maintains water quality regulations currently applicable to vessels (21 CFR 1250 Subpart E), to modify our vessel sanitary inspection process to further emphasize the requirements of 46 U.S.C. 3305.

Thank you for your continuing efforts and focus on maintaining high standards for merchant mariner safety.
Sincerely,

C. E. RAWSON
Commander, U.S. Coast Guard
Chief, Office of Design and Engineering Standards By direction

NMA RESPONSE TO COAST GUARD DESIGN AND ENGINEERING STANDARDS LETTER

January 16, 2010

Subject: **Mariner Health Issues**
Reference: Our Report #R-350, Rev. 5,

- Issue "Q" Protecting Mariner Hearing. Our Report #R-349
- Issue "U" Protecting Our Mariners from Asbestos. Our Report #R-445
- Issue "R" Provide Safe and Adequate Potable Water. Our Report #R-395, Rev. 2.

Dear Commander Rawson,

Thank you for your reply to our letter of October 7, 2009. Our response by paragraph follows:

(¶1.) **Hearing Conservation.** While it is interesting that the Coast Guard plans to wait for the rest of the world before committing its resources to protect mariners against excessive noise levels on board ships before initiating a rulemaking project, we believe the opportunity for the Coast Guard to act presented itself during the early 1980s. You missed the boat and you appear to be missing it again. For this reason, our Association – after identifying this as one of a number of continuing failures within the Marine Safety Directorate – moved beyond our letter of October 7, 2009 and appealed directly to over 50 Members of Congress in our Report #R-205. [Enclosure #1]

(¶2.) **Hearing Conservation:** Towing vessels crewed by our "limited-tonnage" mariners are one of our Association's primary areas of concern. The fact that the Coast Guard has not yet published a Notice of Proposed Rulemaking (NPRM) to inspect towing vessels more than five years after Congress directed it to do so leaves more than 30,000 of our mariners serving on these vessels in a zone of transition between "uninspected" and "inspected" vessels.

The Coast Guard published a book titled United States Coast Guard Requirements for Uninspected Towing Vessels, Change 1, in March 2009 as part of its new "bridging" program. The Coast Guard indicates that it will place greater emphasis on uniformly enforcing a number of longstanding regulations before introducing new regulations. Unfortunately, nowhere in this book is there mention of the OSHA Regulations at 29 CFR §1910.95.

If "Uninspected commercial vessel operators (i.e., employers) must comply with all applicable OSHA regulations regarding health and safety, to include establishing a hearing conservation program for their employees" as you state in your letter, why is this not mentioned in the new Coast Guard book cited above?

Please outline for our Association what steps OSHA and the Coast Guard have taken to protect our mariners' hearing in the past 30 years. If you determine that this is OSHA's responsibility, please liaison with them and ask them to offer a response since I have seen nothing that indicates that hearing conservation aboard towing vessels ever has been actively supported by either agency. Since neither agency appears to have done anything about hearing conservation, I would defend our Association's request for Congressional assistance to decide questions of overlapping authority is in order.

Please fax me a copy of MSC 83/25/13.

(¶3.) **Asbestos.** We agree with your statement that "...when properly enforced, existing OSHA regulations and the Coast Guard guidance provided in NVIC 6-87 sufficiently protect U.S. Merchant Mariners from asbestos exposure." We see an enforcement problem. NVICs are not regulations and cannot be enforced. That was true in 1987 and is true today. Yet, I see no mention of asbestos enforcement in the towing vessel inspection book mentioned above. Is the Coast Guard effectively training both its existing and newly-hired inspectors in the hazards of Asbestos as spelled out in NVIC 6-87 and OSHA regulations? Have the Coast Guard's new Center of Expertise for Towing Vessels and the Center for Expertise for Offshore Operations has been brought up to date on any of these issues?

(¶4.) **Potable Water.** In our letter of Aug, 23, 2006 to Mr. Craig Burch in your office [Enclosure #1] we asked about the progress of the Docket on safe potable water. Our files show that we never received the courtesy of a response to our letter – therefore we assumed there had been no progress. In our opinion, progress is represented by rulemaking. Six years have passed and there is no sign of rulemaking. Yet, the Coast Guard has publications that show exactly how you provide safe, clean potable water to your own vessels.

If you do not have the resources to do what Congress directed you to do on Sept. 9, 2004, approach them for what you need to get the job done.

s/ Richard A. Block, Secretary, NMA

COAST GUARD RESPONSE TO FURTHER NMA INQUIRY

February 26, 2010

Dear Mr. Block:

Thank you for your reply to our letter of January 16, 2010. We appreciate your commitment in this matters, and, in response to your questions, we offer the following comments:

Regarding your questions pertaining to hearing conservation, the United States Coast Guard Requirements for Uninspected Towing Vessels guidebook does not seek to address requirements which may be applicable from other agencies, such as the Public Health Service or the Occupational Safety and Health Administration (OSHA). Guidance on OSHA regulations, including noise regulations contained in Title 29 Code of Federal Regulations (CFR) §1905.95, is available through their website or any of their regional offices. If you wish to know more about OSHA's enforcement activities and steps they have taken in the past to improve hearing conservation aboard uninspected towing vessels, I recommend you contact them directly.

Concerning your inquiries related to asbestos exposure, the Coast Guard's inspector training program is designed to train inspectors to assess compliance with regulations contained in Titles 33 and 36 of the CFR. As part of that training, Coast Guard inspectors are familiarized with the Navigation and Vessel Inspection Circulars (NVIC). However, we do not prepare our inspectors to enforce OSHA regulations, or any other agency's regulations, on uninspected vessels. Neither the Towing Vessel Center of Expertise nor the Offshore Operations Center of Expertise has been contacted by industry with concerns regarding asbestos; however, our office has forwarded your letters and Gulf Coast Mariner's Report #R-205 to ensure they are aware of the potential concerns.

A copy of MSC 83/25/13 is enclosed per your request.

s/ B.J. Hawkins, Commander, U.S. Coast Guard, Acting Chief, Office of Design and Engineering Standards. By Direction

INTRODUCTION TO COAST GUARD – OSHA MEMORANDA OF UNDERSTANDING

Document #1, CPL 2-1.20 titled OSHA/USCG Authority Over Vessels is an interagency agreement between the Occupational Safety and Health Administration (OSHA) and the Coast Guard (USCG) and delineates the authority of the two agencies over inspected and uninspected vessels. The policy is dated Nov. 8, 1996.

OSHA policy differs between inspected and uninspected vessels. At the time the policy was drafted, most towing vessels fell into the uninspected class. Subsequently, Congress changed their status from uninspected to inspected in 46 U.S. Code §3301(15).

Document #2 contains the OSHA-type regulations proposed for "OCS Units" including those vessels working on the Outer Continental Shelf (OCS) on Dec. 7, 1999. The proposed regulations that deal with OSC Workplace Safety and Health are contained on Federal Register pages 68457 through 68467 on that date.



UNITED STATES DEPARTMENT OF LABOR

OCCUPATIONAL SAFETY & HEALTH ADMINISTRATION

Directives

CPL 02-01-020 - CPL 2-1.20 - OSHA/U.S. Coast Guard Authority Over VesselsDirectives - Table of Contents

• Record Type:	Instruction
• Directive Number:	CPL 02-01-020
• Old Directive Number:	CPL 2-1.20
• Title:	OSHA/U.S. Coast Guard Authority Over Vessels
• Information Date:	11/08/1996

OSHA Instruction CPL 2-1.20 November 8, 1996 Directorate of Compliance Programs

SUBJECT: OSHA/U.S. Coast Guard Authority Over Vessels

A. **Purpose.** This instruction provides current policy, information and guidance with respect to OSHA/U.S. Coast Guard authority over inspected vessels, commercial uninspected fishing vessels, and commercial uninspected vessels in accordance with Section 4(b)(1) of the OSH Act, 29 U.S.C. Section 653(b)(1).

B. **Scope.** This instruction applies OSHA-wide.

C. **References.**

1. OSHA Instruction STP 2.22A, CH-5, March 10, 1995, Changes to the State Plan Policies and Procedures Manual.
2. Memorandum of Understanding, U.S. Coast Guard and the Occupational Safety and Health Administration, 48 Federal Register 11366, March 17, 1983, effective date of March 8, 1983.
3. Public Law 100-424, enacted September 9, 1988, "Commercial Fishing Industry Vessel Safety Act of 1988," 46 U.S.C. 4501 et seq.
4. 46 CFR Part 28, "Commercial Fishing Industry Vessel Regulations," Final Rule.
5. 46 CFR Parts 24, 25, and 26 - "Uninspected Vessels."
6. Jones Act, 46 U.S.C. 688.
7. 46 CFR Part 197, Subpart B - "Commercial Diving Operations."
8. OSHA Instruction STD .2, November 4, 1985, Identification of General Industry Safety and Health Standards (29 CFR 1910) Applicable to Shipyard Work.
9. OSHA Instruction CPL 2-1.3B, June 14, 1982, Enforcement of Cargo Gear Regulations and the

Requirements for Gear Certification in the Maritime Program.

10. 29 CFR 1926, Construction Industry Standards.

11. 29 CFR 1910, General Industry Standards.

12. Occupational Safety and Health Act (OSH Act) of 1970, Section 5(a)(1) General Duty Clause, and Section 4(b)(1) preemption of OSHA authority by other Federal or State agencies.

13. OSHA Instruction CPL 2.51 (Series), Exemptions and Limitations Under the Current Appropriations Act.

D. Cancellation. The following guidance documents addressing OSHA and U.S. Coast Guard authority and enforcement with respect to vessels are canceled:

1. Memorandum from Thomas J. Shepich, Directorate of Compliance Programs, April 5, 1989, "OSHA/U.S. Coast Guard Jurisdiction."

2. Memorandum from Gerald P. Reidy, Office of Construction and Maritime Compliance Assistance, to Region X, November 1, 1990, "OSHA/U.S. Coast Guard Jurisdiction; Commercial Fishing Industry Vessels."

3. Memorandum from Gerald P. Reidy, Office of Construction and Maritime Compliance Assistance, to Region X, January 18, 1991, "OSHA/U.S. Coast Guard Jurisdiction, Commercial Fishing Vessels."

4. Memorandum from Patricia K. Clark, Directorate of Compliance Programs, to Region X, July 6, 1990, "OSHA/ U.S. Coast Guard Jurisdiction; Commercial Fishing Industry Vessels."

E. Action. OSHA Regional Administrators and Area Directors shall use the guidelines and procedures set forth in this instruction to determine OSHA's authority with respect to the enforcement of occupational safety and health violations on vessels.

F. Federal Program Change. This instruction describes a Federal Program Change which affects State plan coverage of public sector employees engaged in maritime employment and those States whose programs also cover portions of the private sector maritime issue. States which cover private sector maritime employment and/or have public sector employees engaged in maritime operations are encouraged to follow the guidelines and jurisdictional limitations established by this instruction within the context of applicable State law, i.e., comparable to Section 4(b)(1) of the OSH Act.

1. The Regional Administrator shall ensure that this change is promptly forwarded to each State designee, using a format consistent with the Plan Change Two-Way Memorandum in Appendix P of the State Plan Policies and Procedures Manual (reference C.I., OSHA Instruction STP 2.22A).

2. The Regional Administrator shall explain to each State designee, as requested, the technical content of this change.

3. States which cover private sector maritime employment and/or have public sector employees engaged in maritime operations shall be asked to provide preliminary notification to the Regional Administrator within 30 days from the date of this instruction of their intent to adopt an identical or equivalent policy or not to adopt such jurisdictional limitations based on interpretations of differing provisions of State law.

G. Background. The delineation of OSHA and the U.S. Coast Guard authority over **inspected vessels** has been unchanged since the signing of a Memorandum of Understanding (reference C.2.) in 1983. The Coast Guard has statutory authority to prescribe and enforce regulations affecting the safety and health of seamen on board vessels inspected and certificated by the agency, and has issued comprehensive standards for working conditions on inspected vessels. Therefore, OSHA may not enforce the OSH Act with respect to "seamen" on inspected vessels including the master, ship's officers and crew members.

The extent of the Coast Guard preemption of OSHA authority over **commercial uninspected fishing vessels** underwent significant changes in 1991. In response to Public Law 100-424 (reference C.3.), the U.S. Coast Guard developed and issued specific regulations (reference C.4.) for commercial uninspected fishing, fish processing, and fish tender vessels to improve the overall safety and health working conditions of **commercial fishing industry vessels**.

OSHA authority over **commercial uninspected vessels** (other than uninspected fishing vessels) remains unchanged. The U.S. Coast Guard has published applicable regulations for uninspected vessels (See reference C.5.).

Due to the complexity of determining the extent to which the Coast Guard preempts OSHA authority over inspected vessels, uninspected fishing vessels, and uninspected vessels, additional clarification of OSHA and U.S. Coast Guard authority and enforcement activities on vessels is provided herein.

H. Definitions. Since most definitions related to this instruction are derived from longstanding U.S. Coast Guard rules, where applicable the pertinent U.S. Coast Guard reference is provided within brackets. The following definitions are applicable to this instruction.

1. **Barge** means a non-self propelled vessel. [46 USC Section 2101(2)]
2. **Boundary Line** means a line of demarkation established under Section 2(b) of 33 U.S.C. 151. Generally, boundary lines follow the general trend of the shoreline and cross entrances to small bays, inlets and rivers. For specific descriptions of boundary lines refer to 46 CFR Part 7.
3. **Certificate of Inspection** means a U.S. Coast Guard document issued to United States vessels inspected by the U.S. Coast Guard and which contains, among other information: the description of the vessel, the route the vessel may travel, the minimum crew requirements, the safety equipment and appliances required to be on board, the total number of persons that may be carried, and the names of the owners and operators. [46 USC Section 3309]
4. **Commercial Fishing Industry Vessel** means a fishing vessel, fish tender vessel, or a fish processing vessel which is licensed or registered to engage in commercial fishing industry operations. [46 CFR Section 28.50]
5. **Fish** means finfish, mollusks, crustaceans, and all other forms of marine animal and plant life, except marine mammals and birds. [46 USC Section 2101(11)]
6. **Fish Processing Vessel** is a U.S. Coast Guard **classification for a vessel** that commercially prepares fish or fish products other than by gutting, decapitating, gilling, skinning, shucking, icing, freezing, or brine chilling. [46 USC Section 2101(11b)]
7. **Fish Processing**, as defined by OSHA, is a production function which involves any preparation of a fish or fish product by a worker including gutting, decapitating, gilling, skinning, shucking,

icing, freezing, or brine chilling. It is important to note that the definition of fish processing, as defined by OSHA, is predicated on worker function and, therefore, may occur on vessels other than a U.S. Coast Guard classified "Fish Processing Vessel" (e.g.; "Fish Tender Vessel", "Fishing Vessel").

8. **Fish Tender Vessel** is a U.S. Coast Guard **classification for a vessel** that commercially supplies, stores, refrigerates, or transports fish, fish products, or materials directly related to fishing or the preparation of fish to or from a fishing, fish processing, or fish tender vessel or a fish processing facility. [46 USC Section 2101(11b)]

9. **Fishing Vessel** is a U.S. Coast Guard **classification for a vessel** that commercially engages in the catching, taking, or harvesting of fish or an activity that can reasonably be expected to result in the catching, taking, or harvesting of fish. [46 USC Section 2101(11a)]

10. **Inspected Vessel** means a vessel subject to inspection by the U.S. Coast Guard under 46 U.S.C. 3301 and which is issued a Certificate of Inspection (COI) by the Coast Guard.

11. **Navigable Waters** includes all rivers, tributaries, lakes, bays, and sounds which in their natural and ordinary condition are accessible to and from the high seas by vessels. The U.S. Coast Guard is the agency responsible for making any determination of whether a body of water is considered to be "Navigable Waters."

12. **Seaman** is an individual engaged or employed in any capacity on board a vessel, and who has a more or less permanent connection with a vessel, and who contributes to the function of the vessel or to the accomplishment of its mission. [46 USC Section 10101(3)]

13. **Uninspected Vessel** means a vessel not subject to inspection under 46 USC Section 3301 and not a recreational vessel under 46 USC Section 2101(43). A vessel classified as an "uninspected vessel" by the U.S. Coast Guard is subject to limited Coast Guard inspection of the following areas only: safety check of basic fire fighting equipment, safety check of approved life jackets and lifesaving equipment, ventilation of engine bilges and fuel tank compartments, and backfire traps/flame arresters on inboard engine carburetors using gasoline as a fuel.

I. Geographical Considerations for All Vessels. The authority of OSHA over any vessel is limited to employment performed within a jurisdiction covered by the OSH Act (See Section 4(a), 29 U.S.C. 653(a)). This provision, as modified by later international agreements, states that the OSH Act applies to employment performed in a State of the United States, the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, Northern Mariana Islands, Wake Island, Johnston Island, and the Outer Continental Shelf Lands defined in the Outer Continental Shelf Lands Act. For the purposes of this instruction, the term "State" means each of the jurisdictions previously mentioned, except the Outer Continental Shelf Lands. OSHA only has authority over vessels when they are operating within the limits of State territorial waters.

1. For coastal States, the State territorial waters extend 3 nautical miles seaward from the coast line, except for the Gulf Coast of Florida, Texas and Puerto Rico where the territorial waters extend for 3 marine leagues (approximately 9 nautical miles). "Coast line" is defined as the line of ordinary low water along that portion of the coast which is in direct contact with the open sea and the line marking the seaward limit of inland waters.

2. For States bordering the Great Lakes and St. Lawrence River, all waters in the Great Lakes and associated rivers up to the international boundary line with Canada are State territorial waters.

J. Authority Over Inspected Vessels. The U.S. Coast Guard exercises full authority over the safety

and health of seamen on board vessels which are inspected and certificated by the U.S. Coast Guard; i.e., "inspected" vessels. With respect to inspected vessels, OSHA refers all safety and health complaints regarding the working conditions of seamen to the U.S. Coast Guard for its consideration to determine whether the events complained of constitute hazardous conditions. OSHA retains authority with respect to recordkeeping requirements for seamen on inspected vessels.

1. OSHA may exercise authority over the working conditions of employees, other than seamen, who are exposed to occupational hazards while working on inspected vessels. This includes employees engaged in longshoring operations, and employees engaged in shipbuilding, ship repair, or shipbreaking operations. This authority also includes other employees, such as construction workers (e.g., those on pipe-laying barges) who are not permanent members of the vessel. However, with respect to employees who are not seamen, OSHA may not cite an owner, operator or master of an inspected vessel for hazards specifically addressed by Coast Guard regulations.

2. The following guidance is provided with respect to making a determination as to whether a worker is a "seaman". A seaman is an employee who:

- a. Is engaged or employed in any capacity on board a vessel and has a more or less permanent connection with the vessel, and

- b. Contributes to the function of the vessel or to the accomplishment of its mission. To be a seaman one need not aid in navigation or contribute to the transportation of the vessel, but one must do the ship's work. Land-based maritime workers are not seamen (e.g., shipyard employees, longshoremen).

3. In making a determination of whether an individual or group of individuals would be classified as a "seaman", the vessel's "Certificate of Inspection" (COI) should be reviewed since it will provide relevant information on the crew. However, this document is not absolutely determinative.

4. The COI may specifically indicate crew member billets which would, thereby, classify members of the officer rating by a license, and seamen by the issuance of a Merchant Mariners Documents. This is commonly referred to as a "MMD" (Merchant Mariners Document) or "Z-Card" (identification number starts with the letter Z). However, other individuals may be seamen if they meet the above noted two-part test. (See J.2.a. and b.) Any individual who can be determined to be subject to the Jones Act (reference C.6.), would be classified as a "seaman". Local U.S. Coast Guard offices and staff are willing and helpful in those situations where it is difficult to determine whether an individual or group of individuals would be defined as a "seaman." In situations where a dispute or disagreement arises, or a question remains, the OSHA National Office, Office of General Industry Compliance Assistance (Maritime Division), shall be contacted through the respective OSHA Regional Office before any violation is cited.

K. U.S. Coast Guard Inspected Vessel Regulations. The U.S. Coast Guard regulates safety and health working conditions for seamen on inspected vessels through the issuance of standards which are contained in 46 CFR Chapter I. The enforcement of the U.S. Coast Guard requirements is set forth in their Marine Safety Manual and Navigation and Vessel Inspection Circulars. The U.S. Coast Guard also regulates commercial diving conducted from inspected vessels per 46 CFR Part 197, Subpart B regulations. (See reference C.7.)

1. The types of inspected vessels are set forth in 46 U.S.C. 3301. They are freight vessels, nautical school vessels, off-shore supply vessels, passenger vessels, sailing school vessels, seagoing barges, seagoing motor vessels, small passenger vessels, steam vessels, tank vessels, fish processing vessels of more than 5,000 gross tons, and fish tender vessels of more than 500 gross tons.

2. Inspected vessels must carry a valid "Certificate of Inspection" issued by the U.S. Coast Guard.

L. OSHA Requirements Enforceable on Inspected Vessels. OSHA may exercise its authority to cite employers (other than the owners, operators, agents or masters of inspected vessels **employing only "seamen"**) for all violative working conditions on a vessel when such violations occur within OSHA's geographical jurisdiction. Primarily these employers are those who employ longshoremen and workers engaged in ship repairing, shipbuilding, and shipbreaking.

1. An owner, operator, agent or master of an inspected vessel may be cited for hazards to which non-seamen it employs are exposed if the hazard is not specifically subject to a particular regulation of the U.S. Coast Guard. The reporting of accidents by employers to OSHA is required for all situations where OSHA has geographical jurisdiction in accordance with 29 CFR Section 1904.8.

2. OSHA requirements which remain enforceable on inspected vessels for **employees other than seamen** are as follows:

- a. 29 CFR 1915 for ship repair, shipbuilding and shipbreaking (including applicable 29 CFR 1910 requirements. (See reference C.8.)
- b. 29 CFR 1918 for long shoring operations.
- c. 29 CFR 1919 for cargo handling operations as referenced under 29 CFR 1918 longshoring requirements. (See reference C.9.)
- d. 29 CFR 1926 for marine construction activities. (See reference C.10.)
- e. 29 CFR 1910 for general working conditions not otherwise regulated. (See reference C.11.)
- f. Identified recognized hazardous situations that are causing or are likely to cause death or serious physical harm for which there are no specific OSHA or U.S. Coast Guard standards will be cited under the provisions of Section 5(a)(1) of the Occupational Safety and Health Act (OSH Act). (See reference C.12.)

NOTE 1: Situations will occur where the employee is covered by OSHA, but the vessel hazard is regulated by the U.S. Coast Guard. A common example is the height of guardrails—OSHA requires 42 inches, but the U.S. Coast Guard allows various heights not specifically allowed in the OSHA standards. In such cases involving hardware design specifications, OSHA compliance officers shall not cite the employer for the condition if it complies with the Coast Guard requirements. However, if a longshoring employee were exposed to a fall into a hatch because an installed guard-rail or lifeline was missing or had been taken down, then OSHA compliance officers shall cite the violation.

NOTE 2: Inspected vessels in an immobile status which have been determined to be substantially a land structure are issued a "Certificate of Permanently Moored" by the Army Corps of Engineers and, thereby, lose status as a vessel (i.e., prior U.S. Coast Guard COI is invalid). A "Certificate of Permanently Moored" may include prior vessels being used as a theater, hotel, restaurant, museum, factory, etc. OSHA may exercise its authority to cite employers for all violative working conditions on such prior vessels. If there is any question, call the National Office, Office of General Industry Compliance Assistance (Maritime Division) for guidance.

NOTE 3: Inspected vessels used as gambling boats, tour boats and similar vessels are subject to the 1983 MOU between the Coast Guard and OSHA (reference C.2.). If the worker is determined to be a "seaman" per paragraph J. of this

instruction, then the U.S. Coast Guard regulates the working conditions.

M. OSHA Authority Over Commercial Uninspected Fishing Vessels. Authority over commercial uninspected fishing vessels is shared by the U.S. Coast Guard and OSHA, with the Coast Guard being the lead agency. OSHA is precluded under Section 4(b)(1) of the OSH Act (reference C.12.) from enforcement with respect to working conditions regulated by other Federal agencies. Therefore, the promulgation of 46 CFR Part 28 (reference C.4.) by the U.S. Coast Guard has expanded the extent of the Coast Guard's regulations over "commercial" uninspected fishing vessels, and preempts OSHA with respect to those working conditions specifically addressed by Coast Guard regulations.

1. OSHA will continue to regulate working conditions on uninspected fishing vessels that are not otherwise covered by U.S. Coast Guard standards, within the geographical limits specified in section I for the protection of all employees including seamen. A list of enforceable OSHA requirements is provided in Appendix A of this instruction.
2. Pursuant to 29 C.F.R. 1910.6(a)(3), OSHA deems it necessary to assure the presence of Coast Guard personnel during OSHA inspections of fishing vessels, as a general rule. Therefore, when practical and feasible, the OSHA Area Director will advise the Coast Guard in advance of inspections to be conducted aboard fishing vessels, and OSHA compliance officers will allow U.S. Coast Guard personnel to accompany them at the option of the Coast Guard.
 - a. OSHA shall advise the Coast Guard on a case-by-case basis of OSHA's requirement that vessel owners and employers are not given advance notice of the inspection.
 - b. Specific occupational hazards noted by OSHA compliance officers which are addressed by U.S. Coast Guard regulations will be referred to the local U.S. Coast Guard District Office in writing through the use of the OSHA 90 Form with a cover letter. This procedure will allow Integrated Management Information System queries to be conducted on referrals submitted to the U.S. Coast Guard by OSHA. Otherwise, the violations will be cited by OSHA compliance officers under OSHA procedures and regulations.
3. Pursuant to appropriations limitations, OSHA is currently precluded from conducting "programmed" safety inspections of worksites in the fishing industry with 10 or fewer employees. Field personnel are reminded to review OSHA Instruction CPL 2.51 (reference C.13.) for any applicable limitations placed on OSHA activities by the Congress in the law providing appropriations for the Department of Labor.

N. U.S. Coast Guard Commercial Uninspected Fishing Vessel Regulations. The U.S. Coast Guard regulations for commercial "uninspected" fishing vessels (reference C.4.) are applicable to fish processors up to 5,000 gross tons, fish tenders up to and including 500 gross tons, and all commercial fishing vessels. Fish processors and fish tenders which exceed these limits are "inspected" vessels. Currently, there is only one known vessel (fish processor) which exceeds these limits. The U.S. Coast Guard regulations are primarily performance-oriented requirements. Applicable U.S. Coast Guard regulations in force, which preempt OSHA for commercial uninspected fishing vessels, can be found in Appendix B.

O. OSHA Requirements Enforceable on Commercial Uninspected Fishing Vessels. OSHA may exercise its authority to cite employers using commercial uninspected fishing vessels for all violative working conditions on a vessel when such violations occur within OSHA's geographical jurisdiction, and when such violations are not specifically addressed by Coast Guard vessels. Primarily these employers are those who employ fishing industry employees (e.g., processing line workers), longshoremen and workers engaged in ship repairing, shipbuilding, and shipbreaking.

1. An owner, operator, agent or master of an uninspected fishing vessel may be cited for hazards to which **any employee, including seamen**, are exposed if the hazard is not regulated by the U.S. Coast Guard.

a. OSHA compliance officers will ensure compliance with 29 CFR 1910 standards except for ship repair, shipbuilding, and shipbreaking where 29 CFR 1915 standards apply; and cargo handling operations where 29 CFR 1918 standards apply.

b. Identified recognized hazardous situations that are causing or are likely to cause death or serious physical harm for which there are no specific OSHA or U.S. Coast Guard standards will be cited under Section 5(a)(1) of the OSH Act. (See reference C.12.)

c. The reporting of accidents by employers to OSHA is required for all situations where OSHA has geographical jurisdiction over the working condition(s). (See Appendix A for specific conditions that continue to be subject to OSHA enforcement.)

P. Authority Over Commercial Uninspected Vessels (Other than Commercial Fishing Vessels).

The U.S. Coast Guard conducts limited safety checks on "uninspected vessels." The Coast Guard has regulations dealing with, and conducts safety checks of, working conditions on commercial uninspected vessels involving personal flotation devices, lifesaving equipment, fire extinguishing equipment, fire fighting equipment, ventilation of engine bilges and fuel tank compartments, and back-fire traps/flame arresters on inboard engine carburetors using gasoline as a fuel. Any other working condition on board a commercial uninspected vessel is subject to OSHA authority.

1. U.S. Coast Guard regulations for uninspected vessels are **not applicable** to:

a. Any vessel operating exclusively on inland waters which are not navigable waters. The nearest U.S. Coast Guard Marine Safety Office will provide a determination of navigable inland waters upon request. Any waters from which a vessel cannot access the high seas would generally not be considered navigable waters (e.g., a land locked lake, or a river/lake up-stream of a dam).

b. Any vessel while laid up and dismantled and out of commission.

c. Any vessel with title vested in the United States which is used for public purposes, except vessels of the U.S. Maritime Administration.

2. Towing vessels and tugboats are not listed by the U.S. Coast Guard as "Vessels Subject to Inspection" and are, therefore, uninspected vessels. The two exceptions are **steam powered** towing vessels and tugboats, and **seagoing** towing vessels and tugboats **over 300 gross tons** which operate beyond the Boundary Line and, thus, are inspected vessels.

NOTE: If the vessel always operates within U.S. inland waters then it is not required to be inspected.

Q. U.S. Coast Guard Uninspected Vessels (Other than Commercial Fishing Vessels)

Regulations. U.S. Coast Guard uninspected vessel regulations (reference C.5.) provide clarification of the extent of U.S. Coast Guard authority and enforcement in this area. Applicable U.S. Coast Guard regulations in force which preempt OSHA on uninspected vessels are summarized in Appendix C.

NOTE: U.S. Coast Guard regulations (reference C.5.) shall review prior to conducting inspections of uninspected vessels and prior to the issuance of citations for violations.

R. OSHA Requirements Enforceable on Uninspected Vessels (Other than Commercial Fishing Vessels). OSHA may exercise its authority to cite all employers for all violative working conditions affecting their employees on uninspected vessels when such violations occur within OSHA's geographical jurisdiction and when such violations are not specifically addressed by a Coast Guard regulation.

1. An owner, operator, agent or master of an uninspected vessel may be cited for hazards to which **any employees, including seamen**, it employs are exposed if the hazard is not regulated by the U.S. Coast Guard.

a. OSHA compliance officers will ensure compliance with 29 CFR 1910 standards except for ship repair, shipbuilding, and shipbreaking where 29 CFR 1915 standards apply; longshoring and cargo handling operations where 29 CFR 1918 and 1919 standards apply; and marine construction activities where 29 CFR 1926 standards apply.

b. Identified recognized hazardous situations that are causing or are likely to cause death or serious physical harm for which there are no specific standards will be cited under the provisions of Section 5(a)(1) of the OH Act. (See reference C.12.)

c. A list of the hazards regulated onboard uninspected vessels by the Coast Guard is provided in Appendix C of this instruction.

2. The reporting of accidents by employers to OSHA is required for all situations where OSHA has geographical jurisdiction.

Joseph A. Dear Assistant Secretary

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Appendix A
SPECIFIC CONDITIONS ON UNINSPECTED FISHING VESSELS
SUBJECT TO OSHA ENFORCEMENT

1. Onboard cranes and their maintenance and use. [29 CFR 1910 Subpart N; 29 CFR 1915 Subpart G; 29 CFR 1918 Subpart B, F, G, and H]

NOTE: Cranes used to support ship repair or longshoring operations (i.e., the transfer of cargo to or from a vessel) require certification by a recognized Federal OSHA agency accredited under 29 CFR 1919.

2. Chains, hooks, and slings. [29 CFR 1910 Subpart N; 29 CFR 1915 Subpart G; 29 CFR 1918 Subparts F, G and H]

3. Ropes (wire, manila, and synthetic). [29 CFR 1910 Subpart N; 29 CFR 1915 Subpart G; 29 CFR 1918 Subpart G]

4. Powered vehicles on board. [29 CFR 1910.178; 29 CFR 1918.73]

5. Maintenance and repair (painting, lockout/tagout, deck holes). [29 CFR 1915 Subparts B, C and E]

6. Open-sided floors and platforms. [29 CFR 1910 Subpart D; 29 CFR 1915 Subpart E; 29 CFR 1918

Subpart D]

7. Tools and portable equipment. [29 CFR 1910 Subpart P; 29 CFR 1915 Subpart H]
8. Warning signs and labeling of control switches. [29 CFR 1910.147 and .335; 29 CFR 1915 Subpart J]
9. Temporary cords (use, maintenance, and material construction). [Public Law 91-596 Section 5(a)(1), 29 CFR 1915.92]
10. Exposed electrical wiring related to factory processing equipment. [Public Law 91-596 Section 5(a)(1)]
11. Steam hose use and fittings. [29 CFR 1915.93]
12. Working around radar and other emission devices. [29 CFR 1915.95]
13. Illumination of work areas and accommodation spaces. [29 CFR 1915.92]
14. Washing, bathing, toilet, and clothes washing facilities. [29 CFR 1910.141]
15. Noise. [29 CFR 1910.95]
16. Elevators and dumbwaiters. [29 CFR 1910.212]

NOTE: For vessels classified by the Coast Guard as a "Fish Processing Vessel" hazardous conditions of elevators and dumbwaiters which are identified by OSHA are referred to the Coast Guard for appropriate action.

17. Vessel access (gangways). [29 CFR 1915 Subpart E, 29 CFR 1918 Subpart C]
18. Gas cylinder storage (use and compatibility). [29 CFR 1910 Subpart H, 29 CFR 1915.55]
19. Sources of ignition, including smoking (e.g., tobacco). [29 CFR 1915 Subpart B]
20. Testing of oxygen-deficient atmospheres. [29 CFR 1915, Subpart B]
21. Cutting and welding permits, testing prior to work, and competent persons in these areas. [29 CFR 1915, Subpart B]
22. Confined spaces. [29 CFR 1915, Subpart B]
23. Personal protective equipment, except lifesaving equipment, life preservers, immersion suits, exposure suits, other personal flotation devices; and on 46 CFR Part 28, Subparts C and D vessels, equipment dealing with refrigerant ammonia and the protection of firefighters. [29 CFR 1910 Subpart I; 29 CFR 1915 Subpart I; 29 CFR 1918 Subpart J]
24. Gas masks and canisters, except equipment dealing with ammonia used as a refrigerant; and on 46 CFR Part 28, Subparts C and D vessels, equipment for firefighters. [29 CFR 1910.134; 29 CFR 1915.152]
25. Respiratory protective programs and respirator checks, except ammonia used as a refrigerant; and

on 46 CFR Part 28, Subparts C and D vessels, equipment for firefighters. [29 1910.134; 29 CFR 1915.152]

26. Asbestos and other chemical exposures, except refrigerant ammonia on 46 CFR Part 28, Subparts C and D vessels. [29 CFR 1910 Subpart Z; 29 CFR 1915 Subpart Z]

27. Materials handling and storage. [29 CFR 1910 Subpart N; 29 CFR 1915 Subpart G; 29 CFR 1918 Subpart H]

28. Hazard communication. [29 CFR 1910.1200, 29 CFR 1915.1200]

29. Bloodborne pathogens. [29 CFR 1910.1030, 29 CFR 1915.1030]

30. Emergency response and spill clean up. [29 CFR 1910.120]

31. Reporting of accidents and fatalities. [29 CFR 1904]

NOTE: Section 4(b)(1) of the OSH Act does not apply to reporting; therefore, OSHA and the U.S. Coast Guard may enforce their own rules. Accidents and fatalities which occur within OSHA's geographical jurisdiction are required to be reported to OSHA in accordance with 29 CFR 1910.8.

32. Recording of illnesses and injuries. [29 CFR 1904]

NOTE: Section 4(b)(1) of the OSH Act does not apply to recordkeeping; therefore, OSHA and the U.S. Coast Guard may enforce their own rules.

APPENDIX B APPLICABLE U.S. COAST GUARD REGULATIONS FOR COMMERCIAL UNINSPECTED FISHING VESSELS

1. U.S. Coast Guard requirements which apply to all commercial uninspected fishing vessels (46 CFR Part 28, Subpart B). (See reference C.4.)

a. General lifesaving equipment.

(1) Personal floatation device (PFD) and immersion suits. [46 CFR 28.110]

(2) Ring life buoys. [46 CFR 28.115]

(3) Survival craft. [46 CFR 28.120]

(4) Stowage of survival craft. [46 CFR 28.125]

(5) Lifesaving equipment markings. [46 CFR 28.135]

(6) Readiness, maintenance and inspection of lifesaving equipment. [46 CFR 28.145]

b. Distress signals. [46 CFR 28.145]

c. Emergency Position Indicating Radar Beacons (EPIRBs). [46 CFR 28.150, 46 CFR 25.26].

d. Excess fire detection and protection equipment. [46 CFR 28.155].

- e. Portable fire extinguishers. [46 CFR 28.155].
 - f. Injury placard. [46 CFR 28.165]
 - g. Casualty reporting. [46 CFR 4.05]
 - h. Injury reporting. [46 CFR 4.05]
2. Additional U.S. Coast Guard requirements which apply to documented commercial fishing vessels that operate beyond the Boundary Lines or with 16 or more individuals on board (reference C.4., Subpart C):
- a. Fireman's outfit and self-contained breathing apparatus (SCBA). Each vessel with 49 or more passengers onboard must have two such outfits. Each vessel that uses ammonia as a refrigerant must have two SCBAs, each with a spare bottle. [46 CFR 28.205]
 - b. First aid equipment and training. [46 CFR 28.215]
 - c. Guards for exposed hazards (including machine guarding). This includes, but is not limited to, factory processing equipment on fish processing vessels. [46 CFR 28.215]
 - (1) Each space on board a vessel must meet the requirements of this section.
 - (2) Suitable hand covers, guards, or railing must be installed in way of machinery which can cause injury to personnel, such as gearing, chain or belt drives, and rotating shafting. This is not meant to restrict necessary access to fishing equipment such as winches, drums or gurdies.
 - (3) Each exhaust pipe from an internal combustion engine which is within reach of personnel must be insulated or otherwise guarded to prevent burns.
 - d. Navigational information. [46 CFR 28.225]
 - e. Compass with deviation table. [46 CFR 28.230]
 - f. Anchors and radar reflectors. [46 CFR 28.235]
 - g. General alarm system. [46 CFR 28.240]
 - h. Communication equipment. [46 CFR 28.245]
 - i. High water alarms. [46 CFR 28.250]
 - j. Bilge pumps, bilge piping, and dewatering systems. [46 CFR 28.250 and .255]
 - k. Electronic position fixing devices. [46 CFR 28.260]
 - l. Emergency instructions, training, drills and safety orientation. [46 CFR 28.265 and .270]
 - (1) Abandoning the vessel, fighting fires, recovering an individual from the water, minimizing the effects of unintentional flooding, launching survival craft, recovering lifeboats and rescue boats;
 - (2) Donning a fireman's outfit and a SCBA, making a voice radio distress call and using visual

distress signals, activating the general alarm and reporting inoperative alarm systems and fire detection system; and

(3) Drills, and vessel safety orientation.

3. In addition to the aforementioned regulations, commercial fishing vessels which have had their keel laid or are at a similar stage of construction or which undergo a major conversion completed on or after September 15, 1991, and that operate with more than 16 individuals on board must comply with the following U.S. Coast Guard requirements (reference C.4., Subpart D):

a. Lifesaving/Deck Equipment.

- (1) Lifesaving and signaling equipment. [46 CFR 28.305]
- (2) Launching survival craft. [46 CFR 28.310]
- (3) Means of escape. [46 CFR 28.390]
- (4) Embarkation stations. [46 CFR 28.395]
- (5) Radar & depth sounding devices. [46 CFR 28.400]
- (6) Deck rails, lifelines, storm rails and hand grabs. [46 CFR 28.410]

b. Fire Fighting/Engineering Equipment.

- (1) Fire pumps, mains, hydrants and hoses. [46 CFR 28.315]
- (2) Fixed gas fire extinguishing systems. [46 CFR 28.320]
- (3) Fire detection systems. [46 CFR 28.335]
- (4) Galley hood and other fire protection equipment. [46 CFR 28.330]
- (5) Fuel systems. [46 CFR 28.335]
- (6) Ventilation of enclosed engine and fuel tank spaces. [46 CFR 28.340]
- (7) Electrical standard for vessels greater than 79 feet in length. [46 CFR 28.345]
- (8) General requirements for electrical systems. [46 CFR 28.350]
- (9) Main source of electrical power. [46 CFR 28.355]
- (10) Electrical distribution systems. [46 CFR 360]
- (11) Overcurrent protection and switched circuits. [46 CFR 28.365]
- (12) Wiring methods and materials. [46 CFR 28.370]
- (13) Emergency source of electrical power. [46 CFR 28.375]
- (14) General structural fire protection. [46 CFR 28.380]

(15) Structural fire protection for vessels with more than 49 individuals on board. [46 CFR 28.385]

(16) Hydraulic equipment. [46 CFR 28.405]

4. Stability requirements which apply to documented commercial fishing industry vessels greater than 79 feet (See reference C.4, Subpart E).
5. Requirements which apply to fish processing vessels (See reference C.4., Subpart F).
6. Requirements which apply to fish tender vessels engaged in the Aleutian Trade Act (See reference C.4., Subpart G).

APPENDIX C U.S. COAST GUARD REGULATIONS FOR UNINSPECTED VESSELS

1. Personal Flotation Devices (PFD) and Other Lifesaving Equipment [46 CFR 25.25].

- a. An approved and readily available PFD is required to be on board the vessel for each individual on board. An exposure suit is considered to be an acceptable substitute for a PFD. **All lifesaving equipment designed to be worn is required to be readily available and in serviceable condition.**
- b. Each vessel 26 feet or longer must have at least one approved ring life buoy which is immediately available. **All lifesaving equipment designed to be thrown into the water is required to be immediately available and in serviceable condition.**
- c. An approved commercial hybrid PFD is acceptable if worn when the vessel is underway and the intended wearer is not within an enclosed space; labeled for use on uninspected commercial vessels; and used as marked and in accordance with the owner's manual.
- d. An approved light is required for all PFDs and exposure suits. Also, all PFDs must have approved retro-reflective material installed.

2. Fire Extinguishing Equipment [46 CFR 25.30].

- a. Hand-portable fire extinguishers and semi-portable fire extinguishing systems must be of the "B" type (i.e.; suitable for extinguishing fires involving flammable liquids, greases, etc.).
- b. Hand-portable fire extinguishers and semi-portable fire extinguishing systems must have a plate listing the name of the item, rated capacity (gallons, quarts or pounds), name and address of person/firm for whom approved, and manufacturer's identifying mark.
- c. Portable fire extinguishers must be inspected and weighed every 6 months.
- d. Minimum number of B-II hand portable fire extinguishers required to be on board motor vessels: one if less than 50 tons, two if 50-100 tons, three if 100-500 tons, six if 500-1000 tons, and eight if over 1000 tons.
- e. Fixed fire extinguishing systems must be an approved carbon dioxide type and must meet the U.S. Coast Guard requirements. (See reference C.5., Part 25.30-15.)

3. Backfire Flame Control [46 CFR 25.35].

Every gasoline engine installed after April 25, 1940, except outboard motors, must be equipped with an acceptable means of backfire flame control.

4. Ventilation of Tanks and Engine Spaces [46 CFR 25.40].

Fuel tanks and engine spaces, using fuel with a flashpoint of 110 degrees Fahrenheit or less, must be provided with adequate ventilation to remove explosive or flammable gases from the fuel tank compartment or bilges.

DOCUMENT #2

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PART 142—OUTER CONTINENTAL SHELF ACTIVITIES: WORKPLACE SAFETY AND HEALTH

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Authority: 43 U.S.C. 1333(d)(1), 1347(c), 1348(c); 49 CFR 1.46.

Subpart A—General

§ 142.1 What is the purpose of this part?

The purpose of this part is to promote workplace safety and health by establishing requirements relating to personnel, workplace activities and conditions, and equipment on all Outer Continental Shelf (OCS) units.

§ 142.3 Who does this part apply to?

- (a) Subparts A through D of this part apply to all persons who work on an OCS unit.
(b) Subpart E of this part applies to all persons who work on a fixed or floating facility.

§ 142.5 Where can I find the

definition of a term used in this part?

(a) See § 140.25 of this chapter for the definition of a term used in this part, other than the terms in paragraph (b).

(b) As used in this subpart—

Certified Industrial Hygienist means an industrial hygienist who is certified by the American Board of Industrial Hygiene.

Certified Marine Chemist means a marine chemist who is certified by the National Fire Protection Association.

Confined space means a space that may contain a dangerous atmosphere, including a space—

- (1) That has poor natural ventilation, such as a space with limited openings; or
(2) That is not designed for continuous occupancy by personnel.

Dangerous atmosphere means an atmosphere that may expose personnel to the risk of death, incapacitation, injury, or acute illness or may impair their ability to escape from the atmosphere unaided.

Hot work means work that produces heat or fire, such as riveting, welding, burning, or the use of powder-actuated fastening tools. Work that produces sparks, such as grinding, drilling, or abrasive blasting, is hot work if considered so by a Certified Marine Chemist.

Offshore Competent Person means an individual certified under § 142.372 as trained and experienced in matters relating to confined-space entry.

§ 142.10 Where can I get a copy of a publication referenced in this part?

You may get a copy of a publication referenced in this part from the sources listed in § 140.30 of this chapter.

§ 142.15 Who must ensure compliance with the requirements of this part?

(a) Each holder of a lease or permit under the Act must ensure that all places of employment within the lease area or within the area covered by the permit on the OCS are—

- (1) Maintained in compliance with workplace safety and health regulations of this part; and

- (2) Free from recognized hazards.

(b) Persons responsible for actual operations, including owners, operators, contractors, and subcontractors, must ensure that those operations subject to their control are—

- (1) Conducted in compliance with workplace safety and health regulations of this part; and

- (2) Free from recognized hazards.

(c) The term "recognized hazards", as used in this section, means conditions

that are—

- (1) Generally known among persons in the affected industry as causing or likely to cause death or serious physical harm to persons exposed to those conditions; and
- (2) Routinely controlled in the affected industry.

§ 142.20 What workplace safety information and training must I provide?

Each holder of a lease or permit under the Act must ensure that all personnel are provided with information and training on recognized hazards in their workplace, including, but not limited to, electrical, mechanical, and chemical hazards.

§ 142.25 What emergency response training is required?

Personnel must be trained in emergency response and cleanup, including—

- (a) The actions they are expected to perform and the limitations on those actions;
- (b) The hazards associated with each emergency;
- (c) Their responsibilities for the safety of others involved in the emergency response; and
- (d) The selection and use of proper personal protection equipment.

§ 142.30 Who controls access to medical monitoring and exposure records?

If medical monitoring is performed or exposure records maintained by an employer, the owner, operator, or person in charge must establish procedures for access to these records by personnel.

§ 142.35 To whom can I report a possible workplace safety or health violation?

Any person may notify the OCMI of—

- (a) A possible violation of a regulation in this part; or
- (b) A hazardous or unsafe working condition on any OCS unit.

§ 142.40 After learning of a possible violation, what does the OCMI do?

After reviewing the information received under § 142.35 and conducting any necessary investigation, the OCMI notifies the owner or operator of any deficiency or hazard and initiates enforcement measures as the circumstances warrant.

§ 142.45 If I report a violation, will the Coast Guard keep my identity confidential?

The identity of any person providing information under § 142.35 is not made available, without the permission of that person, to anyone other than those officers and employees of the Department of Transportation who have a need for the information in the performance of their official duties.

Subpart B—Personal Protective Equipment

§ 142.100 What is the purpose of this subpart?

The purpose of this subpart is to prescribe requirements concerning personal protective equipment on an OCS unit.

§ 142.110 Who is responsible for ensuring that personnel use or wear protective equipment and are trained in its use?

- (a) Each holder of a lease or permit under the Act must ensure that all personnel who are required by this subpart to use or wear personal protective equipment do so when within the lease area or the area covered by the permit.
- (b) Persons responsible for actual operations must ensure—
 - (1) That all personnel engaged in the operation are trained in the proper use, limitations, and maintenance of the personal protective equipment specified by this subpart;
 - (2) That the equipment is maintained and used or worn as required by this subpart.
 - (3) That the equipment is made available and on hand for all personnel engaged in the operation.

Eye and Face

§ 142.115 When must I wear eye and face protection?

While you are engaged in or are observing welding, grinding, machining, chipping, handling hazardous materials, or acetylene burning or cutting, you must wear eye and face protectors that—

- (a) Comply with the requirements specified for the operation in Figure 8 of ANSI Z87.1–1989;
- (b) Are maintained in good condition; and
- (c) Are marked with the information required for that type of protector by ANSI Z87.1–1989.

§ 142.120 Where must eyewash equipment be located?

Portable or fixed eyewash equipment providing emergency relief must be immediately available near the drill floor, mudrooms, and other areas where there is a reasonable probability that eye

injury may occur.

Head

§ 142.125 Who must wear head protection and how must it be marked?

While you are working in one of the following areas, you must wear a head protector that meets the specifications of, and marked with the information required in, ANSI Z89.1–1997 for that type of protector and for the hazard involved:

- (a) Where there is a hazard of falling objects.
- (b) Where there may be contact with electrical conductors.

Feet

§ 142.130 What shoes must I wear?

- (a) While you are working in an area, or are engaged in activities, where there is a reasonable probability for foot injury to occur, you must wear footwear meeting the specifications of ANSI Z41–1991, except when environmental conditions exist that present a hazard greater than that against which the footwear is designed to protect.
- (b) Each pair of footwear must be marked with the information specified by ANSI Z41–1991 for the type of footwear.

Hearing

§ 142.135 When must I wear hearing protectors? What standards must they meet?

- (a) If you are working in an area where the noise level is greater than 87 db(A), you must wear hearing protectors capable of reducing the level to 87 db(A) or less. The noise level must be measured as a time-weighted-average (TWA) over 12 hours using a sound level meter and an A-weighted filter or an equivalent device.
- (b) The hearing protectors must have been performance-tested in accordance with ANSI S3.19 or ANSI S12.6–1997.

Clothing

§ 142.140 When must I wear protective clothing?

While you are within an area where there are flying particles, molten metal, radiant energy, heavy dust, or hazardous materials, you must wear clothing and gloves providing protection against the hazard involved.

Electrical

§ 142.145 What training must I have?

To prevent electrical shock, personnel

must be trained in electrical, safety-related work practices in the area of the work they perform, including the use of electrical personal protective equipment appropriate to protect against potential electrical hazards.

Respiratory

§ 142.150 When must I wear respiratory protection equipment?

While you are within an atmosphere specified under ANSI Z88.2-1992 as requiring the use of respiratory protection equipment, you must wear the type of respiratory protection equipment specified in ANSI Z88.2-1992 for that atmosphere.

§ 142.151 What training must I have before I use respiratory protection equipment?

Before you enter an atmosphere specified under ANSI Z88.2-1992 as requiring the use of respiratory protection equipment, you must be trained—

- (a) In the procedures stated in section 7 of ANSI Z88.2-1992 concerning the proper selection of a respirator and individual fit testing;
- (b) In the matters in section 8 of ANSI Z88.2-1992 concerning proper use of the equipment; and
- (c) In the generally recognized short and long term harmful effects of exposure to the atmosphere involved.

§ 142.152 To what standard must respiratory protection equipment be approved, used, and maintained?

- (a) All respiratory protection equipment must be approved, used, tested, and maintained in accordance with ANSI Z88.2-1992.
- (b) The fit-testing standards in section 8 of ANSI Z88.2-1992 may be met also through the use of either qualitative or quantitative fit-testing under NIOSH "Guide to Industrial Respiratory Protection" (publication no. 87-116) or AIHA "Respiratory Protection—A Manual and Guideline" 163-PC-91.

Fall Arrest

§ 142.155 When must I use a personal fall arrest system?

Except when moving from one location to another, you must wear a personal fall arrest system when—

- (a) Engaged in an activity where there is a hazard of falling 1.8 meters (6 feet) or more; or
- (b) Working less than 1.8 meters (6 feet) above—
 - (1) Equipment with irregular surfaces;
 - (2) Exposed moving components; or

- (3) Electrically energized cables or connectors.

§ 142.156 What training do I need?

Before you use a personal fall arrest system, you must be trained in the proper use of the system as described in ANSI Z359.1-1992.

§ 142.157 What standards must a personal fall arrest system meet?

- (a) Each personal fall arrest system must meet the standards for performance, design, marking, and qualification testing in ANSI Z359.1-1992.

(b) A person who has extensive knowledge, training, and experience with personal fall arrest systems must inspect and maintain each system in accordance with ANSI Z359.1-1992.

§ 142.158 May I use a personal fall arrest system to hoist material?

No. You may not use a personal fall arrest system to hoist material. The system and its components are only for personal fall protection purposes.

§ 142.159 When may I re-use a personal fall arrest system that has previously been used to arrest a fall?

Once a personal fall arrest system has been subjected to impact loading, such as by arresting a fall, the system must be removed from service. It may not be used again until all components of the system have been inspected by a person who has extensive knowledge, training, and experience in personal fall arrest systems and found undamaged and suitable for re-use.

§ 142.160 When is a fall arrest system not needed?

You do not need to use a fall arrest system when you are—

- (a) Using a personnel net; or
- (b) Protected from a fall by guardrails or fencing under § 143.1230 of this chapter.

Personnel Nets

§ 142.165 What standards must personnel nets meet?

- (a) Each personnel net must meet the standards for performance, design, marking, and qualification testing in ANSI A10.11-1989.
- (b) A person who has extensive knowledge, training, and experience in personnel nets must inspect and maintain each system in accordance with ANSI A10.11-1989.

Work Vests

§ 142.170 Must I wear a work vest or lifejacket when working over water?

If you are working in a location where, in the event of a fall, you would likely fall into the water, you must wear one of the following:

- (a) A work vest that meets the requirements of § 143.875 of this chapter.
- (b) A lifejacket that meets the requirements of § 143.845 of this chapter.
- (c) A personal fall arrest system that meets the requirements of § 142.157.

Radiation

§ 142.175 When must I wear a personal radiation monitoring device?

If you enter an area where you may receive 25 percent of the allowable whole-body total dose of 1.25 REM per calendar quarter, you must wear an appropriate personal radiation monitoring device, such as a film badge, film ring, pocket chamber, or pocket dosimeter.

§ 142.176 For how long must dosimetry records be kept?

The owner, operator, or person in charge must ensure that the dosimetry records of each person on the facility who is required to wear a monitoring device under § 142.175 are retained for 30 years from that person's last day of employment and made available for inspection.

§ 142.177 When must I conduct a radiation survey?

The owner, operator, or person in charge must ensure that a radiation survey is performed as necessary to comply with §§ 142.175 and 142.178. The survey must evaluate the radiation hazards incident to the production, use, release, disposal, or presence of radioactive materials or other sources of radiation under a specific set of conditions. When appropriate, this evaluation must include a physical survey of the location of materials and equipment and measurements of levels of radiation or concentrations of radioactive material present.

§ 142.178 When must I post signs to warn about radiation?

If a work area may contain radiation emissions of 5 or more millirems per hour, radiation caution signs, labels, and signals as described in 29 CFR 1910.1096(e) must be posted.

§ 142.179 What about naturally occurring radioactive material?

For operations that introduce naturally occurring radioactive material (NORM), the owner or operator must establish a program that includes procedures for—

- (a) Controlling the generation of airborne dust containing NORM;
- (b) Limiting the exposure of personnel to airborne dust containing NORM;
- (c) Managing equipment contaminated with NORM; and
- (d) Disposing of waste contaminated with NORM.

Airborne Substances

§ 142.180 What are the permissible exposure limits for airborne substances?

Exposure of personnel to any airborne substance, other than a substance under § 142.181, must be limited to the permissible exposure limit cited in the material safety data sheet for that substance.

§ 142.181 What are the permissible exposure limits for asbestos and inorganic lead?

- (a) Exposure of personnel to asbestos must not exceed the 8-hour timeweighted average of 0.1 fiber per cubic centimeter of air or the 30-minute excursion limit of 1.0 fiber per cubic centimeter of air.
- (b) Exposure of personnel to inorganic lead must not exceed the 8-hour timeweighted average of 0.05 milligrams of lead per cubic meter of air.

§ 142.182 If an area exceeds the exposure limits, must I restrict entry to certain personnel?

You must not enter, or allow others to enter, an area containing an airborne substance in quantities that exceed the permissible exposure limits in §§ 142.180 or 142.181, unless you are wearing the personal protective equipment appropriate for the substance and are trained in the proper use of the equipment.

§ 142.183 How may I keep exposure to a level within the permissible exposure limits?

To keep exposure to airborne substances to a level within the permissible exposure limits in §§ 142.180 and 142.181, engineering controls, administrative controls, personnel protective equipment, or a combination of these may be used.

Infectious Material

§ 142.185 What must I do to avoid exposure to infectious material?

(a) Before you perform, or are required to perform, a duty that may expose you to a blood-borne pathogen or other potentially infectious material, you must be trained in the procedures and equipment necessary to avoid the exposure.

(b) Each OCS unit must have a written program that describes the training, procedures, and equipment to prevent exposure to blood-borne pathogens.

Subpart C—General Workplace Conditions

§ 142.200 What is the purpose of this subpart?

The purpose of this subpart is to prescribe requirements relating to general working conditions on OCS units.

§ 142.205 What must I do to help prevent tripping and slipping?

- (a) All working surfaces, including staging and platform surfaces, and all walkways, including ramps and stairways, must be kept clear of—
 - (1) Tripping hazards, such as material, portable tools, equipment, and other items not in use; and
 - (2) Slipping hazards, such as spilt substances.
- (b) On the drill floor, footwear and flooring designed to reduce slipping may be used instead of keeping the floor clear of drilling fluid, such as fluid spilt when pulling wet strings of drill pipe.

§ 142.207 How do I manage deck obstructions to avoid interfering with survival craft?

You must keep deck areas where survival craft and rescue boats are stowed free of obstructions that might interfere with the boarding and launching of the craft.

§ 142.210 How must I guard a deck opening?

On a deck that is accessible to personnel, each temporary opening in the deck must be covered or guarded so that a person's foot can not pass through the opening, or the area around the opening made inaccessible to personnel. For requirements for the protection of permanent openings, see the guards and rail requirements in § 143.1230 of this chapter.

Electrical Work

§ 142.215 What safe practices must I use?

- (a) Before you begin work that might expose you to an electrical charge, you must turn off the electricity, unless

doing so is not feasible.

(b) When you turn off equipment, you must follow the lockout or tagging procedures in § 142.220 or 142.225.

Lockout

§ 142.220 How must I disable equipment before I work on it?

If the equipment does not need to be powered during the work and it has a lockout or other device to prevent the equipment from being turned on unintentionally, you must activate that lockout or device.

Tagout

§ 142.225 How must I warn others not to restore power to equipment I am working on?

- (a) Before doing work on equipment that is disconnected from the power source, you must place a tag at the location where the power is disconnected. If there is a control panel for the equipment in line between the equipment and the location where the power is disconnected, you also must place a tag on the control panel.
- (b) Each tag or sign must have words stating—
 - (1) That equipment is being worked on;
 - (2) That power must not be restored or the equipment activated;
 - (3) The name of the person who placed the tag; and
 - (4) The name of the person who authorized the tag.

§ 142.230 Who may remove a tag indicating that power must not be restored?

To remove a tag under § 142.225, you must have the permission of—

- (a) The person who placed the tag;
- (b) That person's immediate supervisor; or
- (c) The relief person of either.

Noise

§ 142.235 What are the requirements for a noise level survey?

- (a) A survey to determine the maximum noise level during normal operations must be conducted in each accommodation space, working space, or other space routinely used by personnel. The survey must be conducted in accordance with ANSI S1.13-1995 and S1.36-1990 or with IMO Resolution A.468(XII), and the survey results kept on the OCS unit.
- (b) A new survey must be conducted when the space is substantially modified or when equipment producing

a high level of noise is added or replaced in the space.

(c) The initial survey for an OCS unit constructed before [effective date of final rule.] must be completed by [date one year after effective date of final rule.].

§ 142.240 What signs must I post in spaces with high-noise levels?

(a) If the noise level throughout a space is determined to exceed 87 db(A), you must post a sign with the legend "NOISE HAZARD—HEARING PROTECTORS REQUIRED" at eye level at each entrance to the space. You must measure the noise level as a timeweighted-average (TWA) over 12 hours using a sound level meter and an A-weighted filter or an equivalent device.

(b) If the noise level is determined to exceed 87 db(A) only in a portion of a space, you may post the sign within that portion in a location visible from each direction of access.

Machine Guards

§ 142.245 What are the requirements for machine guards?

(a) Except as provided in § 142.250, you must guard all exposed rotary, reciprocating, or other hazardous parts of a machine to protect the operator and other personnel in the area from hazards, such as those created by rotating parts, flying chips, and sparks. Guards include, but are not limited to, barrier guards, covers, rails, two-hand tripping devices, and electronic safety devices.

(b) You must attach the guard to the machine; or, if having the guard attached to the machine would itself create a hazard, you must affix the guard elsewhere.

§ 142.250 When is a guard not required?

A guard is not required if it would restrict or prevent the operation of the machine and a warning sign is conspicuously displayed in accordance with § 142.285.

Equipment Use and Maintenance

§ 142.255 What are the general requirements?

(a) All equipment, including machinery, cranes, derricks, and portable power tools must be used in a safe manner and in accordance with the manufacturer's recommended practice, unless otherwise stated in this subchapter.

(b) All machinery and equipment must be maintained in proper working

order, unless removed from service.

Slings

§ 142.260 What are the requirements for slings?

(a) Slings must be used, inspected, repaired, and tested according to the manufacturer's recommendations.

(b) Slings must be inspected visually before each use.

(c) Unsafe, damaged, or defective slings must be removed from service immediately and either tagged out or destroyed.

(d) Slings must be marked with information showing their size, grade, and rated capacity.

Personnel Transfer Nets

§ 142.265 How must they be used and maintained?

(a) Personnel transfer nets must be used and maintained in accordance with API RP 54.

(b) The load on a personnel transfer net must not exceed the manufacturer's specifications.

§ 142.270 How must they be constructed?

(a) Personnel transfer nets must be constructed of new material that resists deterioration by ultraviolet light or sea water.

(b) All lines and other component parts of the nets must have a minimum tensile strength of at least six times the manufacturer's maximum rated load for each line or other component part.

§ 142.275 Must I inspect every net before each use? What do I do with a damaged net?

(a) A personnel transfer net must be inspected visually before each use.

(b) If a load bearing part of the net, such as a pick up line, load line, or lifting ring, is frayed, damaged, worn, or corroded, the net must be withdrawn immediately from service and discarded.

(c) If a non-load-bearing part is frayed, damaged, worn, or corroded, the part must be replaced before the net is used again. The replacement part must be equivalent to the original in strength, material, and method of construction.

§ 142.280 What are the lifting procedures for personnel transfer nets?

When a crane is being used with a personnel transfer net to transfer personnel over water, personnel must wear a Coast Guard approved personal flotation device. The crane operator

must not lift or lower personnel directly over an OSC unit or attending vessel, except to clear or land personnel.

Warning Signs

§ 142.285 What are the warning sign requirements?

(a) This section applies to all warning signs added or replaced after [the effective date of the final rule]. The requirements for the use of tags for disabled equipment are in §§ 142.225 and 142.230.

(b) Signs must be used to alert personnel and identify specific hazards that might lead to accidental injury.

(c) Signs warning personnel of immediate danger and the need for special precaution must use the color red.

(d) Signs warning personnel against potential hazards or cautioning against an unsafe practice must use the color yellow.

(e) A sign must be removed when the hazard it warns of is eliminated.

(f) Signs need not be used where tags, guarding, or other means of protection are used.

Subpart D—Confined-Space Entry General

§ 142.300 What is the purpose of this subpart?

The purpose of this subpart is to reduce the likelihood of personnel inadvertently entering a confined space containing a hazardous atmosphere that can cause death or serious injury.

§ 142.305 What does an Offshore Competent Person do?

Under the supervision of the person in charge, an Offshore Competent Person identifies confined spaces, tests the atmosphere in those spaces, calibrates equipment used to test the atmosphere, posts permits, records the results of calibrations and tests, and performs the other functions assigned to an Offshore Competent Person under this subpart.

§ 142.306 What do the Certified Industrial Hygienist and the Certified Marine Chemist do?

Under the supervision of the person in charge, the Certified Industrial Hygienist and the Certified Marine Chemist may perform any of the functions under this subpart assigned—

(a) To them, by name; or

(b) To an Offshore Competent Person.

Entry Requirements for Personnel

§ 142.310 When may I enter and work within a confined space?

You may enter and work within a confined space if—

- (a) You are certified to enter confined spaces under § 142.362;
- (b) You see a permit or certificate and, if required, a log under § 142.335 posted at the entrance to the space;
- (c) You are wearing or using the personnel protection equipment required in the program under § 142.375 or noted on the permit, certificate, or log;
- (d) You follow the requirements noted on the permit or certificate and on the log while in the space; and
- (e) You follow the procedures for working within confined spaces as provided in your training under § 142.360 and in the program under § 142.375.

§ 142.311 When must I leave a confined space?

You must leave a confined space immediately when—

- (a) You experience a symptom that you believe indicates that you should leave the space; or
- (b) You notice the conditions in the space have changed.

§ 142.312 What do I do if there is no permit or certificate posted?

If there is no permit or certificate posted at the entrance to a confined space or if the permit or certificate posted has expired, you may not enter the space until the proper documents under § 142.335 are posted.

Steps Required Before Personnel May Enter the Space

§ 142.315 What steps must be taken before personnel may enter a confined space?

Before personnel may enter a confined space, the following steps must be taken:

- (a) The space must be prepared, and the non-atmospheric hazards in the space controlled, under § 142.320.
- (b) The equipment used to test the atmosphere in the space must be calibrated under § 142.325.
- (c) The atmosphere in the space must be tested under § 142.330 from the outside of the space.
- (d) The atmosphere in the space must be tested under § 142.332 from inside of the space.
- (e) A permit or certificate and, if required, a log under § 142.335 must be posted at the entrance to the space.

Preparing a Space for Entry

§ 142.320 What must be done within the space to prepare it for the entry of personnel?

Before personnel may enter a confined space, the following must be done to prepare the space:

- (a) The space must be isolated from gas, liquid, mechanical, and electrical hazards by positive means, such as by locking out, disconnecting pipes, double blocking and bleeding, blocking moving mechanical parts, disconnecting power supply lines, and relieving trapped pressure and tension on springs.
- (b) The space must be ventilated before and during entry at a sufficient volume and flow rate to establish and maintain an atmosphere that meets the "Safe for Workers" designation under § 142.331(a). If the space can not be ventilated to meet that designation, a Certified Industrial Hygienist or a Certified Marine Chemist must certify that the atmosphere in the space meets the "Enter with Restrictions" designation under § 142.331(b) and specify the restrictions, such as the use of personnel protection equipment, necessary for entry.
- (c) The discharge areas for the ventilation system must be tested to ensure that there is no buildup of toxic or flammable vapors.
- (d) Liquid residues of hazardous materials must be removed as thoroughly as practicable.
- (e) Workplace hazards within the space, such as trip and fall hazards and excessive heat and noise, and problems with access to and from the space must be identified and controlled.
- (f) Signs prohibiting sources of ignition or warning of other hazards within the space must be posted at the entrances to the space.
- (g) Rescue equipment must be prepositioned and readied for use, as specified in the program under § 142.375.

Calibrating Atmospheric Testing Instruments

§ 142.325 When and how must instruments used in testing be calibrated?

- (a) Before use in an atmospheric test under this subpart, each instrument to be used must be calibrated on the day of use. The instrument must be recalibrated during the test when indicated by the instrument's reading.
- (b) The instrument must be tested by using a known concentration of test gas in a manner consistent with the manufacturer's recommendations under the conditions in which the instrument will be used.

§ 142.326 Who must calibrate the testing instruments?

The individual under §§ 142.330 and 142.332 who will test the atmosphere from outside and within the confined space must calibrate the testing instruments to be used in that test.

§ 142.327 What records of the calibration of testing instruments must be kept?

- (a) The owner, operator, or person in charge must keep a record of the calibrations under § 142.325.
- (b) The records must be kept on the OCS unit for at least 3 months and made available to the Coast Guard upon request.
- (c) Also, the calibration must be recorded on the permit or certificate under § 142.335.

Testing the Atmosphere

§ 142.330 What atmospheric test must be conducted from outside of the confined space?

- (a) The atmosphere within a confined space must first be tested from outside of the space. The test must be conducted as specified in the program under § 142.375 and include sampling at varying heights within the space.
- (b) The Offshore Competent Person may test only for oxygen, flammable gas, benzene, and hydrogen sulfide.
- (c) If the Offshore Competent Person determines that the atmosphere, or the nature of the work to be conducted, indicate that toxins other than benzene or hydrogen sulfide may be present, a Certified Marine Chemist or Certified Industrial Hygienist must test the space.

§ 142.331 What atmospheric conditions are necessary for entry?

- (a) If the outside test is conducted by the Offshore Competent Person under § 142.330(b), the atmosphere must meet the "Safe for Workers" designation under NFPA 306, chapter 2, section 2-3.1, before entry may be authorized.
- (b) If the outside test is conducted by a Certified Marine Chemist or Certified Industrial Hygienist under § 142.330(c), the atmosphere must meet the "Safe for Workers" designation under NFPA 306, chapter 2, section 2-3.1, or "Enter with Restrictions" designation under NFPA 306, chapter 2, section 2-3.3, before entry may be authorized.

§ 142.332 What tests and examinations must be conducted from inside of the confined space?

- (a) Once the test conducted from outside of the space under § 142.330 indicates that the atmosphere in the

space meets the requirements of § 142.331, the space must be tested from the inside.

(b) This test must be conducted by the same individual who conducted the outside test under § 142.330.

(c) The individual conducting the test must—(1) Physically enter the space and again test the atmosphere to verify that it meets the appropriate NFPA designation under § 142.331; and (2) Visually examine all areas of the space and identify and control potential fire or other hazards within the space, such as liquid residues capable of regenerating vapors to hazardous levels.

Permits, Certificates, and Logs

§ 142.335 What type of document must be posted at the entrance to the space?

(a) When tests under §§ 142.330 and 142.332 show that the atmosphere in the confined space meets the appropriate NFPA designation under § 142.331 and when the space is prepared under § 142.320, the individual who conducted the tests must post, at each entrance to the space, a permit under paragraph (b) or a certificate under paragraph (c).

(b) If the tests under §§ 142.330 and 142.332 were conducted by an Offshore Competent Person or a Certified Industrial Hygienist, the document to be posted is a copy of the Offshore Confined-space Entry Permit (Coast Guard Form CSE) in appendix A of this subpart, with the information on the document relating to the space filled out.

(c) If the tests under §§ 142.330 and 142.332 were conducted by a Certified Marine Chemist, the document to be posted is a Marine Chemist's certificate under NFPA 306, with the information on the document relating to the space filled out.

(d) If the permit or certificate is more than 24 hours old, a log must be posted next to the permit or certificate. The log must identify the space and contain the following:

- (1) The name of the OCS unit.
- (2) The time, date, results of each subsequent test under § 142.340 and the name of person conducting the test.
- (3) A description of the operations performed by personnel in the space since the previous test, such as cleaning and hot work.
- (4) Additional instructions, as needed.
- (e) The documents posted under this section must remain posted until the work to be done in the space is finished or the permit or certificate expires, whichever occurs first.

§ 142.336 What happens when a permit or certificate expires or is no longer posted?

(a) When the permit or certificate expires or is removed under § 142.335(e), the owner, operator, or person in charge must keep a copy of the document and corresponding log for 3 months.

(b) These documents must be made available to the Coast Guard upon request.

Subsequent Testing

§ 142.340 What is required to maintain the certificate or permit?

(a) The atmosphere in the space must be re-tested and the space re-examined at least once every 24 hours. More frequent testing and examining may be necessary depending upon factors, such as potential hazards, temperature and cleanliness of the space, type of work being done in the space, and frequency of work breaks.

(b) The Offshore Competent Person must repeat the tests and examinations under § 142.330 and § 142.332, including physically entering the space to verify that conditions have not changed.

(c) An Offshore Competent Person may conduct the tests and examinations under this section, even if the permit or certificate was issued by a Certified Marine Chemist or a Certified Industrial Hygienist.

(d) If the original document posted is a Certified Marine Chemist's certificate and the certificate states that certain tests need not be repeated, those tests are not required.

(e) The results of tests under this section must be recorded on the log posted under § 142.335 at each entrance to the space.

When Conditions in the Space Change

§ 142.345 What if conditions change while I'm in the space?

(a) You must leave the space when conditions that could affect the atmosphere change, such as a failure of the ventilation or the introduction of hazardous substances into the space.

(b) Before you may re-enter the space, it must be re-tested under §§ 142.330 and 142.332 and a new permit or certificate posted under § 142.335.

Restrictions on Equipment and Work

§ 142.350 What are the restrictions on equipment used in a confined space?

(a) All equipment in the confined

space capable of generating a static electricity discharge must be bonded.

(b) All fans in the space must have non-sparking blades.

(c) All lighting and electrical equipment in the space must be explosion proof.

§ 142.351 When may I perform hot work within a confined space?

(a) If you perform hot work in one of the following areas, you may do so only to the extent authorized by a Certified Marine Chemist under the provisions of NFPA 306:

(1) In a fuel or cargo tank.

(2) On the boundary of a fuel or cargo tank.

(3) On the boundary of spaces adjacent to a tank carrying a Grade A, B, or C flammable liquid.

(4) On pipelines, heating coils, pumps, fittings, or other appurtenances connected to fuel or cargo tanks.

(b) If a Certified Marine Chemist is not available, a person authorized by the OCMI may conduct the necessary tests and inspections in accordance with NFPA 306 and authorize the hot work.

(c) Hot work conducted in spaces other than those listed in paragraph (a) of this section may be regulated by the Mineral Management Service under 30 CFR 250.52 and must meet those requirements as applicable.

§ 142.352 What is required to maintain the Marine Chemist's Certificate for hot work?

(a) If hot work under § 142.351(a) does not begin within 24 hours after the Marine Chemist's Certificate is issued, the Offshore Competent Person must maintain the Certificate under NFPA 306, paragraph 2-6.

(b) The results of the tests and inspections under paragraph (a) of this section must be recorded on the log under § 142.335(d).

Testing and Protective Equipment

§ 142.355 What equipment must be provided?

(a) The owner or operator must ensure that all equipment needed to protect personnel in a confined space and to determine and control the hazards within and affecting the confined space is provided.

(b) The equipment may vary depending on the particular space and may include—

- (1) Testing and monitoring instruments;
- (2) Ventilating equipment;
- (3) Communications equipment;
- (4) Personal protective equipment;

- (5) Lighting equipment;
- (6) Barriers and shields;
- (7) Equipment to provide access to and from the space, such as a ladder;
- (8) Rescue equipment; and
- (9) Emergency medical equipment.

Personnel Training

§ 142.360 What training must I have?

The person in charge must ensure that all personnel who enter confined spaces are trained how to—

- (a) Safely perform all duties required by this subpart, by the program under § 142.375, and by a permit or certificate under § 142.335;
- (b) Recognize a confined space and how it can produce a dangerous atmosphere;
- (c) Anticipate the hazards of entering and working within a confined space;
- (d) Determine what personal protective equipment is needed and how to use it;
- (e) Recognize the physical signs of exposure to a dangerous atmosphere;
- (f) Control hazards in the space; and
- (g) Know when to evacuate the space.

§ 142.361 When must I receive the training?

- (a) You must receive the training under § 142.360 before you are allowed to enter a confined space.
- (b) If the operations or duties that you were trained for under § 142.360 change, you must be trained in the areas under § 142.360 that relate to your new operations or duties.

§ 142.362 How can I show that I have been trained?

- (a) Before you may enter a confined space, you must have a certificate under this section.
- (b) When you successfully complete the training under § 142.360, the owner, operator, or person in charge must issue a certificate to you certifying that you successfully completed the training.
- (c) The certificate must contain your name, the name and title of the person who issued the certificate under paragraph (b) of this section, and the date of the certification.
- (d) The certificate must be kept on the OCS unit and made available for inspection by the Coast Guard.

Rescue Team

§ 142.365 How are rescue operations conducted?

- (a) The owner, operator, or person in charge must ensure that a team is established to rescue personnel from confined spaces and provide emergency

medical attention.

- (b) The rescue team must be located on the OCS unit and be available for emergency response while personnel are in a confined space.

(c) The team must follow the rescue and medical procedures in the confined-space entry program under § 142.375.

of the team and the equipment they will need, the owner, operator, or person in charge must consider the type of confined spaces that will be encountered, the nature of the particular hazards in those spaces, and the type of work to be conducted in them.

§ 142.366 What additional training is required for rescue team members?

- (a) The owner, operator, and person in charge must ensure that, in addition to the training under § 142.360, each member of the rescue team is trained to use the personal protective, rescue, and medical equipment needed to perform their functions as part of the team.
- (b) Each member must have a current Emergency Response Certificate and a Cardio-Pulmonary Resuscitation (CPR) for the Professional Rescuers Certificate from the American Red Cross or the equivalent certificates.
- (c) At least one member must have a current registration with the National Registry of Emergency Medical Technicians (EMT) at the EMT Intermediate level.
- (d) Members must practice their functions as part of the team at least once every 12 months, unless the team performs an actual rescue during that 12-month period. The practice must use mannequins, rescue equipment, and a confined space to closely approximate an actual rescue.

Offshore Competent Person

§ 142.370 What education, training, and experience must an Offshore Competent Person have?

An Offshore Competent Person must have the following education, training, and experience:

- (a) Have completed the following courses at an accredited college or university:
 - (1) Two semesters or three quarters of general chemistry.
 - (2) Two semesters or three quarters of organic chemistry with laboratory training.
 - (3) One course in analytical methods with laboratory training.
 - (4) One course in industrial hygiene sampling and analysis involving hands-on use of testing instruments.
- (b) Have completed a course or seminar on confined-space entry with

hands-on calibration and the use of testing instruments and scenarios that simulate confined spaces that will be encountered.

- (c) Have at least 3 years of experience in the offshore oil and gas industry, with at least 2 years of active involvement in an offshore safety program.

(d) Have, within the past 6 months, conducted a confined-space entry test offshore or received training in conducting such a test.

§ 142.371 What abilities and knowledge must an Offshore Competent Person have?

- (a) An Offshore Competent Person must be able to—
 - (1) Interpret and apply the confined-space entry program under § 142.375, the regulations in this subpart, and the standards in NFPA 306;
 - (2) Recognize the confined spaces on the facility or unit;
 - (3) Identify the particular hazards and their sources associated with each confined space on the facility or unit and with the work conducted within that space;
 - (4) Select and apply the appropriate engineering or administrative controls, such as ventilation equipment, lock out procedures, safe work practices, and personal protective equipment;
 - (5) Select, calibrate, use, and maintain the testing instruments for confined-space entry;
 - (6) Interpret the results of tests under this subpart;
 - (7) Determine when a Certified Marine Chemist or Certified Industrial Hygienist is needed;
 - (8) Complete a permit and log under § 142.335;
 - (9) Monitor the work authorized by the permit and conditions in the space while that work is going on; and
 - (10) Maintain the records required by this subpart.
- (b) The Offshore Competent Person also must have a knowledge of—
 - (1) The configuration of the OCS unit, including its structure, pipe systems, arrangement of spaces, and nomenclature; and
 - (2) The operations on the OCS unit and how they affect safe confined-space entry.

§ 142.372 Who certifies the Offshore Competent Person, what must the certificate contain, and where must it be kept?

- (a) If a person meets the requirements of §§ 142.370 and 142.371, the owner or operator may certify that person as an Offshore Competent Person.

- (b) The certification must be in writing and contain the name of the person being certified, the name and title of the person who issued the certificate under paragraph (a) of this section, and the date of the certification. It also must state that the person being certified meets the requirements of §§ 142.370 and 142.371.
- (c) The certification must be kept on the OCS unit where the person is working and made available for inspection by the Coast Guard.

§ 142.373 What refresher training must the Offshore Competent Person have?

The Offshore Competent Person must have annual refresher training that reviews confined-space entry procedures and precautions, provides hands-on experience with new instrumentation, and identifies new regulations and standards concerning confined-space entry and exposure levels.

Program for Confined-Space Entry

§ 142.375 What type of confined-space entry program is required?

- (a) The owner and operator must ensure that a written program is maintained on the OCS unit that explains how tests, training, rescues, and other matters related to confined-space entry are to be carried out. The program is intended to supplement the requirements in this subpart and must not conflict with these requirements.
- (b) The program must contain at least the following:
 - (1) A list of all confined spaces on the OCS unit and the hazards associated with each space.
 - (2) A description of duties and training requirements of—
 - (i) The person in charge;
 - (ii) The Offshore Competent Person;
 - (iii) Personnel who work within confined spaces; and
 - (iv) The rescue team.
 - (3) A description of all personal protective equipment required for confined-space entry and how and when it is to be used.
 - (4) A description of atmospheric testing instruments by type, model, and capabilities.
 - (5) The procedure for calibrating atmospheric testing instruments and interpreting and recording the results of the calibrations.
 - (6) The procedures for conducting atmospheric tests under §§ 142.330, 142.332, 142.340, and 142.352.
 - (7) The procedures and signals used to evacuate a space.

- (8) A description of the methods used to prevent unauthorized entry.
- (9) The procedure to follow if a permit, certificate, or log under § 142.335 is missing.
- (10) The procedures for conducting rescue operations and the methods for keeping the rescue team ready to respond.
- (11) A list of the medical services that must be available during confined-space entry.

Subpart E—Hazardous Material on Fixed or Floating Facilities

§ 142.400 What is the purpose of this subpart?

The purpose of this subpart is to ensure that all personnel on a fixed or floating facility are made aware of what materials on the facility are hazardous and what the hazards associated with their use, handling, storage, and intermingling are.

§ 142.405 Who does this subpart apply to?

This subpart applies to all persons who work on a fixed or floating facility.

Hazard Communication Program

§ 142.410 What must the hazard communication program contain?

- (a) Each fixed or floating facility must have a hazard communication program (HCP) available for the training of, and review by, all personnel on the facility.
- (b) The program must be in writing and describe or include—
 - (1) Each hazardous material on the facility;
 - (2) The potential hazards of the material;
 - (3) The material's intended use on the facility;
 - (4) The methods for handling and storing the material;
 - (5) The protective measures and equipment to be used to avoid hazardous exposure;
 - (6) The labeling, marking, or tagging of the material;
 - (7) The special precautions, such as lockout and tagout under §§ 142.220 and 142.225, that should be emphasized when working around the material;
 - (8) Information and training required for personnel onboard the facility; and
 - (9) A material safety data sheet (MSDS) for the material.
- (c) The information on a material safety data sheet on the material may be used as a substitute for items in paragraph (b) that are addressed in the sheet.

- (d) The program must be supplemented as necessary to address each hazardous material newly introduced on the facility.

§ 142.415 What is the hazard communication program used for?

- (a) The person in charge must ensure that, before a person is allowed to work at the facility—
 - (1) A copy of the hazard communication program is made available to the person; and
 - (2) The person is trained in the information contained in the program.
- (b) The training must be supplemented to address each hazardous material newly introduced on the facility.

§ 142.420 Must I make the material safety data sheets available to all personnel?

- (a) The person in charge must ensure that a material safety data sheet (MSDS) for each hazardous material on the fixed or floating facility is made available to all personnel on the facility.
- (b) Each MSDS must contain at least information on the use, proper storage, potential hazards, and appropriate protective measures to be taken when exposed to or handling the material.

§ 142.425 How must I label, tag, and mark a container of hazardous material?

You must label, tag, or mark each container of hazardous material with the identity of the hazardous material and the appropriate physical and health hazard warnings. The only exception is for portable containers for transferring a hazardous material from a labeled container to the work site for immediate use by the person who performs the transfer.

Appendix A to Part 142, Subpart D

Coast Guard Form CSE: OFFSHORE CONFINED-SPACE ENTRY PERMIT

Offshore Facility	Type of Facility	Owner																											
Offshore Competent Person or Certified Industrial Hygienist		Person in Charge (OIM, etc.)																											
		Permit Valid From:																											
Space (Location, designation)		Date: _____ Time: _____ to _____ Date: _____ Time: _____																											
Potential Hazards Pre-entry Preparations: (Completed by Offshore Competent Person or Certified Industrial Hygienist and Reviewed by Facility Person in Charge) ☐ Space thoroughly ventilated ☐ Space cleaned as needed ☐ Access and egress arrangements are adequate ☐ Arrangements made for continuous ventilation ☐ Lighting is adequate ☐ Other physical hazards are adequately controlled: ☐ Heat Stress ☐ Noise ☐ Other _____ ☐ Rescue and resuscitation team & equip are ready ☐ Communication system tested and ready ☐ All personnel properly clothed and equipped ☐ Pre entry brief held with all entrants, attendant, rescue team, offshore competent person, and person in charge ☐ Emergency and evacuation procedures established and understood by all persons involved ☐ Space has been isolated ☐ Testing instruments calibrated ☐ Space tested (complete results section below.) ☐ Arrangements made for frequent atmospheric checks ☐ Energy (refer to company lock out program) ☐ Other _____ ☐ Attendant at entrance is designated and ready ☐ All equipment inspected and in good condition																													
<table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:33%;">Tests Performed:</th> <th style="width:33%;">Results:</th> <th style="width:33%;">Requirements:</th> </tr> </thead> <tbody> <tr> <td>☐ Oxygen (O₂)</td> <td>_____</td> <td>>19.5%, <22%</td> </tr> <tr> <td>☐ Flammability (LEL)</td> <td>_____</td> <td><10% of the LEL</td> </tr> <tr> <td>☐ Toxicity (Specify) _____</td> <td>_____</td> <td>_____ (Specify)</td> </tr> <tr> <td>☐ Toxicity (Specify) _____</td> <td>_____</td> <td>_____ (Specify)</td> </tr> <tr> <td>☐ Toxicity (Specify) _____</td> <td>_____</td> <td>_____ (Specify)</td> </tr> <tr> <td>☐ Toxicity (Specify) _____</td> <td>_____</td> <td>_____ (Specify)</td> </tr> <tr> <td>☐ Toxicity (Specify) _____</td> <td>_____</td> <td>_____ (Specify)</td> </tr> <tr> <td>☐ Toxicity (Specify) _____</td> <td>_____</td> <td>_____ (Specify)</td> </tr> </tbody> </table>			Tests Performed:	Results:	Requirements:	☐ Oxygen (O ₂)	_____	>19.5%, <22%	☐ Flammability (LEL)	_____	<10% of the LEL	☐ Toxicity (Specify) _____	_____	_____ (Specify)	☐ Toxicity (Specify) _____	_____	_____ (Specify)	☐ Toxicity (Specify) _____	_____	_____ (Specify)	☐ Toxicity (Specify) _____	_____	_____ (Specify)	☐ Toxicity (Specify) _____	_____	_____ (Specify)	☐ Toxicity (Specify) _____	_____	_____ (Specify)
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☐ Flammability (LEL)	_____	<10% of the LEL																											
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☐ Toxicity (Specify) _____	_____	_____ (Specify)																											
Additional Requirements or Precautions Required During Entry: _____ _____ _____ _____																													
Work to be Completed During Entry: _____ _____ _____ _____																													
This space meets the "Safe for Workers" criteria contained in NFPA 306, Control of Gas Hazards. Authorized employees may enter this space to conduct work the work described on this permit, using the precautions described on this permit.																													
Name (Printed), Offshore Competent Person		Name (Printed), Person in Charge																											
Signature, Offshore Competent Person		Signature, Person in Charge																											

See Offshore Competent Person's Log for Results of Subsequent Atmospheric Tests.
THIS PERMIT IS RENDERED INVALID IF ANY CONDITION NOTED ON THE PERMIT CHANGES.



124 North Van Avenue
Houma, Louisiana 70363-5895

Phone: (985) 851-2134

Fax: (985) 879-3911

E-mail: info@nationalmariners.org

Website: www.nationalmariners.org

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

November 2, 2011

ATTN: Desk Officer for the Coast Guard
Office of Management and Budget, OIRA
725 17th Street, NW
Washington, DC 20503

Docket # USCG-2011-0710

VIA PRIORITY MAIL, RETURN RECEIPT REQUESTED.

Subject: Information Collection Request, OMB Control #1625-0001 – Coast Guard form CG-2692, Report of Marine Accident, Injury or Death.

Dear Sir or Madam,

Please enter these comments and enclosures in Docket # USCG-2011-0710.

While our response to the invitation to submit comments refers to only a small portion of the \$464,944 that requires an OMB Control number for re-authorization, the continued use of CG Form 2692 in its present form without revision is the source of a serious problem that faces our constituency. Having tried other approaches, we will start at the bottom with a form and a program that needs immediate attention.

What is the National Mariners Association?

Our Association speaks on behalf of an estimated 126,000 credentialed "limited-tonnage" merchant mariners on workplace health, welfare and safety issues. Our mariners serve on all types of inspected and uninspected commercial vessels including tugs, towboats, small passenger vessels, charter boats, offshore supply vessels and workboats.

I will direct my remarks to the basic CG Form 2692 and my concern with the continued use of this form for collecting statistics that purport to reflect reportable personal injuries as required by 46 CFR §4.05-1(a)(6) involving: "An injury that requires professional medical treatment (treatment beyond first aid) and, if the person is engaged or employed on board a vessel in commercial service, that renders the individual unfit to perform his or her routine duties..."

I will limit my remarks to "injuries" and will not deal with death or physical damage to vessels.

Uses of the Data

The data collected from the public populates "part of a comprehensive marine casualty database at Coast Guard Headquarters. This database is utilized extensively by the Coast Guard for (a) identifying specific safety problems and analyzing longer-term trends, (b) publishing casualty summaries and annual statistics for public use, (c) supporting the need for additional safety oversight or regulation, (d) measuring the effectiveness of existing safety regulatory programs, and, (e) better focusing of limited Coast Guard marine safety resources."⁽¹⁾ [⁽¹⁾Supporting statement §2.]

While these are all laudable and worthy goals, we assert that there are major problems with the thoroughness with which the collection of personal injury data on CG Form 2692 has been undertaken. This is a longstanding problem because the industry treat this method of information collection is a joke. According to COMDTINST 16200.3A, Enclosure 5, Table 5-A, the basic penalties of not reporting violations of 46 CFR Subpart 4.05 range

from \$500 to a maximum of \$1,000 per violation – and these penalties are rarely applied.

Our Concerns With Mariner Injury Data – DOT

In 2001, our Association's attorney found that there were far more mariner injury cases that were being litigated by injured mariners than were ever reported to Coast Guard Marine Safety Offices. Our Association, then known as the Gulf Coast Mariners Association (GCMA) filed suit as explained in our Report #R-292 [Enclosure #1].

We spelled out the problem to the Department of Transportation's Inspector General in a letter dated Oct. 4, 2001 – but to no avail. [Enclosure #2].

When maritime employers do not care for their employees injuries, there is no "Workman's Compensation." Often, our mariners must hire a lawyer and file suit. This is expensive, time consuming, and frustrating. Most of our "limited tonnage" mariners do not belong to a union and are "at will" employees that can be fired for any reason whatsoever. Filing a lawsuit against your employer most likely will be the end of your employment. "Black-listing," widespread in the industry, may signal the end of a mariner's career.

What role does the Coast Guard play? For bringing up 45 cases where one employer never notified the Coast Guard on CG Form 2692 brought nothing more than a "slap on the wrist" as [Enclosure #3] clearly shows. My response to the DOT Inspector General's Counsel reveals our Association's frustration lack of concern by the Coast Guard for our mariners' health and welfare as well as their lack of real concern about reporting requirements of their own regulations. [Enclosure #4].

Our Concerns With Mariner Injury Data – DHS

In 2007, the Department of Homeland Security's Inspector General audited the performance of the Coast Guard's Investigations and Analysis Branch. Two auditors from Boston visited my office and spent the morning with us. Thereafter, I communicated with Mr. Richard Johnson at the DHS OIG office in Washington and furnished him with 15 volumes of information of information relative to Coast Guard investigations. Volume 9 dealt with the "under-reporting of injuries" problem.

Mr. Johnson was particularly interested in the fact that mariners were litigating cases of personal injuries that the Coast Guard knew nothing about. In fact, he was interested enough to visit our attorney, Mark L. Ross, Esq. in his office in Lafayette, LA. Mr. Johnson is an experienced, deep-sea merchant marine officer who fully understood the importance that CG Form 2692 should play in accident reporting. In fact, after his visit with Mr. Ross, he made arrangements and procured funding to gather additional information of a similar nature and extensively researched court and Coast Guard records in New Orleans.

The DHS Inspector General published the "investigations" report titled United States Coast Guard's Management of the Marine Casualty Investigations Program as Report #OIG-08-51 in early 2008. Unfortunately, the report did not mention the problem of under-reporting of personal injuries to mariners.

I recently spoke with one of the remaining DHS auditors to determine why the revelations of massive under-reporting was not included in the final report and was told that the information had not been developed to "audit grade" by the time of the agency's internal deadline set for releasing the report. Apparently, the Department of Homeland Security dropped the ball on this issue. Soon after OIG-08-51 was released, Mr. Johnson was re-assigned to other duties in the Inspector General's office that were not related to Coast Guard activities.

Purposes of Information Collection

On page 2 of the Coast Guard's "Supporting Statement for Marine Casualty Information..." submitted for this Information Collection Request, under 2) Purposes of the Information Collection appears this statement: "Receipt of a marine casualty report (CG-2692) is often the only way in which the Coast Guard becomes aware of a marine accident. It is therefore a necessary first step that provides the Coast Guard with the opportunity to determine the extent to which a casualty will be investigated...."

I can inform you that the towing industry, in an open discussion I witnessed several years ago at a Towing Safety Advisory Committee (TSAC) meeting, industry management representatives consider CG Form CG-2692 to be little more than a joke. This attitude is regrettable, but the effect on our mariners can be profound.

The Effect on Mariners

Mariners who are injured need immediate attention and often need extended care. However, many employers ignore their injuries, deny them basic "maintenance and cure" payments, terminate their employment, and end their health insurance coverage if they are no longer able to work. There may, or may not be, short or long term disability insurance in play. However, to bring the significance of these personal injuries to our mariners to your attention, I enclose a copy of NMA Report #R-202, Rev. 5 as [Enclosure #6].

Our Association asserts that Coast Guard investigators have not effectively enforced the collection and processing of this form to adequately inform themselves of reportable injuries that our working mariners suffer – and that this is a longstanding problem. As a result, the injury data that is collected and compiled is, at best, inaccurate, incomplete, and suspect. As such, inaccurate injury statistics based upon those reported in CG Form 2692 should not be released to the public.

Injured mariners, who are thrown to the wolves by their employers, are further disadvantaged by 46 U.S. Code §6308 that denies their lawyers the ability to use, “findings of fact, opinions, recommendations, deliberations, or conclusions” in civil or administrative proceedings. Their attorneys must start from scratch. When employers do not even tell the Coast Guard that an injury has occurred, and the Coast Guard accepts tardy written documentation but takes no action, our mariners are not well served by their government. In fact, employers and employees do not receive equal treatment as they should. We believe they deserve better treatment than that!

Physical Damage vs. Personal Injuries

We opine that physical damage to inanimate objects (e.g., vessels and infrastructure) should not be collected on the same form or in the same manner as accidents to human beings (e.g., our mariners). We assert that the methods that OSHA uses to collect and follow-up injuries is far superior to that used by the Coast Guard. In fact, we suggested a change to the 112th. Congress as indicated in NMA Report #R-350, Revision 6, Issue “Y.” A copy of that excerpt is attached as [Enclosure #5].

The Action We Seek from OMB

We ask the Office of Management and Budget to reject the Paperwork Reduction Act Submission for the Department of Homeland Security for OMB Control #1625-0001 until a complete investigation on the allegations cited above is completed and up-to-date information is available comparing “reportable injuries” to “reported injuries” on a national basis. The latest data is from 2007 and must be preserved. Additional investigation into the discrepancies between the injuries suffered by ALL maritime personnel that are accurately reported to Coast Guard officials and cases litigated in court seeking damages for maritime accidents need to be reconciled for a true picture. These steps were started by the Department of Homeland Security in 2007 but were not reported and all activities to get to the root of the problem were dropped. We plan to bring this to the attention of the Secretary of the Department of Homeland Security.

Very truly yours,

Richard A. Block
Master #1186377, Issue #9
Secretary, National Mariners Association

U.S. Department of
Homeland Security

United States
Coast Guard



Commandant
United States Coast Guard

2100 Second Street, S.W.
Washington, DC 20593-0001
Staff Symbol: CG-545
Phone: (202) 372-1029
FAX: (202) 267-1416

16732
December 9, 2011

Golden Gate Bridge, Highway and Transportation, Ferry Division
Attn: Mr. Christian Nicolaus Stark
101 East Sir Francis Drake Boulevard
Larkspur, CA 94939-1899

Dear Sir:

This letter is a consolidated response to the comments you and several others submitted with respect to the Information Collection Request (ICR) renewal process for Coast Guard (CG) form(s) 2692, CG-2692A and CG-2692B. The Coast Guard published a thirty-day notice in the *Federal Register* requesting comments on 76 FR 62424, October 7, 2011. The comment period ended November 7, 2011. The following outlines our position:

1. As background, the CG-2692 form is required to be submitted to the Coast Guard by the vessel owner, agent, master, operator, or person in charge (reporting party) within five days following a casualty that is reportable per Notice of Marine Casualty, Title 46, Code of Federal Regulations (CFR), Section 4.05-1. The CG-2692A applies *only* to reportable marine casualties involving multiple tow/barge vessel arrangements which allows for easier documentation of vessels in concert with the CG-2692 form. The CG-2692B form is submitted *if* a reportable marine casualty is also a Serious Marine Incident as described in 46 CFR 4.03-2, to document chemical testing results.
2. The information contained on the forms is utilized to gather factual information and determine appropriate Coast Guard's investigative posture per 46 CFR 4.07-1. The data obtained serves as the foundation for annual submissions to Congress per Title 46, United States Code (U.S.C.), 6307(c) and is made available to the public in accordance with 46 U.S.C. 6305. The data is not intended to fix civil or criminal liability and is excluded from legal proceedings per 46 U.S.C. 6308. Additionally, the information provided serves as the basis for promoting safety of life and property at sea through resultant lessons-learned and provides an accurate data capture mechanism from which new/revised regulatory decisions may be determined.
3. Each commenter contested the accuracy of the one hour estimate for filling out the forms, specifically the CG-2692 form. For the vast majority of incidents, one hour is adequate to complete the applicable blocks on the form. Approximately one-third of the information blocks are readily available to a reporting party such as general vessel and company information. The remaining blocks contain factual information outlining the specific

circumstances surrounding the reportable marine casualty. Most of the blocks are either check boxes or brief one word/sentence descriptions. There is one free-form narrative block that provides the reporting party the ability to describe how the accident occurred and any potential corrective actions. There is no evidence that more than one hour is required to complete any of the forms.

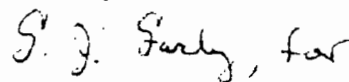
4. These forms have historically proven to be very effective in identifying factual and circumstantial information received from a very wide spectrum of industry submitters. Vessel operations covered by this form range from small commercial vessel operations to complex, deep-draft vessel operations. The form is intended to be concise, while providing the submitter with the appropriate latitude to articulate more detailed incident circumstances.
5. Each commenter took issue with the actual number of forms submitted to the Coast Guard. The ICR process identified 4,792 reportable marine casualties as the number of forms submitted. In early December 2011, a comprehensive, in-depth program analysis suggests this information is accurate based upon the latest four year average. However, there are other incidents that have been reported via the CG-2692 form(s), but are not included in the national investigative summary data for the following reasons:
 - a. Incidents that are by definition reportable, yet determined by Coast Guard policy to not warrant inclusion in the agency's investigative data. The rationale for this course of action is that incidents of a minor nature (i.e. bump and go groundings, broken fingers/toes) should not be utilized in the annual report to Congress or to determine safety trends necessitating new or revised regulatory scheme decisions. This assists in ensuring data integrity.
 - b. Forms are received from industry that are unsolicited by Coast Guard personnel that are technically outside of the Coast Guard's authority/jurisdiction to investigate. For example, many large foreign-flagged cruise ships that regularly operate to and from domestic ports will submit incidents outside Coast Guard jurisdiction.
 - c. There have also been anecdotal incidents whereby local Command Center personnel (vice qualified Investigating Officers) have asked for submission of a CG-2692 as a part of their Quick Response Checklist (QRC) procedures. These may or may not have been reportable casualties; however, there is currently no mechanism to differentiate between these numbers within the data. To alleviate potential for these unnecessary submissions, the Coast Guard is currently finalizing policy guidance that will encourage local units to discourage this practice and ensure local QRC's are revised so as to not require or suggest CG-2692 submission without consult of a qualified Coast Guard Investigating Officer.
6. Current Coast Guard investigative policy is to not proceed with any further action for the incidents cited in paragraph five (a through c). Because the information is not utilized for data purposes, there is currently no mechanism to ascertain the actual number of forms submitted for the reasons provided above. An update to the Marine Information for

Safety and Law Enforcement (MISLE) data base scheduled for release in 2013 will include this functionality for future analysis.

7. Each commenter raised concerns regarding the submission of CG-2692's that fail to meet the regulatory criteria. While these circumstances may have occurred, they are the exception and not the rule. However, as noted above, forthcoming Coast Guard policy guidance will be promulgated that will assist industry personnel with regulatory definitions of what constitutes a reportable marine casualty. It will also assist Coast Guard personnel in ensuring reportable marine casualties are defined consistently throughout the nation.
8. Two commenter's cited concerns related to the necessary inclusion of legal counsel (which in their opinion would incur greater financial impacts than identified in the ICR) prior to the submission of forms. As noted above, these forms are available at public request; however, they are prohibited in civil legal proceedings external to the Coast Guard per 46 U.S.C. 6308. Any enforcement actions taken by the Coast Guard itself are initiated as a result of a full and thorough investigation of the all the facts and circumstances following a reportable marine casualty, not based solely upon submission of any one of the forms. Any enforcement actions not agreed to by the cited party is fairly adjudicated by all of the facts by either a Hearing Officer or an Administrative Law Judge.
9. Two commenter's noted "auditing" concerns and/or resultant post casualty vessel operating restrictions issued by the Officer in Charge Marine Inspection (OCMI) or Captain of the Port (COTP) as inappropriate. This is outside the scope of the ICR process. However, the pending aforementioned Coast Guard guidance will also reiterate current policy to OCMI's and COTPs. Submission of a marine casualty report form in and of itself should not automatically lead to vessel operating restrictions unless the vessel is determined to need such operational controls by a qualified marine inspector.

A copy of this letter will be placed into Docket No. USCG-2011-0710, and also sent to OMB/OIRA for inclusion in the Coast Guard's periodic renewal submission request for ICR 1625-0001.

Sincerely,



D. S. FISH
Chief, Office of Investigations and Analysis
Captain, U.S. Coast Guard

COMMERCIAL VESSEL SAFETY CIVIL PENALTIES

1. Purpose. The Marine Inspection (MI) program administers statutes, regulations and standards for the purpose of promoting safety of commercial vessels and of units operating on the Outer Continental Shelf.
2. Enforcement Measures Generally.
 - a. The civil penalty process is but one of the tools available to the OCMI to achieve compliance with statutory and regulatory requirements and standards. Others include, but are not limited to, initiating suspension and revocation proceedings against merchant seamen's licenses, certificates, or documents; issuing CG-835's requiring correction of deficiencies within a specified time frame; revoking a Certificate of Inspection; intervening under SOLAS provisions; or issuing letters of warning.
 - b. Not all of these mechanisms are available against potentially responsible parties in all situations. For instance, suspension and revocation proceedings may only be used for licensed, certificated, or documented personnel when jurisdiction can be established. Similarly, civil penalty action may only be used in cases involving specific violations of statute or regulation, and penalties may only be assessed against the individuals or entities specified in the statute or regulation. Also, situations may occur which warrant enforcement action against more than one party for a single offense. For example, a failure to operate, maintain, equip, or man a particular vessel as required may be the responsibility of the vessel's owner, operator, agent, master, and/or person in charge.
 - c. The Officer in Charge Marine Inspection (OCMI) must evaluate the nature and seriousness of the offense, the likelihood of recurrence, competing investigative workload, the availability of other remedial actions, and other factors before selecting the proper tool or tools for enforcement purposes. If civil penalty, suspension and revocation, or criminal penalty action is selected, the OCMI must also identify the responsible parties and evaluate each party's degree of culpability.
 - d. This instruction is not intended to imply that civil penalty action is the preferred enforcement method to be used in all situations. The intent of this instruction is to provide general civil penalty enforcement guidance and to provide a standardized method of determining appropriate recommended civil penalty amounts.

2. e. The term "remedial action" as used in this enclosure includes initiating suspension and revocation proceedings, revoking a Certificate of Inspection (COI), and issuing a letter of warning, as well as initiating civil penalty action. It does not mean mere correction of a deficiency.
3. Vessel Inspection.
 - a. Statutory authority and requirements for vessel inspection are contained in 46 U.S.C. Subtitle II; in 43 U.S.C. Chapter 29; and in 33 U.S.C. Chapters 26 and 33. Regulatory requirements are found in 46 CFR and 33 CFR Subchapters N, O, and P.
 - b. The MI program maintains a vigorous enforcement policy of ensuring that vessels subject to inspection are in basic compliance with the law. Accordingly, when evidence indicates that a vessel required to be inspected is operating without a certificate of inspection, initiation of civil penalty action is appropriate.
 - c. Because the congressional intent of vessel inspection laws is to encourage safety, the thrust of MI enforcement policies for deficiencies uncovered during inspections is to encourage compliance by requiring correction and not through civil penalty assessment. Requiring on the spot correction, issuing a CG-835, or restricting the operation so that the deficiency will no longer exist is sufficient action to correct most deficiencies.
 - d. Although simple notification of the deficiency and follow up actions to insure the deficiency is corrected are proper, there may be times when initiation of civil penalty action, and/or other remedial action is appropriate. On this issue the circumstances and conditions vary so greatly that it is difficult to cover all situations. The following categories of deficiencies and actions are offered as general guidance (these categories are not intended to be all inclusive nor are the actions suitable for all cases):
 - (1) Category I - Operating with an expired Certificate of Inspection, being overdue for drydock examination, failing to notify the OCMi of alterations or repairs as required by regulation, and failing to correct deficiencies within a specified time frame are offenses normally warranting the initiation of civil penalty action, and other remedial action.

3. d. (2) Category II - Required equipment missing during vessel operations. If it can be established that a vessel was operated on a voyage without required equipment, e.g., lifesaving equipment, fire protection equipment, charts, publications, flares, etc., the initiation of civil penalty action, and/or other remedial action is appropriate.
- (3) Category III - The vessel or its required equipment is defective and requires immediate correction. There may be instances where the owners, managing operators, and/or vessel personnel have allowed the vessel or required equipment to reach such a state of disrepair that the initiation of civil penalty action and/or other remedial action is appropriate. In these instances consideration should be given to the prior knowledge or the obviousness of the state of disrepair or defects, and the prior opportunity to correct the situation. Examples include:
- (a) Lifeboat is deteriorated to the extent that it is holed;
 - (b) Safety devices are bypassed;
 - (c) Fire or bilge pump is inoperative;
 - (d) Operating with reduced manning when automatic controls are not functioning properly;
 - (e) The inert gas system or any of its components is inoperative;
 - (f) The vessel's hull is holed or cracked and permanent repairs have not been effected; and
 - (g) Soft patches on the fire main or foam system.
- (4) Category IV - Design deficiencies may be discovered during the plan review process, during the initial inspection for certification, or at subsequent inspections during the life of the vessel. These would not normally warrant remedial action beyond requiring correction, unless modifications were made without the approval of the OCMI. Examples include:
- (a) Inappropriate wiring or other electrical devices;
 - (b) Inadequate means of escape from each space; and
 - (c) Inappropriate piping arrangements.

3. d. (5) Category V - Required test, drills, and inspections performed by a vessel's crew are important to the overall safety of the vessel. Failure to accomplish such items warrants the initiation of civil penalty action, and/or other remedial action such as suspension or revocation proceedings or a letter of warning.

4. Manning.

- a. Statutory authority and requirements for the manning of vessels are contained in 46 U.S.C. Part F. Regulatory requirements are contained in 46 CFR Part 15.
- b. Statutory and regulatory requirements are considered minimums necessary for the safe operation of a vessel. Accordingly, when evidence exists that a vessel is not manned in accordance with its Certificate of Inspection or other applicable requirements, the initiation of civil penalty action, and/or other remedial action is appropriate. When evaluating evidence concerning whether a vessel is manned in accordance with its COI, due consideration shall be given to the provisions of 46 U.S.C. 8101(e) and 46 U.S.C. 8103, which permit the master, under certain conditions, to sail short, or to replace crew members with individuals who are not U.S. citizens.

5. Seamen's Protection and Relief.

- a. Statutory authority and requirements concerning seamen's protection and relief are contained in 46 U.S.C. Part G. Regulatory requirements are contained in 46 CFR Part 14.
- b. While Coast Guard personnel no longer perform the duties of Shipping Commissioners, enforcement of statutes and regulations pertaining to seamen's protection and relief remains a function of the Coast Guard. Violations of this type are normally in the realm of labor/management disputes and are frequently non-safety related. Less serious examples would be wage/salary disputes, minor complaints concerning working hours, sailing schedules and accommodations. More serious situations would be crew member complaints concerning vessel seaworthiness or sanitary conditions, an owner/operator or master requiring individuals to routinely work illegally excessive hours when no emergency exists, a master failing to utilize shipping articles when required, a master failing to maintain a logbook or failing to make proper entries therein, as required by law.

5. c. Situations of this type warrant a case by case evaluation when determining whether or not initiating civil penalty action is appropriate.
6. Tonnage Measurement.
 - a. Statutory authority and requirements for tonnage measurement are contained in 46 U.S.C. Part J. Regulatory requirements are found in 46 CFR Part 69. Measurement under Annex I of the International Convention on Tonnage Measurement of Ships, 1969, is required for U.S. vessels that engage in international voyages; no domestic regulatory applications exist under this Convention.
 - b. Tonnages may have a substantial impact in determining when a vessel is subject to regulatory standards and requirements. Tonnage violations most frequently are found when a vessel is altered but not remeasured.
 - c. Also, tonnages may be subject to adjustment when a vessel changes from a specific operating condition. For instance, a vessel that is entitled to lower tonnage assignments when it carries drill water to offshore drilling units could be subject to higher gross tonnage when it ceases that operation. A vessel that is entitled to tonnage reductions when operating as a passenger vessel may be subject to higher tonnages when it ceases carrying passengers for hire. Other possible violations could include improper tonnage openings, the absence of required tonnage marks, or incorrect placement of the tonnage mark in relation to the vessel's loadline. Failure to ensure that appropriate steps are taken may have adverse safety impacts. Offenses related to tonnage measurement warrant the initiation of civil penalty action and/or other remedial action. Questions regarding the appropriateness of a tonnage assignment should be referred to higher authority.
7. Vessel Documentation.
 - a. Statutory authority and requirements related to vessel documentation are contained in 46 U.S.C. Chapter 121. Regulatory requirements are found in 46 CFR Parts 67 - 68.
 - b. As stated in 46 CFR 67.01-3, "Documentation is required for the operation of vessels in certain trades, serves as evidence of vessel nationality, and, with certain exceptions, permits vessels to be subject to preferred mortgages." Examples of more serious documentation offenses are operating either a documented or undocumented vessel in a trade for which it is not

7. b. (cont'd) documented, placing a documented commercial vessel under the command of a non-citizen, knowingly providing false information when documenting a vessel, intentionally altering a Certificate of Documentation, etc. Less serious offenses are tardiness in renewing a Certificate of Documentation, inadvertently providing inaccurate information when documenting a vessel, etc.
- c. The initiation of civil penalty action and other remedial action is appropriate for more serious offenses, and for second or repeated less serious offenses.

8. Load Lines.

- a. Statutory authority and requirements related to load lines are contained in 46 U.S.C. Part C. Regulatory requirements are found in 46 CFR Parts 42 - 46.
- b. The assignment of a load line is specifically conditioned upon the structural efficiency and satisfactory stability of a vessel. Proper observance of the assigned load line and related operating requirements is therefore critical to vessel safety. When load line violations are established, initiating civil penalty action or other remedial action is appropriate. Chapter 7, Volume V, of the Marine Safety Manual provides detailed procedures for investigating load line violations.

9. Negligent Operations.

- a. Statutory penalty provisions concerning negligent operations of a vessel are contained in 46 U.S.C. Section 2302. Regulatory provisions regarding proper use of a vessel against which a determination of negligence could be made are in 33 CFR and 46 CFR.
- b. Negligence is defined in 46 CFR 5.29 as "the commission of an act which a reasonable and prudent person of the same station, under the same circumstances, would not commit, or the failure to perform an act which a reasonable and prudent person of the same station, under the same circumstances would not fail to perform." This definition is applicable to 46 U.S.C. 2302. A determination of negligence therefore requires a careful evaluation of the act or omission, the circumstances surrounding same, and a comparison with whatever action could have been reasonably expected of a reasonable and prudent person faced with similar circumstances.

9. c. Negligent acts may be divided into several broad categories. The first covers situations in which the act by its nature was obviously negligent, such as operating a vessel while intoxicated. A second category includes those instances in which a presumption of negligence arises, such as when a grounding occurs outside a marked channel. A third category encompasses those instances in which the standard of care must be established against which the act or omission can be compared. A standard of care may be established either through the existence of applicable legal precedents and standards, or by statements made by qualified individuals concerning what their actions would have been under similar circumstances (i.e., expert witnesses).
- d. Unless the negligence is minimal, negligent acts warrant civil penalty action, and/or other remedial action. In evaluating cases for negligence, care must be exercised to determine whether a specific violation of law or regulation has occurred for which a civil penalty provision exists other than that contained in 46 U.S.C. 2302. If so, initiation of civil penalty action for that specific offense is generally preferable to one citing negligent operation of a vessel. In some cases, citing both a specific offense and negligent operation may be appropriate.

10. Reporting Requirements.

- a. Statutory authority and requirements for marine casualty reporting are contained in 46 U.S.C. Chapter 61. Regulatory requirements are contained in 33 CFR Parts 146, 150 and 173, and 46 CFR Parts 4, 26, 35, 78, 97, 109, 167, 185, 196 and 197.
- b. Statutory authority and requirements for owner/operators to report vessels either unheard from or overdue are contained in 46 U.S.C. Section 2306. Regulatory requirements are contained in 46 CFR 4.04.
- c. Failure to submit such reports as required warrants the initiation of civil penalty action and/or other remedial action.

11. Outer Continental Shelf Activities.

- a. Statutory authority and requirements for units engaged in OCS activities are contained in 43 U.S.C. Chapter 29 and in 46 U.S.C. Subtitle II. Regulatory requirements are contained in 33 CFR 140 and in 46 CFR Subchapter I-A.

11. b. On all units engaged in OCS activities, the Outer Continental Shelf Lands Act, as amended, currently requires the Coast Guard to place the owner or operator of the unit on notice of the deficiency, and to allow that person a "reasonable period" in which to comply by correcting the deficiency. Following a failure to correct deficiencies within the "reasonable period," a civil penalty case should be prepared and forwarded to the Department of the Interior for evaluation in accordance with 33 CFR 140.40. The DOI, if it deems it appropriate, will assess and collect a civil penalty.
- c. Certain units engaged in OCS activities, however, are also subject to the concurrent statutory and regulatory requirements of 46 U.S.C. and 46 CFR respectively. For these vessels, including U.S. flag MODU's and other vessels required to maintain a valid Certificate of Inspection, civil penalty action may be initiated under the authority of 46 U.S.C. through normal Coast Guard channels. In such cases, the notice and opportunity provisions described above do not apply.

12. Uninspected Vessels.

- a. Statutory authority to require certain equipment for uninspected vessels is contained in 46 U.S.C. Chapters 41, 43, and 45. Regulatory requirements are in 46 CFR Subchapter C and 33 Parts 175 - 177.
- b. Since the MI program does not routinely board uninspected vessels, violations of statutes and regulations applicable to uninspected vessels will normally be discovered as a result of investigation of marine casualties and complaints. Such violations normally warrant the initiation of civil penalty action and/or other remedial action.

13. Table of Recommended Penalties.

- a. Table 5-A is the marine inspection program table of recommended penalties. It covers most violations within the purview of the MI program. Footnotes are contained on the last page of the table. For violations which are not listed, the district program manager should base the recommended amount on listed violations which are similar in nature.
- b. Field personnel are reminded that the preceding guidance in paragraph 2 should be used for determining when a report of violation should be submitted. Table 5-A should not be interpreted by field personnel as an indication that a report of violation should be submitted for every deficiency noted during vessel inspections simply because the deficiency appears on the list.

- c. 46 U.S.C. 2107 sets forth factors that must be considered when a penalty is assessed. These factors are: the nature, circumstances, extent, and gravity of the prohibited acts committed and, with respect to the violator, the degree of culpability, any history or prior offenses, ability to pay, and other matters that justice requires.

Table 5-A. Marine Inspection Civil Penalty Ranges

<u>Specification</u>	<u>Nature of Specification</u>	<u>Recommended Penalty Low</u>
<u>SUBCHAPTER A - PART 4 - MARINE CASUALTIES AND INVESTIGATIONS</u>		
Subpart 4.04 - Notice of Potential Vessel Casualty		
46 CFR 4.04-1	Failure to notify the Coast Guard there is reason to believe a vessel is lost or imperiled.	\$1,000
Subpart 4.05 - Notice of Marine Casualty and Voyage Records		
46 CFR 4.05-1 & 5	Failure to give proper notice as soon as possible of a marine casualty.	\$500
46 CFR 4.05-10(a)	Failure of a marine employer to report a marine casualty in writing to the OCMI.	\$500
46 CFR 4.05-12(a)-(d)	Failure to make required determination of alcohol or drug use.	\$500
46 CFR 4.05-15(a)	Failure to retain voyage records of a vessel involved in a marine casualty.	\$500
46 CFR 4.05-20	Failure to report accident to aid to navigation.	\$500
Subpart 4.06 - Mandatory Chemical Testing		
46 CFR 4.06-60(a)-(d)	Failure to submit required reports and test results.	\$500



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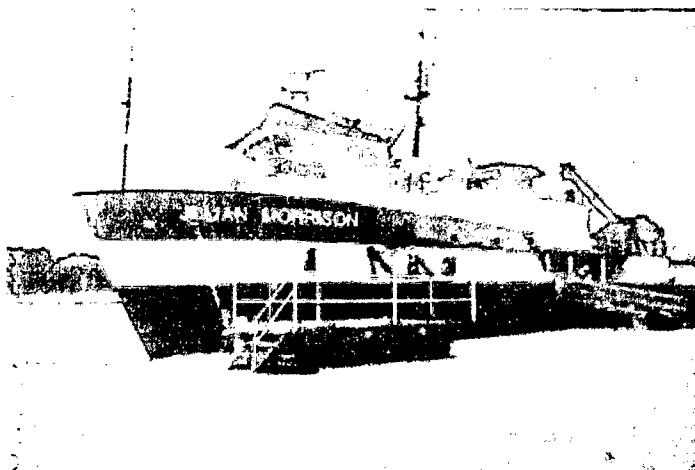
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Asserting our right "...to petition the Government for redress of grievances."
Amendment 1, U.S. Constitution, Dec. 15, 1791

In Search of Justice for Chief Engineer Leon Manderson



The Dive Boat Jillian Morrison pictured while afloat (before it exploded) in its better days

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THE SIGNIFICANCE OF THIS CASE FOR ALL LIMITED TONNAGE MARINERS

Our Association recognized the significance of this case for our mariners from the outset. We have long been aware of insufficient manning and violation of "hours-of service" regulations on many limited tonnage vessels crewed by our mariners – officers and ratings – and especially those vessels in 24-hour service. We first brought these issues to the attention of the Coast Guard in May 2000 in our 200-page report titled Mariners Speak Out on Violation of the 12-Hour Work Day.⁽¹⁾ After making little progress with the Coast Guard, we brought undermanning and work-hour abuse to the attention of Congress where we believed we had made reasonable progress during the past decade. [⁽¹⁾NMA Report #R-201.]

However, our Association's belief in the laws and regulations that are supposed to guide the marine industry were severely shaken by the case discussed in this report that involve a number of key laws and regulations governing this industry that the Fifth Circuit Court of Appeals in New Orleans appears to have trashed.

We first brought this case to your attention on Mar. 31, 2011 following a trial that we attended in U.S. District Court in Lafayette, LA, and that produced a number of adverse decisions. However, both the mariner and his employer separately appealed the decision for a number of different reasons. The Fifth Circuit Court of Appeals decided the appeals on Jan. 3, 2012 with a decision that will have great significance for all of our mariners for years to come.

LEON MANDERSON VS. CHET MORRISON CONTRACTORS

Our Association is in search of justice for Chief Engineer Leon Manderson whose career ended as a result of illnesses he contracted or exacerbated while aboard the M/V Jillian Morrison – referred to by several mariners who served on her as a dangerous and overcrowded, floating cesspool.

Our Association's Directors learned that significant issues affecting the health, welfare, and safety of our limited-tonnage merchant mariners would have to be decided in a lawsuit months before the case went to trial.

We requested and were given access to read a number of pre-trial depositions that were taken in preparation for the trial of Leon Manderson vs Chet Morrison Contractors (hereinafter "Chet Morrison"⁽¹⁾ or CMC). We were invited to attend the trial held before Judge Richard T. Haik, Sr. in U.S. District Court for the Western District of Louisiana, in Lafayette, LA on May 24-25, 2009. [⁽¹⁾Note that our reference to "Chet Morrison" is to Chet Morrison Contractors, Inc. and not to the company's CEO.]

Attorney Mark L. Ross, Esq.⁽¹⁾ represented Chief Engineer Leon Manderson at trial. We were favorably impressed with Mr. Ross' thorough pre-trial preparations and with his representation of Chief Engineer Manderson during the trial itself. However, we were acutely disappointed with many of the District Court's subsequent decisions as well as by those of the panel of three judges at the Fifth Circuit Court of Appeals in New Orleans. [⁽¹⁾Mark L. Ross, Esq., 600 Jefferson St., Suite 512, Lafayette, LA. 70501. ☎337-266-2345; Fax # 337-266-2345.]

We came away with the distinct impression that the trial judge had not done his homework. Consequently, we were not surprised that Attorney Mark L. Ross filed a timely notice of appeal from the final judgment to the U.S. Fifth Circuit Court of Appeal in New Orleans on Oct. 22, 2010 that was perfected on Mar. 4, 2011. The basis for District Court's jurisdiction arose under the laws of the United States, including the Jones Act and the general maritime laws of the United States. The Fifth Circuit Court of Appeal has jurisdiction over this timely appeal filed from the final decision of the District Court.

Background

Leon Manderson served as the Chief Engineer on the M/V Jillian Morrison, a 150.7-foot, 1800 horsepower vintage 1982 offshore supply vessel recently converted into a diving support vessel with a crew of seven (7) and fitted with accommodations to handle 28 to 33 "industrial personnel" – usually divers and other offshore pipeline maintenance and mission support personnel. The vessel's Coast Guard-issued Certificate of Inspection (COI) specified a crew of seven including...

- 1 Master
- 2 licensed Mates (Qualified as Officers-in-Charge of a Navigation Watch)
- 2 Able Seamen (Qualified as Ratings of a Navigation Watch)
- 1 Ordinary Seaman
- 1 Chief Engineer

When on voyages of less than 24 hours – a fact that really was not important at trial – the industrial personnel could be raised from 28 to 33 and the vessel's crew reduced to 5. That figure always included one licensed Chief Engineer. The vessel owners, Chet Morrison Contractors, never paid particular attention to the COI or the vessel's crew or the welfare of the "industrial personnel" it carried.

The M/V Jillian Morrison was a thirty-year-old converted offshore supply boat refurbished as a diving support vessel and equipped with a "four-point mooring system" to hold the vessel on location in open waters of the Outer Continental Shelf (OCS) and a crane to perform various offshore construction and maintenance projects.

One provision of the vessel's Certificate of Inspection (COI) stated: "The specified manning level is contingent upon the proper operation of the engineering automatic control monitoring system." The proper operation of this automated system is a fact disputed throughout this case. The COI required that "Any major alteration or essential component failure must be reported immediately to the cognizant OCMI."

NMA EXPRESSES OUR CONCERNS FOR VESSEL ENGINEERS

Our Association had an interest in this case for three reasons:

- We assert that the vessel operated under an inadequate engineroom manning scale – a creation of the Coast Guard as reflected in the vessel's Certificate of Inspection that provided only one engineer and no qualified engineroom support personnel for a vessel in 24-hour service. We previously brought similar vessel manning issues to the attention of Congress⁽¹⁾ and will continue to do so until properly addressed. We also point out the human cost of comparable and widespread work-hour abuses aboard uninspected towing vessels that are not operated as inspected vessels⁽²⁾. In both areas, the Coast Guard fails to protect the health, safety and welfare of mariners who serve in the enginerooms aboard "limited-tonnage" commercial vessels. This case shocks us because it shows the indifference to our mariners' working conditions extends from the vessel owners, to the Coast Guard, and now to the federal court system. Who, we ask, is left to enforce the existing statutes and related federal regulations designed to protect our mariners if federal judges refuses to do so? We had hoped that the Fifth Circuit Court of Appeal would rise to the challenge but they did not do so. [⁽¹⁾Refer to NMA Report #R-279, Rev. 8. ⁽²⁾Refer to NMA Report #R-412.]
- The physical condition of this inspected vessel and its engineering plant were not effectively managed or monitored by company supervisors or local Coast Guard Marine Safety inspectors.
- The deteriorated living conditions for the "industrial personnel" housed on board the vessel were substandard but were not corrected by company supervisory personnel following reports by the Master of the vessel. One vessel Master reported vessel safety conditions to our Association beyond those covered here that we reported to the Marine Safety Office in Morgan City, LA. Their response was delayed and, at best, lethargic and incomplete.

Shortly after Chief Engineer Manderson was disabled and hospitalized, the M/V Jillian Morrison, while engaged in an offshore pipeline repair job, suffered a major engineroom explosion⁽¹⁾ that killed the engineer and two passengers and severely injured several other persons, before it sank in the Gulf of Mexico. The vessel was later raised, brought ashore and subsequently cut up as scrap. This catastrophic event was covered extensively in the trade and local media but, although mentioned here, did not become part of the Manderson case. [⁽¹⁾On Mar. 11, 2008.]

INADEQUATE VESSEL MANNING ON THE M/V JILLIAN MORRISON

As early as April 2001, our Association reported to Congress⁽¹⁾ about Coast Guard manning requirements that imposed significant and constant burdens upon vessel engineers who are the sole individual assigned to manage, maintain, and repair on a 24-hour a day basis the propulsion machinery, electrical generating equipment, heating-ventilating and cooling systems, pumps, compressors and often deck equipment such as capstans, winches, and windlasses found on limited-tonnage vessels. The fact that the M/V Jillian Morrison was not operating as an offshore supply vessel at the time is not relevant to our complaint since its basic OSV machinery as well as additional specialized equipment was still in place and had to be constantly maintained, operated, and repaired. Furthermore, divers using the vessel in support of the vessel's mission brought their own equipment that also required considerable maintenance effort by Chief Engineer Manderson on behalf of Chet Morrison's customers who leased the vessel to conduct a variety of projects. [⁽¹⁾NMA Report #R-279, Rev 8, *supra*.]

Since our original report to Congress (cited above), our concerns for the health, safety and welfare of the person

serving as the sole engineer extended to other vessels such as large inland and offshore towing vessels and even some "small" passenger vessels carrying large numbers of passengers without the services of any trained engineers whatsoever. We are appalled that the Coast Guard, as a regulatory agency, never has been attentive to this well documented problem. In the Manderson case, we are further disturbed that the District Court neglected this important issue and that the Coast Guard refused to step forward and support our mariners by at least submitting an Amicus brief to the Court of Appeal relative to the numerous regulations and statutes the District Court chose to ignore. This reinforces our opinion that the Coast Guard really is not concerned about the safety of our mariners that Congress gives them to superintend!

One of our ongoing complaints is that our working mariners continue to have absolutely no voice in vessel manning. This allows substandard owners and operating companies to make their profits on the backs of engineers like Leon Manderson by providing him and the vessel he serves on with grossly inadequate support for the tasks they undertake. In this regard, **the Coast Guard is as much to blame as the company** because they allowed the disgraceful conditions to continue on an inspected vessel without providing adequate enforcement of statutes and regulations to protect our mariners. There is no sign that this case has attracted their attention. Even the report of the explosion and sinking of the vessel that drew media attention has not been completed.

Not only did the operating company leave Chief Engineer Leon Manderson without any qualified assistance in his engine room, but they also cheated on terms contained in their Certificate of Inspection by not providing the vessel with a second licensed Mate as required for this vessel although it was crowded with "industrial personnel" and operated in 24-hour service. The District court had ruled that this was a "minor violation of the COI." The Appeals court rejected this violation as a ground for Manderson's unseaworthiness claim – a finding on causation – because: [Manderson] claims that only the improper manning of the engine room is what caused his alleged injuries, not the manning of the deck."⁽¹⁾ [⁽¹⁾Decision on Appeal #10-31063, Jan.3, 2012, pgs. 10, 11.]

The Coast Guard in allowing the vessel to be manned with only one engineer, especially when the vessel had to provide "hotel services" for as many as 33 people, ignored the fact that the vessel was on a 24-hour a day job and must meet the demands and requirements imposed over a continuous period by this number of persons crowded into such small living and working spaces. The exceptional demands made to maintain functioning "hotel services" provided on the vessel alone are considerable.

Poor Vessel Maintenance

On Nov. 27, 2006, our Association at the request of ■⁽¹⁾ a crewmember on the M/V Jillian Morrison filed a formal complaint with the Coast Guard regarding unsafe deck and engine conditions reported to our Association on the vessel. These conditions are detailed later in this report. [⁽¹⁾Identity protected against reprisal by NMA.]

We asked the Coast Guard to inspect the vessel and to oversee the repair of safety violations and, further, to examine a potential safety violation that we described in exceptional detail. We had to request a report of the inspection under the Freedom of Information Act from Coast Guard Headquarters to eventually discover that this safety violation apparently was never looked at. With such an ineffective response, were not surprised to hear months later that this vessel exploded and sank. It is also a sad commentary on the Coast Guard's entire Marine Safety program – one that was reflected in retired Vice Admiral James Card's 2008 report to the Commandant.⁽¹⁾ [⁽¹⁾Reprinted as NMA Report #R-401-E]

THE NATURE OF THE CASE AND ITS BENCH TRIAL

Chief Engineer⁽¹⁾ Leon Manderson brought his case to recover monetary damages for injuries caused by working excessive hours averaging 16 to 20 hours a day over a fourteen month period aboard the M/V Jillian Morrison. As we understood the law by plain reading and discussion with his maritime attorney, Manderson's employer violated a number of important regulations⁽²⁾ designed to enforce international treaty obligations⁽³⁾ by refusing to provide him ten hours of uninterrupted rest per 24 hour day and instead, on occasion, worked him up to 24 hours a day. [⁽¹⁾Licensed as Chief Engineer, unlimited horsepower, limited to service on vessels of 1,600 gross register tons. ⁽²⁾46 CFR §15.1111(a) ⁽³⁾The International Convention on Standards of Training and Watchkeeping for Seafarers, 1978, as amended in 1995 and the Seafarer's Training, Certification and Watchkeeping Code.]

Mr. Manderson also introduced virtually uncontradicted medical evidence that the de facto 24 hour a day on call schedule Chet Morrison imposed upon him caused or contributed to the first time onset of his Type II diabetes mellitus.

Leon Manderson's excessive work schedule stemmed from Chet Morrison's refusal to obey minimum manning requirements of either the vessel's Certificate of Inspection (COI) that spell out those requirements clearly, as well as

requirements of federal laws and regulations based on those laws. The law⁽¹⁾ prohibits a vessel owner from operating his vessel without the full crew complement required by its Coast Guard COI. [⁽¹⁾46 U.S. Code §8101(d).]

Chet Morrison's violation of the manning requirements of its vessel's COI, as well as numerous federal work hour and manning statutes, was particularly egregious since its dive vessel often operated on a 24 hour a day on a seven days a week schedule. Contrary to the District Court's findings, both Chief Engineer Manderson and former Chet Morrison Master Frank Billiot gave uncontradicted live trial testimony that they repeatedly advised company managers that the M/V Jillian Morrison was dangerously undermanned – but to no avail.

Chet Morrison contractors occasionally assigned untrained deck personnel supposedly to assist Chief Manderson in violation of specific regulations that mandate only trained personnel work in a periodically unmanned engineroom. However, the Appeals Court found that "The only evidence showing the assistants may have done anything more than unskilled-nature work was when Manderson trained or assigned them to do so..." and a retired Coast Guard Commander brought in as an expert witness by CMC testified that the Jillian Morrison was properly manned, in accordance with Coast Guard regulations and the vessel's Certificate of Inspection.⁽²⁾ [⁽¹⁾46 CFR §15.1103(c) – based on a U.S. treaty obligation). ⁽²⁾Appeals transcript, p. 8.]

Chet Morrison also violated a federal statute⁽¹⁾ that prohibits assigning deck crew to duties in the engine room. The company also violated the vessel's COI by failing to properly maintain an automated engineroom system.⁽²⁾ However the Appeals Court appears to have accepted the assertion by the expert witness, a former Coast Guard Commander that the vessel was properly manned according to its COI. [⁽¹⁾46 U.S. Code §8104(e)(1)(A). ⁽²⁾NVIC 1-69]

Leon claimed the exhaustion and stress generated by his excessive work hours caused the first time onset of his diabetes, aggravation of his pre-existing ulcerative colitis. As a result of his illnesses contracted aboard Morrison's vessel, Chief Engineer Manderson sought maintenance and cure from Chet Morrison. However, Chet Morrison instead terminated his group health insurance, demanded that Manderson reimburse the company for two previous months of health insurance premium payments, and refused to pay his maintenance and cure as required by law.⁽¹⁾ This treatment gives our mariners an exposure to the tactics used by Chet Morrison and a number of other substandard maritime employers who prey on our mariners. It certainly is not the first case like this that our Association encountered as recited in our most widely read reports.⁽¹⁾ [⁽¹⁾Refer to NMA Reports #R-344-A, Rev. 1; R-344-B; and #R-202, Rev. 4.]

Ironically, Manderson's exhaustion-generated health problems probably saved his life from the fatal unseaworthiness of this dilapidated dive boat before the vessel itself took what turned out to be "its final dive" on Mar. 12, 2008, six weeks after Leon was admitted to the hospital (at his own expense). On that date, the M/V Jillian Morrison's engineroom was engulfed in a tremendous gas explosion that killed the vessel's engineer, two other persons, and causing the boat to sink off the Louisiana coast.

Leon's case was tried before the District Court in a bench trial (i.e., without a jury) on May 24-25, 2010. The District Court denied Manderson's claims against Chet Morrison for Jones Act negligence and unseaworthiness. However, Judge Haik did find that Chet Morrison Contractors (CMC) arbitrarily and capriciously denied Leon's maintenance and cure and awarded him "maintenance and cure" that, several years after the fact, helped to cover well over \$100,000 of medical expenses that were required to keep him alive. In fact, as discussed with his attorney, Leon's appearance in the courtroom to testify in this trial remained in doubt until the last moment as a result of the seriousness of his illnesses. CMC would appeal that their actions in handling Manderson's claims were not "arbitrary and capricious."

MANDERSON PRESENTED EIGHT "REVERSIBLE ERRORS" FOR REVIEW ON APPEAL.

Attorney Mark Ross presented the U.S. Fifth Circuit Court of Appeal in New Orleans with these issues to decide on appeal....

- **Error #1.** Whether the District Court was clearly erroneous in finding that appellant Leon Manderson, failed to provide any evidence, including "objective" evidence that Chet Morrison routinely worked Leon Manderson 16 to 20 hours a day, without relief, in violation of federal manning and work hour limitation statutes.
- **Error #2.** Whether the District Court erred as a matter of law in holding crewmen like appellant Leon Manderson ultimately responsible for setting their own work and rest schedules
- **Error #3.** Whether the District Court erred as a matter of law in finding that 46 CFR. §15. 1111(g)), which

directs a vessel master's duty to establish watch schedules, did not apply to Chet Morrison's dive vessel.

- **Error #4.** Whether the District Court erred as a matter of law in finding that Leon Manderson failed to prove that Chet Morrison violated 46 CFR §15.1103(c)), which prohibited Morrison from transferring untrained deck personnel to the engineroom, because Manderson supposedly failed to prove his actual work hours, an unrelated issue.
- **Error #5.** Whether the District Court erred as a matter of law in holding that Leon Manderson, was contributorily negligent and/or assumed the risk in working excessive hours given Chet Morrison's acknowledged statutory violations of federal manning and work hour limitation statutes.
- **Error #6.** Whether the District Court erred as a matter of law in failing to find that Chet Morrison's violation of its COI and multiple manning and work hours statutes, together with plaintiff's medical evidence proving causation, shifted to Chet Morrison the burden to show that the violations could not have caused or exacerbated appellant Leon Manderson's injuries.
- **Error #7.** Whether the District Court erred as a matter of law in failing to find Chet Morrison's vessel unseaworthy.
- **Error #8.** Whether the District Court abused its discretion in denying (recovering certain costs involved in trying the case) to Mr. Manderson pursuant to Federal Rule of Civil Procedure 54(d) upon no other ground than the District Court's erroneous conclusion that it is within its unbounded discretion to do so.

SUMMARY OF CHIEF ENGINEER MANDERSON'S APPEAL

The District Court was clearly erroneous in failing to be aware of eye-witness testimony and Chet Morrison's stipulations that Mr. Manderson worked an average of 16 to 18 hours a day without adequate relief.

The District Court erred as a matter of law in holding that Mr. Manderson and the M/V Jillian Morrison's crew had the legal obligation to set their own work schedules in the face of federal statutes placing that duty upon the vessel's master.

The District Court erred as a matter of law in holding Chet Morrison could not know it failed to properly man its own vessel unless Mr. Manderson told them of the manning shortage.

The District Court erred as a matter of law in holding Mr. Manderson was 100% negligent and assumed the risk of working excessive hours. No Jones Act seaman can assume the risks of his employment. Additionally, Mr. Manderson cannot be found contributorily negligent in the face of Chet Morrison's numerous statutory violations. In like manner, the District Court erred as a matter of law in finding that 46 CFR §15.1111(g), which directs a vessel master's duty to "post watch schedules where they are easily accessible" found it was not "practical within this industry for masters of vessels manned with such a small crew to post a rest schedule." In addition, the former Coast Guard Commander who was CMC's expert on Coast Guard regulations testified: as a chief and licensed engineer, Manderson was ultimately responsible for ensuring he got enough rest. And Captain Plain, who served with Manderson aboard the Jillian Morrison testified: Manderson set his own hours; he never observed Manderson working more than 12 hours per shift; and Manderson never complained about his work schedule.⁽¹⁾ [⁽¹⁾Appeal transcript, pgs. 6, 7.]

[NMA Comment: It is not hard to understand that if a Master is not concerned about posting a watch schedule required by regulations, such an officer would not be concerned about the work hours performed by an engineer working several decks below as long as he kept the vessel running. However, the loose concept of being on 24-hour call is in direct conflict with the NTSB's concern for developing scientifically based hours of service regulations, Crew Endurance Management, and international treaty obligations under STCW for vessels operating in international waters. We assert that the "on call" concept deserves the attention of Congress since it has been overlooked by Coast Guard regulators.]

The District Court erred as a matter of law in finding that Leon Manderson failed to prove that Chet Morrison violated 46 CFR §15.1103(c), which prohibited Chet Morrison from transferring untrained deck personnel to the

engine room, because Manderson supposedly failed to prove his actual work hours. Proof that Chet Morrison violated the regulation is not contingent upon showing excessive work hours by Leon Manderson, but instead that Chet Morrison transferred untrained deck personnel to the engineroom.

The District Court also erred as a matter of law in failing to find Chet Morrison violated 46 U.S. Code §8104(e)(1)(A), which prohibits assigning deck crew to the engineroom. The District Court was further clearly erroneous in failing to recognize that Chet Morrison's assignment of untrained deck personnel to engine room duty is objective evidence that the vessel, and specifically the engine department, is undermanned.

The District Court erred as a matter of law in failing to find the M/V Jillian Morrison unseaworthy since it was undermanned in violation of the vessel's COI, as well as multiple federal manning and work hour statutes. Chet Morrison's violation of numerous manning and work hour statutes, coupled with the largely uncontradicted medical evidence establishing a causal relationship between Leon Manderson's shipboard work schedule and his injuries, proved the vessel's unseaworthiness.

In like manner, the District Court erred as a matter of law in failing to shift to Chet Morrison the burden of showing its many statutory violations did not cause or contribute to Chief Engineer Manderson's injuries, a burden Chet Morrison never met.

Finally, the District Court abused its discretion in denying Mr. Manderson costs pursuant to FRCP 54(d). The District Court erred in failing to recognize that Mr. Manderson, as the prevailing party, is presumed to be entitled to an award of court costs. The District Court's decision to deny court costs must be grounded on some basis other than the District Court's unfettered discretion.

Given the forgoing, we believe the Fifth Circuit Court of Appeal should have reversed the District Court's failure to find Chet Morrison liable for Mr. Manderson's injuries and remand the case to the District Court to determine Mr. Manderson's damages. Unfortunately, the Appeals Court did no such thing!

Our Association offers its initial comments to each of these possible "Errors." We re-state each of these errors based on our experience and a review of all the documents in our possession. We will revise and update this report as the case proceeds through the appeal process.

NMA VIEWS ON ERROR #1

NMA Re-statement: We believe the District Court erroneously found that Chief Engineer Leon Manderson, failed to provide any evidence (including "objective evidence") that Chet Morrison Contractors routinely worked him for 16 to 20 hours a day, without relief, in violation of federal manning and work hour limitation statutes.

[NMA Comment: We had no trouble finding sufficient evidence in both depositions and testimony and in court. Why the judge was unable to do this is incomprehensible other than to say that he did not grasp the implications of the case and its effect on limited-tonnage mariners. For a Federal Judge to ignore so many laws (and regulations based upon those laws) puts every mariner's health, safety, and welfare at risk and must not be taken lightly. Our Association is concerned that since the Appeals Court went far beyond this point in its decision on appeal, it leaves every mariner who contests any of the existing hours-of-service statutes and regulations in the future.]

[NMA Comment: We understand that the Coast Guard was invited to prepare an "Amicus Brief" regarding their position on the laws and regulations mentioned in this report. We are disappointed that they were unwilling to commit themselves to explain their interpretations of the laws they are paid by taxpayers to uphold.]

[NMA Comment: We also express our disappointment in the Coast Guard's Marine Safety Inspections conducted on the M/V Jillian Morrison in the months leading up to her final fatal explosion.]

Testimony of Former Crewmembers

The M/V Jillian Morrison was a worn out, converted offshore supply vessel (OSV) whose dilapidated condition required constant attention. For example, **Captain Frank Billiot**, an experienced veteran aboard anchor handling tugs, supply boats, and dive vessels testified that the vessel's sewage system routinely overflowed feces and sewage (i.e. both "black-" and "gray water") throughout the vessel, including the galley. Captain Billiot told Chet

Morrison's management about the stench and contamination but the company did little if anything to respond to these conditions. Not only did the vessel's crew have to live with the stench and often inoperable sewage system, but the employees of the vessel charterer had to endure these unsanitary conditions.

Seaman Jason Giuliani, a ship's clerk who occasionally worked as an engineroom helper aboard the vessel provided a deposition that was introduced into evidence at trial. Mr. Giuliani first helped clean a major sewage overflow in April 2007 and recalled that raw sewage filled a 30-foot by 20-foot by 3-foot deep bilge and that sewage was everywhere. Sewage overflows occurred about once a month, and one overflow took as long as three days to clean.

Relevant to Leon's claims, Mr. Giuliani testified the unseaworthy sewage system added to Manderson's already overburdened work schedule. Leon estimated that the unseaworthy sewage system required him to spend an additional, "two or three or four hours every day," just cleaning the filth.

Leon told Chet Morrison's port engineer, John Brunet, about the defective sewage system as well as the vessel's numerous other unseaworthy conditions. Leon even gave Mr. Chet Morrison, the company's CEO, a personal guided tour to underline the desperate need to repair the vessel. However, Mr. Morrison refused to remedy the choking stench from the sewage overflow up to the time the vessel exploded and sank. Morrison filed a limitation of liability proceeding the morning of the vessel's explosion in the U.S. District Court in New Orleans.

Howard Leonard is a licensed Chief Engineer, Limited, Any Horsepower. Attorney Mark Ross introduced Mr. Leonard's deposition testimony into evidence. Mr. Leonard worked for Chet Morrison as a vessel engineer and temporarily replaced Manderson on an earlier occasion. He described the M/V Jillian Morrison as a vessel "of antiquated vintage" in need of constant attention and should have been retired from service altogether.

Mr. Leonard cited one illustrative incident when a rotten potable water line⁽¹⁾ broke, threatened to pour 40,000 gallons of water into the vessel's and flood its interior. The vessel's captain moved the vessel to safety by pushing it into the mud to keep it from sinking. ⁽¹⁾*Our Association spent much time and energy alerting Congress to the need for closer inspection of vessel potable water systems. Refer to NMA Report #R-395, Rev.3.]*

The M/V Jillian Morrison's COI required the vessel to have an automated engineroom system which could be controlled from the pilothouse. The COI cautioned that the vessel's manning requirements in turn were, "contingent upon the proper operation of the engineering/automated control /monitoring systems." If the vessel's so-called "automated" engine room did not function, then the vessel required additional engineroom crewmembers and the Coast Guard's Officer-in-Charge Marine Inspection was to be notified.

Chief Engineer Leon Manderson asserted that the M/V Jillian Morrison never had a fully operational automated engineroom system required by the vessel's COI. The vessel, therefore, never complied with the vessel's manning requirements for a non-automated engineroom equipped vessel. Mr. Manderson recalled that of all the pilothouse based systems that could comprise an automated engineroom system, only a tachometer worked. Part time clerk/engine room helper Jason Giuliani described the M/V Jillian Morrison's engineroom operation as "manual" as opposed to "automated."

Former chief engineer Howard Leonard described the vessels alleged automated engineroom system as "unreliable" and cited the failure of the enginerooms bilge alarm to sound when the vessel almost sank at the dock. In his deposition transcript he noted a log entry dated Aug. 23, 2007: "Chief notified captain taking on water in engineroom. No alarm sounded.

Captain Billiot also described one incident illustrating the unseaworthiness of the M/V Jillian Morrison that had life-threatening consequences. He described shutting down diving operations when the vessel's defective port anchor chain parted. Nevertheless, the company ordered Captain Billiot to continue diving operations with only one bow anchor cable in his four-point mooring system deployed. Captain Billiot refused to do so for fear of killing divers and instead returned to port. In response, the company fired Captain Billiot and he reported this incident to our Association after his employment was terminated. We directed a lengthy report to the Coast Guard Marine Safety Unit in Morgan City with much red tape and very little satisfaction.

The M/V Jillian Morrison Operated 24 Hours a day for Weeks at a Time

Former M/V Jillian Morrison Captain Frank Billiot testified that dive boats operate 24 hours a day, seven days a week "until the job is completed." Former ship's clerk Jason Giuliani recounted that work aboard the dive boat never stopped: "the boat was always operating. It's a 24/7 operation." Chief Manderson explained the M/V Jillian Morrison remained offshore two to six weeks at a time, and while offshore the vessel and Chief Engineer Manderson worked up to 24 hours a day.

With a large number of divers plus vessel crew on board, Mr. Manderson had numerous duties related to the divers' operations as well as tending to the vessel's engine room.

Manderson Introduced Evidence of Working 16-20 Hours A Day Without Rest

The District Court found Manderson failed to provide any evidence of his work schedule aboard the M/V Jillian Morrison. The District Court also ruled Manderson failed to introduce evidence showing whether he did or did not rest 10 hours out of every 24 as mandated by 46 CFR §15.1111(a).

The District Court's findings are clearly erroneous. The District Court not only disregarded Mr. Manderson's uncontradicted testimony, but was apparently unaware of evidence presented by ship's clerk Jason Giuliani, former engineer Howard Leonard and former Master Frank Billiot that showed the engineers who served on this vessel, including Mr. Manderson, routinely worked 16 to 18 hours a day. The uncontradicted evidence also showed Chet Morrison failed to ensure that Manderson could rest 10 hours out of every 24 hours given the vessel's chronically undermanned crew.

Former ship's clerk Jason Giuliani recorded the ship's personnel on board and thus was in a unique position to know that Chet Morrison Contractors made Leon Manderson work alone. This is clear from his transcript that was entered into evidence. For example, in April 2007, Mr. Giuliani volunteered to assist Leon whenever he could break away from his job as ship's clerk. Until Mr. Giuliani volunteered to try to help Mr. Manderson as an untrained "wiper" (i.e., a helper to clean the engineroom) Chet Morrison, "didn't have a position for a wiper or even a trained oiler on its Certificate of Inspection. The Chief Engineer did the engineering and that was that."

When Jason Giuliani volunteered to assist Leon in the engineroom, Jason had absolutely no sea experience and no engineroom experience. The engineroom and other "machinery spaces" on vessels of this type and size are dangerous places equipped with large electric generators, hydraulic and pneumatic equipment, large propulsion engines and other rotating equipment.⁽¹⁾ Leon could not leave Jason alone in an engineroom since he was not qualified and thus might inadvertently cause, "any number of catastrophic events to affect not only the vessel and its crew but also the divers as well. However, given Jason Giuliani's lack of experience, Chief Engineer Leon Manderson remained on call 24 hours a day, without a scheduled off-duty period. Consequently, Jason knew, based on his work with Leon that Manderson averaged at least 16 hours of actual work a day. Jason Giuliani often assisted Leon Manderson, would go off shift, shower, sleep and then return to work to find Leon was still up and working. In addition, Jason witnessed occasions on which Leon worked 24 hours or more straight time – all without any kind of provision for overtime pay for these extra hours. [⁽¹⁾The danger became evident when the engineroom exploded six weeks after Leon Manderson left the M/V Jillian Morrison for the last time. Refer to NMA Report #R-428. Rev.1.]

Jason Giuliani, as the ship's clerk, knew that Chet Morrison did not provide Leon Manderson with a minimum of 10 hours a day rest. Mr. Manderson, as the vessel's licensed Chief Engineer, confirmed that the vessel's Captain never assigned anyone to assist him who was sufficiently competent or legally qualified to allow Mr. Manderson to take off 10 hours a day for rest. Mr. Giuliani witnessed and testified to the results of Leon's sleep deprivation when he would fall asleep while eating in the galley. Given Manderson's lack of any scheduled off-duty time, he tried to nap in a Zodiac inflatable rescue boat on deck since constant work interruptions made trying to sleep in his own quarters "pointless."

Even Jason Giuliani's individual and voluntary efforts to help Leon Manderson were frequently interrupted when the Captain called him back to the pilot house to work as the ship's clerk again for "a week here and two weeks there." When Jason knew he would be unable to assist in the engineroom, Leon would go back to working like he did before, by himself. In any instance, Manderson worked on a 24-hour basis without an adequate relief. This was the result of a failure by the Coast Guard to provide a realistic manning for the engineroom on the vessel's Certificate of Inspection and the failure of the Master to provide and post a reasonable work schedule. The Master was limited in that the company failed to provide sufficient trained and qualified crewmembers to operate the vessel properly.

Manderson's Replacement Engineer Also Worked Over 16 Hours a Day

In finding that Chief Engineer Leon Manderson did not present any evidence of his excessive work hours, the District Court also ignored the deposition testimony of Mr. Howard Leonard. Mr. Leonard is a former licensed chief engineer.

The M/V Jillian Morrison was one of three Chet Morrison vessels Howard worked on. He temporarily replaced Leon on that vessel on Aug. 16, 2007. Chet Morrison also worked Mr. Leonard, like Manderson, 16 to 18 hour days on the M/V Jillian Morrison. Mr. Leonard, like Mr. Manderson, was on call 24 hours a day. The vessel's captain never scheduled Howard's work so that he could receive the 10 hours of rest per day as required by regulations. Mr. Leonard's work schedule instead was wholly "unpredictable". In addition to not providing for his required rest, Chet Morrison fired him for his perceived lack of enthusiasm for working 16 to 18 hour days.

Even His Employer Agreed Leon Manderson Worked Alone in the Engineroom

The District Court was clearly erroneous in finding Manderson failed to provide the Court with evidence showing whether or not he was adequately relieved of his duties. Objective evidence of Manderson's lack of relief includes Chet Morrison's stipulations that Manderson worked on a 24 hour a day "on call" basis without any relief. **Chet Morrison in fact made the circular argument that because Chet Morrison did not provide Mr. Manderson with a relief, no "watch" system existed and Manderson was not entitled to be relieved.** In the Court Reporter's Official Transcript of the Motion Hearing before the judge, Chet Morrison stipulated Manderson remained on call 24 hours a day, which Chet Morrison incorrectly claimed, was "customary." Chet Morrison admitted in open court that Manderson worked virtually alone for the first five months of his fourteen months employment with Chet Morrison. Leon presented uncontradicted testimony that whenever Chet Morrison professed to provide Manderson with an engineroom assistant, such personnel were grossly unqualified. After Mr. Manderson told port engineer John Brunet and personnel manager Larry Bourg of his average 16 to 18 hour daily work schedule, Chet Morrison assigned an unlicensed, **untrained engineroom "helper"** to allegedly assist him.

Mr. Manderson quickly found that his new "assistant"... "wasn't no oiler. He wasn't no helper." Chet Morrison replaced their first "helper" with yet another unlicensed, untrained person whose lack of qualifications limited his duties to painting the boat.

Dive boats and other service vessels, which lawfully operate in the Gulf of Mexico routinely, employ at least two engineers so each can work a 12-hour shift with 12 hours off-duty to rest. Captain Frank Billiot testified that in his 33 years of seamanship he has worked with dive boat companies including Cal-Dive International, Edison Chouest and Torch Offshore, which employ two or more engineers. Manderson likewise testified that he worked with other dive companies who relieved him with another qualified engineer. In accord, Howard Leonard deposition, Chet Morrison chose to keep its vessels undermanned.

The Vessel's Master Told Chet Morrison that M/V Jillian Morrison Undermanned

We believe the District Court was clearly erroneous in finding that Leon Manderson failed to present any evidence that Chet Morrison knew it kept the M/V Jillian Morrison habitually undermanned and compelled Manderson to work 16 to 18 or more hours a day. The District Court appeared to be **unaware** of former captain Frank Billiot's deposition and direct testimony. Captain Billiot determined after his first 28-day shift that the vessel was undermanned by at least one mate, one engineer and one designated engineer trainee (DET). Captain Billiot told Chet Morrison personnel manager Larry Bourg that the vessel was short one mate, a galley hand, one engineer and a DET - persons he believed were necessary for the vessel to perform its assignments. Mr. Manderson likewise told Chet Morrison personnel manager Larry Bourg and port captain John Brunet that he worked 16 to 18 hour days and needed relief. It is noteworthy that Chet Morrison did not call either Mr. Bourg or Mr. Brunet as witnesses at trial.

Chet Morrison Did Not Keep Time Records for its Engineers

If the District Court's reasons for their judgment demand for **"objective evidence"** includes time records, they were clearly erroneous in finding Manderson failed to present any evidence, including "objective" evidence, of his excessive work load aboard M/V Jillian Morrison. If the District Court's reference to "objective" evidence means written time records, **Chet Morrison stipulated that it did not keep time records.** In fact, this is a perfect example of why our Association fought for years to inform Congress of the need to require "official logbooks" on all inspected vessels - that finally was recognized by amending logbook requirements in §607 of the Coast Guard Authorization Act of 2010.⁽¹⁾ **Yet if engineers are allowed to serve on an "on call" basis rather than to stand a regular "watch" assigned by the vessel's Master, this amendment may become meaningless in the eventual goal of providing engine room personnel with scientifically based hours-of-service.** [⁽¹⁾46 U.S. Code §11304.]

Chet Morrison **at first falsely represented that it supposedly kept time records for Manderson** and other engineers on the M/V Jillian Morrison. Morrison initially claimed that Leon Manderson and other engineers were supposedly obligated to document their actual work hours in logs which Chet Morrison promised to bring to trial, guaranteeing, in the Court Reporter's official transcript that: "[T]he logs do exist." Chet Morrison initially claimed Mr. Manderson failed to fill in time records, as the Chief Engineer plaintiff was responsible for completing the Engineer's log on a daily basis despite this fact that **Leon admitted that he did not enter the number of hours he worked into his logs. In reality, Morrison never kept time records for its engineers.** Former Chet Morrison engineer Howard Leonard testified that Chet Morrison never asked him to fill out time sheets. In addition, no one with Chet Morrison ever showed Mr. Leonard a time sheet he had to fill out. Nor did Chet Morrison ever

reprimand Mr. Leonard for supposedly failing to fill out time sheets. In fact, no one with Chet Morrison ever mentioned the subject of time sheets to Mr. Leonard, including three different Chet Morrison vessel captains.

Furthermore, Chet Morrison displayed a shocking ignorance of what records it did maintain. For example, they denied the existence of captain's rough logs until Leon Manderson proved their existence during a hearing on his "Motion to Compel" before the Magistrate Judge Mildred Methvin during which the judge debated whether she should cross-examine Chet Morrison personally on what records his company did or did not have.

As it was, Magistrate Judge Methvin sanctioned Chet Morrison for its bad faith and overall "strange answers" to Mr. Manderson's discovery. Subsequently, through his attorney, Mr. Manderson filed a "Motion for Application of an Adverse Inference" against Chet Morrison for its persistent misrepresentation that Chet Morrison engineers either kept or were supposed to keep detailed records of their work time.

In response, Chet Morrison changed course and claimed it never said its engineers kept time records: In fact, Chet Morrison never maintained that it required its engineers to record the number of hours that they worked, nor has it ever claimed that it. If the District Court's reference to "objective evidence" is to written time records, no such records ever existed.

Undermanning a Vessel Violate its COI and Provides "Objective Evidence" of Excessive Work Hours

The District Court was clearly erroneous in finding that such statutory violations supposedly played no role in Manderson's Herculean work schedule. As a matter of fact in finding that Chet Morrison violated its Coast Guard Certificate of Inspection by sailing without one of its two required Mates aboard the vessel, this was a statutory violation.

The District Court reasoned that since Manderson "claims that only the improper manning of the engine room caused his injuries, not the manning of the deck", Chet Morrison's decision to sail a mate short was of no importance. Leon Manderson testified his work was not limited to the engine room. His work on a dive vessel with 32 or more divers required him to work on dive related equipment above decks, including the divers' "hot water machine...air compressor machine for jetting, the jet pump." Mr. Manderson related that with 24 hour a day dive operations, he had to constantly monitor a deck crane, air compressors and dive compressors. In fact, the presence of a carefully supervised mate could have assisted Mr. Manderson.

Ship's clerk Jason Giuliani, who normally worked in the pilothouse, tried to assist Chief Engineer Manderson to the extent allowed by his lack of training and experience. However, the vessel's captain often called Giuliani back to work as ship's clerk in the pilothouse, leaving Leon to work alone again. Mr. Giuliani's transcript provides an illustration of how too few deck personnel impacted Leon's access to even untrained help.

When Captain Frank Billiot told Chet Morrison personnel manager Larry Bourg that the M/V Jillian Morrison was undermanned by one mate according to its posted Certificate of Inspection and one engineer, among other deficiencies, Bourg told Captain Billiot to use Able Seamen from the deck department. However, Captain Billiot correctly refused to assign his Able Seaman to the engineroom, because Captain Billiot needed the AB to act as lookout in the pilot house – as required by the Rules of the Road.⁽¹⁾ Furthermore, Chet Morrison's violation of the vessel's Certificate of Inspection also violates law and regulation⁽²⁾ that forbid Chet Morrison from sailing without the minimum complement specified in the vessel's COI. The District Court's conclusion that Chet Morrison's violation of its vessel's COI manning requirements, "is of no moment to the case at hand," is deficient. [⁽¹⁾33 CFR §83.05. ⁽²⁾46 CFR. §15.515(a) and 46 U.S. Code §8101(d).]

Manderson's Medical Evidence Provides the Causal Link Between his Work Schedule and his Injuries.

Mr. Manderson required hospitalization for exacerbated ulcerative colitis on Jan. 24, 2008, that subsequently required removal of his entire colon a year later. Attorney Mark Ross obtained depositions from four highly qualified medical experts who supported the medical causation between Leon's non-stop work schedule and exacerbation of his ulcerative colitis as well as diabetes. We summarize key items from of their deposition that are believe are important for all of our mariners to be aware of as follows:

- Working on an exhausting 24 hour a day basis is a specific stressor that would cause a flare up of ulcerative colitis.
- Exhaustion is a "profound physical stressor." If a person with pre-existing ulcerative colitis worked on call 24 hours a day for months on end, these working conditions create a "stressful situation" known to increase flare-ups of the condition.
- Stress generated by such an extreme work schedule more than likely aggravated the illness.
- Stress can alter the course of a number of diseases including ulcerative colitis. The irritable bowel syndrome is a disease known for its direct relationship to stress. Patients can very often connect situational difficulties with their symptoms.

- During stress a number of hormones are produced. The most important hormone are the steroids produced in the adrenal glands and the other hormones, like the growth hormones that can stimulate the body to become increasingly more inflamed. Hormonal theory is reasonably well established.
- Stress generated by working 16 to 20 hours a day for weeks on end would aggravate ulcerative colitis, as well as any other malady from which he suffered: "In my opinion, yes, stress can alter the course of most illnesses. Certainly, specifically, the ones Mr. Manderson had."
- Sleep deprivation from a 24 hour a day on-call schedule with at best broken up, sporadic opportunities to rest is a definite stressor likely to exacerbate pre-existing ulcerative colitis: The lack of a regulated, well-entrained sleep-wake schedule leads to sleep restriction, would exacerbate underlying ulcerative colitis.

Mr. Manderson also introduced largely uncontradicted medical evidence that the 24-hour a day on call schedule Chet Morrison imposed upon him caused or contributed to the first time onset of his Type II diabetes mellitus.

- The stress of insufficient sleep, inadequate sleep, and a cumulative sleep debt were a major risk factor for the unmasking of diabetes. Although Leon had a family history that may have put his baseline at a higher risk for diabetes. The timing of the diagnosis for the onset of diabetes strongly suggests that the sleep restrictions he underwent on the job presented a contributing factor.
- When asked whether a causal correlation existed between Mr. Manderson's 24 hour a day on call work schedule, average daily working hours of 16 to 18 hours, plaintiff's sporadic sleep opportunities and the January 2008 onset of Manderson's diabetes, the fourth medical expert witness emphatically replied "yes": The lack of sleep can cause insulin resistance. It can cause cortisone release, which can cause elevated sugar. Cortisone release that is much higher than normal leads to decreased blood sugar. Sleep deprivation causes hormonal changes that leads to diabetes: Increased abdominal fat is one of the main criteria for insulin or one of the main acquired or ways in which one can acquire insulin resistance. Sleep deprivation contributed to Mr. Manderson's diabetes: **The expert on diabetes would not permit Leon to return to work offshore given the risk of a loss of consciousness from hypoglycemic shock. This, among other medical factors ended Leon's career.**

Employer's Medical Expert Did Not Effectively Oppose Manderson's Experts and Treating Physicians

Chet Morrison medical expert conceded that he lacked the training, expertise or knowledge to rebut Mr. Manderson's case on medical causation and specifically had no expertise concerning sleep deprivation. For example, he did not know the five stages of sleep and deferred to Leon's sleep specialist concerning how sleep affects a multitude of bodily functions. Morrison's expert agreed with Mr. Manderson's experts that the physical stress generated by "sleep deprivation, working sixteen, eighteen hours a day, day after day", can exacerbate ulcerative colitis. He agreed with Mr. Manderson's medical experts that stress obviously would have contributed to a flare-up of the disease. He stated if a patient sought treatment for diabetes he would have to refer him to a diabetologist or an endocrinologist and admitted he is not qualified to comment on any association between chronic insufficient sleep and diabetes. Further, Morrison's expert deferred to Manderson's diabetes doctor on whether sleep deprivation is a contributing factor to Type II diabetes. Consequently, Manderson's medical causation evidence was not rebutted by Chet Morrison.

NMA VIEWS ON ERROR #2

NMA Re-statement: We believe the District Court erred as a matter of law in holding that crewmen like Chief Engineer Leon Manderson ultimately are responsible for setting their own work and rest schedules.

[NMA Comment: 46 CFR §15.705 states in part: "Title 46 U.S.C. 8104 is the law applicable to the establishment of watches aboard certain U.S. vessels. The establishment of adequate watches is the responsibility of the vessel's Master."]

The District Court in its "Reasons for Judgment erred as a matter of law in holding Jones Act seamen like Mr. Manderson ultimately responsible to rest as they saw needed. 46 CFR §15.705 titled, "Watches" states simply: "The establishment of watches is the responsibility of the vessel's Master." 46 CFR §15.1109 directs the vessel's Master, to "ensure observance of the principles concerning watchkeeping..." 46 CFR §15.1111(g) states: "The Master shall post watch schedules where they are easily accessible. They must cover each affected member of the crew and must take into account the rest requirements of this section as well as port rotations and changes in the vessel's itinerary."

The District Courts holding contradicts federal statutes, interpreted by Coast Guard regulations, which, consistent with centuries of maritime law, hold the vessel's Master responsible for setting watches. The District Court's decision invites chaos aboard any ship on which each crewmember, from galley hand to Mate, interprets work hour statutes, "to rest as they saw needed." Unfortunately, this decision was affirmed by the Court of Appeals.

The District Court's opinion further suggests that Mr. Manderson, for unexplained reasons, was supposedly determined not to rest and would have refused commands to do so: "The Court cannot assume that the posting of a watch schedule would have compelled the plaintiff to rest more."

The Court in The DENALI case in 1939 took a far more realistic look at a claim that a vessel's Mates "customarily" and "voluntarily" served additional watches out of alleged love for their employer:

This is surprising testimony. Knowing something of the modern sailor and the watchfulness of corporate managers over their labor costs, this maritime court wonders how long the second and third mates would have held their jobs if they failed "customarily" and "voluntarily" to violate the provisions of this safety statute and...serve over its required time.

In accord, the 1954 Bradt vs. United States case held concerning the destroyed health of that sleep-deprived vessel engineer, that "The duty of ship owners to seamen, who are wards of admiralty, is not so lightly discarded by...a willingness to continue with his tasks."

The District Court erred as a matter of law in holding that since crewmembers like Mr. Manderson supposedly assumed the responsibility for setting their own watches, Mr. Manderson and other crewmembers likewise assumed the risk of "failing" to rest as they saw needed. The District Court's finding that Manderson allegedly "assumed the risk" of his employment is a defense Congress eliminated in 1939. In 1958, the U.S. Supreme Court in *Kernan v. American Dredging Co.*, explained that "assumption of the risk" is not a defense in Jones Act cases: First, Section 4 relates entirely to the defense of assumption of risk, abolishing this defense where the injury was caused by the employer's negligence or by violation...of any statute enacted for the safety of employees.

NMA VIEWS ON ERROR #3

NMA Re-statement: We believe the District Court erred as a matter of law in finding that 46 CFR §15.1111(g), that directs a vessel Master to establish watch schedules on his vessel, did not apply to Chet Morrison's dive vessel.

The District Court held it did not find it practical, "within this industry for Masters of vessels manned with such a small crew to post a schedule", setting watches for the crew. Unfortunately, this decision also was affirmed by the Court of Appeals.

In 46 CFR §15.1111(g) actually provides that a vessel's master, "shall post watch schedules where they are easily accessible."

The District Court's conclusion that dive vessels are exempt from 46 C.F.R. 15.1111(g) is erroneous as a matter of law and ironic as a matter of fact. The M/V Jillian Morrison had a "small crew" since, among other things, the vessel sailed one mate short in violation of the vessel's COI - a very significant fact in light of the large number of passengers it was carrying and that the vessel was in continuous 24-hour service.

Although Steward's Department personnel generally are not specified on a vessel's COI, former Captain Frank Billiot also determined as a practical matter that the vessel lacked a galley hand necessary to provide support for the cook. The cook was expected to provide food service and regular meals not only for the vessel's crew but also for up to 32 additional "industrial personnel" carried aboard the vessel for various work projects carried out on behalf of its charterers.⁽¹⁾ [⁽¹⁾Refer to NMA Report #R-455, Rev. 3.]

The District Court's exemption of Chet Morrison from 46 CFR §15.1111(g) is nothing less than a reward for refusing to lawfully man its vessel is a clear legal error. Unfortunately, this decision as well was affirmed by the Court of Appeals.

46 CFR §15.1111 Work hours and rest periods.

(a) Each person assigned duty as an **officer in charge of a navigational or engineering watch**, or duty as a rating forming part of a navigational or engineering watch, on board any vessel that operates beyond the Boundary Line shall receive a minimum of 10 hours of rest in any 24-hour period.

(b) The hours of rest required under paragraph (a) of this section may be divided into no more than two periods, of which one must be at least 6 hours in length.

(c) The requirements of paragraphs (a) and (b) of this section need not be maintained in the case of an emergency or drill or in other overriding operational conditions.

- (d) The minimum period of 10 hours of rest required under paragraph (a) of this section may be reduced to not less than 6 consecutive hours as long as—
(1) No reduction extends beyond 2 days; and
(2) Not less than 70 hours of rest are provided each 7-day period.
(e) The minimum period of rest required under paragraph (a) of this section may not be devoted to watchkeeping or other duties.
(f) Watchkeeping personnel remain subject to the work-hour limits in 46 U.S.C. 8104 and to the conditions when crew members may be required to work.
(g) The Master shall post watch schedules where they are easily accessible. They must cover each affected member of the crew and must take into account the rest requirements of this section as well as port rotations and changes in the vessel's itinerary. [CGD 95-062, 62 FR 34539, June 26, 1997, as amended by USCG-2006-24371, 74 FR 11263, Mar. 16, 2009]

NMA VIEWS ON ERROR #4

NMA Re-statement: We believe the District Court erred as a matter of law in finding that Leon Manderson failed to prove that Chet Morrison violated 46 CFR §15.1103(c) that prohibited Morrison from transferring untrained deck personnel to perform engineroom duties, because Manderson supposedly failed to prove his actual work hours. The two issues are unrelated.

The District Court found Mr. Manderson failed to prove whether he was adequately relieved by a competent replacement as the M/V Jillian Morrison's engineer.

The District Court held if Mr. Manderson had proved his work hours, the District Court may then have found Chet Morrison violated "46 CFR §15.1103(c)" which states: Unfortunately, this was affirmed by the Court of Appeals.

46 CFR §15.1103(c) Employment and service within the restrictions of an STCW endorsement or of a certificate of training.

(c) On board a seagoing vessel driven by main propulsion machinery of 750 kW [1,000 hp] propulsion power or more, no person may employ or engage any person to serve, and no person may serve, in a rating forming part of a watch in a manned engine-room, nor may any person be designated to perform duties in a periodically unmanned engine-room, except for training or for the performance of duties of an unskilled nature, unless the person serving holds an appropriate, valid STCW certificate or endorsement issued in accordance with part 12 of this chapter. [CGD 95-062, 62 FR 34539, June 26, 1997, as amended by USCG-1999-5610, 67 FR 55069, Oct. 30, 2002; USCG-2004-18884, 69 FR 58344, Sept. 30, 2004; USCG-2006-24371, 74 FR 11263, Mar. 16, 2009]

Mr. Manderson need not prove his actual hours worked to show Chet Morrison violated 46CFR §15.1103(c) by burdening him with untrained Able Seamen, a ship's clerk or laborers who are not engineer officers or engineer ratings. Mr. Manderson, former Captain Frank Billiot, and former ship's clerk Jason Giuliani presented uncontradicted testimony that Chet Morrison insisted Mr. Manderson accept unskilled and unqualified deck crew as his "relief".

Chet Morrison's assignment of untrained deck personnel to the engine room also violates 46 U.S. Code §8104(e)(1)(A), which prohibited Chet Morrison from assigning seaman from working alternatively in the deck and engineroom departments.

Nothing in the language of either the regulation or statute conditions the statutes' application upon proof Mr. Manderson worked excessive hours. On the contrary, the District Court failed to appreciate that Morrison's unlawful assignment of unlicensed Able Seamen and other untrained personnel to the engine room is objective evidence the M/V Jillian Morrison was undermanned, that Chet Morrison failed to provide Mr. Manderson with adequate, trained, and qualified relief and, as a result, Mr. Manderson worked excessive hours in violation of 46 CFR §15.1111(a).

NMA VIEWS ON ERROR #5

NMA Re-statement: We believe the District Court erred as a matter of law in holding that Leon Manderson was contributorily negligent and/or that he assumed the risk in working excessive hours regardless of Chet Morrison's acknowledged violations of federal manning and work hour limitation statutes.

Legal citations from similar maritime lawsuits provided by Attorney Mark L. Ross concluded that Chet Morrison's relentless violation of work hours and manning statutes as well as Chet Morrison's refusal to follow U.S. Coast Guard regulations designed to provide for the safety of seamen all reflect negligence by themselves per se, i.e., without reference to other facts in the case. In other maritime cases, for example, it was decided that...

- Violation of 12 Hour Rule for tug pilots contributing cause of collision.

- Plaintiff's fatigue was a substantial factor in causing the plaintiff to fall overboard and drown.
- The strain of being on call often twenty-four hours a day was very stressful" and led to a stroke.
- Unshared strains, the innumerable equipment breakdowns, the interrupted sleep...all contributed to a vessel engineer's tubercular condition.
- Excessive hours worked by vessel engineer caused a pulmonary embolism, and "constitute a patent violation of the Jones Act..."
- Defendant's failure to follow U.S. Coast Guard regulations on the use of respirators is negligence per se.
- Absence of U.S. Coast Guard required line throwing device to rescue drowning crewman negligence per se.
- Violation of Coast Guard regulations requiring hand guards aboard fishing boat negligence per se.

The Jones Act expressly grants to seamen the rights and remedies available to railroad workers under the Federal Employers' Liability Act (FELA), 45 U.S. Code §53 of FELA declares that the alleged contributory negligence of an employee is disregarded where the violation of a safety statute contributes to the employee's injuries or death. The District Court's conclusion that Leon Manderson is 100% responsible for his own injuries by "negligently" remaining on call 24 hours a day is erroneous as a matter of law.

Contrary to the District Court's rulings, the manning of the M/V Jillian Morrison and setting of watches is a responsibility controlled by the ship's owner or master under several federal statutes. The District Court was clearly erroneous as a matter of law in holding Mr. Manderson 100% comparatively negligent for "overworking" as a result of the vessel's undermanned crew, dearth of qualified, licensed engine room personnel and unlawful work schedules. Unfortunately, the Court of Appeals affirmed the District Court's decision.

NMA VIEWS ON ERROR #6

NMA Re-statement: We believe the District Court erred as a matter of law in failing to find that Chet Morrison's repeated violation of numerous manning and work hours statutes, together with Manderson's medical evidence that proved causation, shifted the burden of proof to Chet Morrison to show that the violations could NOT have caused or exacerbated plaintiff's injuries.

The District Court erred as a matter of law in failing to find that Chet Morrison's multiple work hour and manning statutory violations, coupled with Leon Manderson's overwhelming evidence on medical causation, shifted the burden of proof to show its numerous statutory violations could not have caused or exacerbated Mr. Manderson's injuries.

Mr. Manderson proved through largely uncontradicted medical evidence by medical experts that the 24 hour a day unrelieved, on-call work schedule Chet Morrison imposed upon him caused and/or contributed to the aggravation of his pre-existing ulcerative colitis and the first time onset of his diabetes mellitus II.

The Fifth Circuit Court of Appeal previously held⁽¹⁾ that the proof necessary to show medical causation between Chet Morrison's multiple acts of negligence and Mr. Manderson's injuries is slight. A Jones Act seaman is entitled to recovery under the Jones Act if he adduced **probative evidence** that the company's negligence played **any part however small** in the development of his condition. The Court added that whether a Jones Act seaman's evidence of a causal nexus between his employer's negligence and the injury at issue "preponderates is irrelevant". Rather, the test is whether the Jones Act seaman "proffered some evidence of such a nexus, **and that is all that is required** to survive appellate review..." [⁽¹⁾Davis v. Odeco, Inc.]

In other cases⁽¹⁾ this Court held a Jones Act employer's negligence need not be the sole proximate cause of an injury, "but may merely be a contributing cause". Chet Morrison is liable to Leon Manderson if Morrison's "negligence played any part, **even the slightest**, in producing the injury for which damages are sought." [⁽¹⁾Reyes v. Vantage Steamship Company, Inc. and Gautreaux v. Scurlock Marine, Inc.]

Chet Morrison's persistent violation of work hours and manning statutes, as well as the vessel's Certificate of Inspection should have shifted the burden to Morrison the burden to show the violations could not have caused or exacerbated Leon Manderson's health problems and total disability. This Court held in simplest terms, that rule states that where a vessel is guilty of a statutory violation, the defaulting ship must show "not merely that her fault might not have been one of the causes, or that it probably was not, **but that it could not have been.**"⁽¹⁾ [⁽¹⁾Candies Towing Company, Inc. v. M/V B & C ESERMAN.]

Chet Morrison violated the following statutes:

- 46 CFR §15.1111(g) that requires the vessel Master to post watch schedules.
- The M/V Jillian Morrison's Coast Guard Certificate of Inspection by sailing one mate short.
- Violation of 46 CFR §15.515(a) and 46 U.S. Code §8101(d), that require vessels to sail with at least the minimum

complement specified by the vessel's COI

- 46 CFR §15.725, that requires a vessel sailing with less than the crew specified in the COI to notify the Officer in Charge, Marine Inspection and file a "report of sailing short".
- Failing to maintain an "automated engine room" as defined by 46 CFR §15.715,
- 46 CFR §15.801, that assigned to Chet Morrison the responsibility for manning its vessel pursuant to law;
- 46 CFR §15.705 and 15.1109, both entitled, "Watches", from which the District Court erroneously exempted Chet Morrison.
- 46 CFR §15.825(a), that requires the person in charge of an engineering watch be a licensed assistant engineer.
- 46 CFR §15.1103(c) and 46 CFR §15.401 that require persons whom Chet Morrison assigned to the engine room to be licensed.
- 46 CFR §15.1111(a) entitled, "Work hours and rest periods", that required Chet Morrison to provide Mr. Manderson with ten hours of rest per day including one uninterrupted 6-hour period.
- 46 U.S. Code § 8104(e)(1)(A) that prohibits Chet Morrison from assigning seamen to work alternatively in the deck and engine departments.

If the Fifth Circuit Court of Appeal presumes causation in the face of statutory violations, legal precedents show that Chet Morrison must overcome the presumption of fault. The U.S. Supreme Court⁽¹⁾ held that a statutory violation raises this legal issue. Can it be said in this case that the statutory fault **could not by any possibility** have contributed to the Mr. Manderson's disability? [⁽¹⁾*The Martello, (1894)*]

The District Court erred as a matter of law in failing to shift to Chet Morrison the burden of showing its myriad statutory violations did not cause or contribute to Leon Manderson's injuries. This Appellate Court can find liability in favor of Mr. Manderson on this basis alone. **Unfortunately, the Court of Appeals did not do so!**

NMA VIEWS ON ERROR #7

NMA Re-statement: We believe the District Court erred as a matter of law in failing to find the M/V Jillian Morrison was unseaworthy.

The District Court ruled that because "the Court does not hold the defendant improperly manned its vessel in accordance with statutory requirements, it cannot hold the defendant liable based on a minor violation of the Certificate of Inspection."

The District Court found Mr. Manderson failed to prove the M/V Jillian Morrison was unseaworthy. The District Court's ruling is clearly erroneous as a matter of fact and law.

Chet Morrison's decision to operate its vessel in such a manner that Leon Manderson had to be on duty 24/7, without ever having a scheduled, licensed, competent person on board who could fully relieve him, rendered the vessel unseaworthy. As noted, the vessel lacked a Mate required by its COI, as well as additional qualified engineroom personnel. A vessel is unseaworthy when its crew is inadequate or incompetent. Legal precedents show:

- 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.
- An inexperienced and undermanned engineroom, together with the lack of automatic engineroom like that required by the vessel's COI, all contributed to make that vessel unseaworthy.

Chet Morrison's vessel boasted of **additional unseaworthy features** in that it stank like a country outhouse on a hot July day as a result of a defective sewage system up until the day the vessel exploded and sank. Furthermore, Morrison fired any Captain who voiced safety concerns and the vessel almost sank while docked due to the vessel's physical deterioration. The District Court's conclusion it could not find the M/V Jillian Morrison unseaworthy due to "minor violations" of the vessel's COI is clearly erroneous as a matter of fact and law. **Unfortunately, the Court of Appeals did not support these arguments!**

NMA VIEWS ON ERROR #8

NMA Re-statement: We believe the District Court abused its discretion in denying court costs to Mr. Manderson pursuant to F.R.C.P. 54(d) upon no other ground than the District Court's erroneous conclusion that it is within its unlimited discretion to do so.

Although the District Court denied Mr. Manderson's claims for Jones Act negligence and unseaworthiness against Chet Morrison and its dive vessel, the District Court granted Mr. Manderson's claims for sizeable maintenance and cure and attorney's fees. Mr. Manderson is therefore the "prevailing party" under Federal Rules of Civil Procedure (FRCP) #54(d)(1). Unfortunately, the Court of Appeals revoked the attorney fees the District Court assigned to Attorney Mark Ross but cut in half the judgment granted to Leon Manderson for maintenance and cure by deciding that Chet Morrison's conduct was not "arbitrary and capricious."⁽¹⁾ [⁽¹⁾Appeal decision, pgs. 15, 16.]

The Fifth Circuit Court of Appeal previously ruled⁽¹⁾ that a prevailing party under FRC. 54(d) need not win all or even the major portion of a lawsuit: "A party need not prevail on all issues to justify a full award of costs, however. Usually the litigant in whose favor judgment is rendered is the prevailing party for purposes of rule 54(d)... A party who has obtained some relief usually will be regarded as the prevailing party even though he has not sustained all his claims... Cases from this and other circuits consistently support shifting costs if the prevailing party obtains judgment on even a fraction of the claims advanced. [⁽¹⁾United States of America v. Mitchell and Wright & Miller.]

On Feb. 2, 2011, the District Court denied Mr. Manderson's Motion to Tax Costs as the prevailing party. Generally, if you are the prevailing party (e.g., Manderson), the other party (e.g., Chet Morrison) pays for certain costs of the trial, for example for the deposition of expert witnesses used in trial.

In this case, the District Court held that it had already awarded Mr. Manderson attorney's fees and costs in connection with his maintenance and cure claims. Attorney Mark L. Ross stated that the District Court erred since it only awarded attorney's fees but not costs.

The District Court further ruled that a prevailing party is entitled to have costs taxed against the losing party, unless the court otherwise directs." The District Court believed it possessed unfettered discretion whether or not to award costs and chose not to do so and, in addition, gave no reason for its denial of court costs to Mr. Manderson.

The Fifth Circuit Court of Appeal mandates that where the District Court denies the prevailing party court costs, the District Court's general discretion is circumscribed: "by the judicially-created condition that a court "may neither deny nor reduce a prevailing party's request for cost without first articulating some good reason for doing so."

FRCP 54(d) states a prevailing party is presumed entitled to court costs: Unless a federal statute, these rules, or a court order provides otherwise, costs-other than attorney's fees-should be allowed to the prevailing party. The Courts hold FRCP 54(d) creates a presumption in favor of awarding costs to the prevailing party. Costs of obtaining depositions from "experts" the court recognizes are expensive, and we believe Leon Manderson is entitled to recover those costs.

CONCLUSION AND RELIEF SOUGHT ON APPEAL

In his appeal to the Fifth Circuit Court of Appeal, the Appellant, Leon Manderson, asked the Court to:

- Reverse the District Court's denial of his claims against Chet Morrison Contractors, Inc. for Jones Act negligence and the unseaworthiness of the M/V Jillian Morrison
- To find that Leon Manderson proved by a preponderance of the evidence that Chet Morrison Contractors, Inc. negligently caused or contributed to the exacerbation of his ulcerative colitis, colonectomy and first time onset of his diabetes mellitus II;
- To find that the M/V Jillian Morrison was unseaworthy and that this was a substantial cause of his injuries;
- To remand this matter to the District Court to decide damages to which Mr. Manderson is entitled as a result of Chet Morrison's actions.
- To reverse the District Court's denial of costs to Mr. Manderson pursuant to FRCP 54(d) and award those costs in the total amount of \$15,408.31.
- To award him for all costs and expenses incurred in filing this appeal.
- For all such further relief as this Court may deem just.

PROBLEMS ON M/V JILLIAN MORRISON OUR ASSOCIATION PREVIOUSLY REPORTED TO COAST GUARD INSPECTORS

Our Letter to the Coast Guard Reported Before the March 11, 2008 Explosion

In November 2006 we received a report from ■, a crewmember on the M/V Jillian Morrison, that one or more

unsafe conditions may exist on the vessel. We passed this information to the Coast Guard's Morgan City Marine Safety Unit and asked that their marine inspectors check it out at their next inspection opportunity. The mariner who making the report had with many years experience in the Gulf on both inspected and uninspected vessels and could supply further information as may be required. We understood that Coast Guard inspectors performed a "topside inspection" a week earlier. The mariner wanted us to withhold his name for fear of being "blacklisted" within the industry. The report included the following safety issues:

- The laundry room reportedly had a 220-volt junction box that located at or near deck level (about 3" above the deck) on the second deck. There is concern that if a washing machine spills water onto the deck that that water could slosh onto the junction box because it is so close to the deck and could electrocute a crewmember. He pointed out that the deck drain to the laundry room doesn't always work and the water often overflows the drainpipe.
- In the shower room, there are two hot water heaters whose thermostats are set so high that there is a danger of scalding and that the hot water heaters are not fitted with safety valves normally found upon hot water heaters.
- The emergency lights that illuminate the vessel's four liferafts did not work and the electrician could not find why they did not work.
- The vessel's single sideband radio reportedly did not work.
- The compass deviation card did not exist and there was no evidence that the compass ever was calibrated.
- The tachometers for both main engines were inoperative.
- The cook complains of electric shocks when he touches the stove and the deep fryer.
- reported lack of support from appropriate company personnel when he reported a badly frayed mooring cable on one of the "four-point" anchors. He was subsequently unable to recover the cable using his anchor winch. He noticed the problem and expressed concern that divers would be working underwater in the vicinity of a frayed anchor cable that was likely to part. Such a frayed cable, or even a cable with only a few "fishhooks," has the potential of causing significant personal injury to a diver underwater. Rather than to continue to use the cable, he cut the damaged cable, buoyed it off for future recovery, and returned the boat to shore to change out the damaged cable with the intent to return to the dive site in open water in South Timbalier Block 140. For making this decision and apparently based on the additional expense it incurred, he was terminated and replaced by the company. This led him to believe that this company placed profit above personal safety.
- also reported that the company does not use lift bags to support the weight of the steel cable as the vessel moves into position over an underwater site – in this case a pipeline valve. It appears that the maneuver ruptured the valve or pipeline as shown by the photos and an "Incident Summary" reported by the supervisor. He cited a superior system used by Cal-Dive on their vessels. He also mentioned that workers for Cal-Dive are not expected to work over the side of the vessel with the type of safety implications explained below.

The most significant item, however, dealt with the status of the vessel's four-point mooring system as described from detailed phone notes passed on to the Coast Guard inspectors our Association asked to look into the matter.

The vessel's four anchors were attached directly to steel cables which are lowered and raised by winches – one on each side of the bow and stern. These anchors are held outboard of the hull by a metal framework called (and resembling) a "cow catcher" preventing the anchor shanks from being pulled into a hawsepipe as on a conventional offshore supply vessel. The four winches spool the four wire ropes onto four drums and do not use chain. Therefore, the deck machinery is classified as winches and NOT windlasses. They work with 7,000 lb. anchors.

When the anchor is lifted it is pulled up to the "cow catcher" with the flukes held under the cow catcher framework. The anchor is secured to the "cow catcher" by tension in the cable that is held by a handbrake and by constant air pressure. The handbrake alone will not hold the anchor. If air pressure fails, the anchor can drop suddenly. Consequently, when underway or at the dock the anchor is secured to a padeye on top of the bulwarks and directly to the swivel on the top of the anchor by a short length of approx. 5/16-inch chain. This chain is independent of the anchor and must be put in place manually. On this particular vessel, the bulwarks have not always been strong enough to support the weight of a 7,000 lb anchor. Consequently they repeatedly bend, and are reinforced by welding, and then bend again. In addition, part of the strength of the bulwarks was removed by cutting the swinging door in the bulwarks.

Our concern is with the method of securing the anchor to the cow catcher. In order to secure the anchors on the bow, a mariner must open one of the swinging steel door cut out of the bulwarks on the port and starboard side giving access to the cow catcher. He must step out onto a small platform about a half-foot below the main deck level, while holding on to the bulwarks. Finally, he must hold onto a sheave (or roller) over which the anchor cable

passes. He must then go to his knees on the small exterior platform only about one and one half to two feet wide that is directly above the anchor secured to the cow catcher. The anchor flukes are pointing upward to the inside of the cow catcher. The platform is often greasy as a result of the grease used to lubricate the sheave. Excess grease drips or sprays from the sheave onto the small platform making the footing dangerous.

Once on his knees, the mariner then holds on to the vessel with one hand while kneeling on the small platform outboard of the hull and constrained by his work vest. He must then accept a piece of chain fed to him by another crewmember on deck, reach down to his full arm's length with his other hand and thread the chain through the eye of the swivel attached to the shank of the anchor. He must then take the loose end of the chain and, after pulling as much slack out as possible by hand, rise from his knees, and apply a chain binder so the anchor will remain in place at sea. All this takes place outboard of the vessel's hull.

Apparently, three or four men are required to participate in this process. However, the Master reported that **no restraints or harnesses are used to secure the mariner who remains outboard of the bulwarks.**

We asked the Coast Guard, at the next dockside inspection of this vessel, that the crew be asked to perform this evolution and that it be evaluated in its entirety by the Officer-in-Charge Marine Inspection to ensure the safety of the participating mariners.

Our concern is based on the possibility that a mariner without proper restraint harness would slip from the small platform outboard of the hull and injure himself falling on the crown of the anchor held in place by the "cow catcher." Also **consider that this evolution must be performed offshore in a seaway** even though we only ask its demonstration take place dockside. Also consider that during cold winter months, the temperature of the Gulf waters approaches the 59 degree cold water survival threshold of NVIC 7-91 and that recovery operations may be restricted by the vessel's role in offshore construction activities. We also ask that the use of a safety harness be evaluated under actual working conditions.

On Nov. 27, 2006 we reported that the M/V Jillian Morrison was at her dock and urged that the Marine Safety Unit send out an inspector. After going through a FOIA request to Headquarters seeking information in regard to the requested inspection, we received a very abbreviated report that led us to make this statement in a letter to the Commanding Officer of MSU Morgan City on Mar. 7, 2007. "(I cited)...a unique situation that apparently exists on that vessel that the Master was particularly concerned about. I would hope that the inspectors were given a copy of our letter before visiting the vessel. However, I do not see whether this particular area of concern was addressed during their visit. The area was of concern because it requires seamen to work outside the bulwarks of the vessel in open water. I believe to check that, it would be necessary to determine whether the evolution in question could be performed safely by the crewmembers in the opinion of the inspectors. Perhaps this was checked, but I cannot determine from the inspection report. Perhaps the Coast Guard is not allowed to put crewmembers in danger by actually performing the evolution. If not, a demonstration or explanation citing the safety equipment available or in use probably would suffice considering the conditions that were normally reported existing on the vessel as described in our letter."

[NMA Comment: We never received a reply to our letter from the Commanding Officer of the Coast Guard Marine Safety Unit in Morgan City, LA. The question became moot after the Jillian Morrison exploded, sank, and was scrapped. We chose not to follow the case beyond this point.]

[NMA Comment: The Court of Appeals affirmed most of the District Court's decisions in this case and the results devastated Chief Engineer Leon Manderson.]

**IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT**

United States Court of Appeals
Fifth Circuit

FILED

January 3, 2012

Lyle W. Cayce
Clerk

No. 10-31063

LEON MANDERSON,

Plaintiff - Appellant - Cross-Appellee

v.

CHET MORRISON CONTRACTORS, INCORPORATED,

Defendant - Appellee - Cross-Appellant

Appeals from the United States District Court
for the Western District of Louisiana

Before SMITH, BARKSDALE, and BENAVIDES, Circuit Judges.

RHESA HAWKINS BARKSDALE, Circuit Judge.

Leon Manderson challenges the denial of his claims under the Jones Act and general maritime law and of his costs; Chet Morrison Contractors, Inc. (CMC), challenges the amount Manderson was awarded for cure and his being awarded attorney's fees, including the amount. Primarily at issue are: the district court's application of the collateral-source rule in determining the amount of cure awarded Manderson; and the court's finding CMC's maintenance-and-cure denial was arbitrary and capricious, resulting in Manderson's being awarded attorney's fees. **AFFIRMED** in part; **MODIFIED** in part; **VACATED** in part; **REMANDED** for entry of judgment consistent with this opinion.

No. 10-31063

I.

In November 2006, Manderson began working for CMC as a licensed engineer aboard a CMC dive vessel, the M/V JILLIAN MORRISON, operating in the Gulf of Mexico. In January 2008, Manderson, aboard another CMC dive vessel, left it abruptly and was hospitalized, receiving treatment for ulcerative colitis, diabetes, and a liver condition. He did not return to work.

That June, Manderson filed this action. He maintained CMC was liable under the Jones Act, 46 U.S.C. § 30104, *et seq.*, for violating various work-hours statutes and Coast Guard safety regulations, contending these violations constituted negligence *per se*. He also claimed relief under general maritime law, maintaining the JILLIAN MORRISON was rendered unseaworthy by CMC's violation both of manning statutes and of its certificate of inspection, and by failing to repair the vessel's marine sanitary device. Manderson requested: general damages for Jones Act negligence, the unseaworthiness of the JILLIAN MORRISON, exacerbation of his ulcerative colitis, the removal of his colon, and his diabetes diagnosis; special damages for treatment of his medical conditions and lost earnings; and maintenance and cure, including all medical expenses incurred since 24 January 2008 (with no deduction for medical payments by Manderson's insurer), cost-of-living expenses recoverable under *Hall v. Noble Drilling*, 242 F.3d 582 (5th Cir. 2001) (food and lodging), and attorney's fees for CMC's claimed arbitrary-and-capricious denial of maintenance and cure.

CMC demanded a jury trial. Before trial, the district court, *inter alia*: granted summary judgment to CMC against Manderson's claim for maintenance, cure, and damages relating to his Hepatitis C and his alleged need for a liver transplant, finding no medical evidence linking that condition with his CMC employment; granted Manderson's motion *in limine*, excluding evidence of medical expenses paid by Manderson's insurer; granted his motion to amend his complaint pursuant to Federal Rule of Civil Procedure 9(h) (permitting

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designation of claims as admiralty or maritime and, consequently, negating right to jury trial), and his corresponding request to change from a jury, to a bench, trial; and granted his motion to add a punitive-damages claim regarding CMC's denial of maintenance and cure, but denied his motion to add such a claim regarding CMC's termination of Manderson's group-health insurance.

After a two-day bench trial, the district court denied relief under the Jones Act and general maritime law, but awarded maintenance and cure and attorney's fees incurred in obtaining that relief. *Manderson v. Chet Morrison Contractors, Inc.*, No. 08-CV-881, 2010 WL 3035491 (W.D. La. 2 Aug. 2010) (First Opinion). The court subsequently ruled CMC was liable for \$14,680 for maintenance and \$169,691.06 for cure. Second Amended Reasons for Judgment, 30 Sept. 2010 (Second Opinion). Regarding its attorney's-fees finding in the First Opinion, the court found CMC had acted "in an arbitrary and capricious manner in failing to pay maintenance and cure" and, as a result, awarded Manderson \$110,950 in attorney's fees and costs on those claims. *Id.* Later, the court denied the parties' Federal Rule of Civil Procedure 54(d) motions for costs, explaining, regarding Manderson's request: he had already been awarded costs on his successful maintenance-and-cure claims, and no other costs would be awarded because he did not prevail on other claims. Ruling on Costs, 2 Feb. 2011 (Third Opinion).

II.

Manderson challenges denial of his claims under the Jones Act and general maritime law and of his costs. CMC challenges the amount awarded for cure; attorney's fees being awarded; and the amount of that award. Not challenged are Manderson's being awarded maintenance and cure and his *not* being awarded punitive damages, in addition to attorney's fees, regarding CMC's maintenance-and-cure denial.

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Evidence for the bench trial included: testimony from Manderson, Captain Plain (worked aboard JILLIAN MORRISON with Manderson), DeBlieux (CMC representative), Commander Sharpe (CMC's expert on vessel operation, manning, and Coast Guard regulations), and Captain Billiot (worked aboard JILLIAN MORRISON before Manderson); depositions of Guiliani (clerk, wiper, and oiler aboard JILLIAN MORRISON who assisted Manderson in engine room), Leonard (worked briefly as Manderson's replacement as engineer aboard JILLIAN MORRISON), and physicians who treated Manderson; and the JILLIAN MORRISON vessel logs, Manderson's medical and insurance records, and correspondence between CMC and Manderson regarding payment of his medical bills.

"In an action tried on the facts without a jury . . . , the court must find the facts specially and state its conclusions of law separately." FED. R. CIV. P. 52(a)(1). "Findings of fact, whether based on oral or other evidence, must not be set aside unless clearly erroneous"; and, especially critical in this instance, "the reviewing court must give due regard to the trial court's opportunity to judge the witnesses' credibility". *Id.* 52(a)(6).

"In a bench tried admiralty case, a district court's [rulings] concerning negligence and causation are findings of fact [and, consistent with Rule 52(a)(6),] reviewable by this court only for clear error." *Johnson v. Cenac Towing, Inc.*, 544 F.3d 296, 303 (5th Cir. 2008). "A finding is clearly erroneous when the appellate court, viewing the evidence in its entirety, is left with the definite and firm conviction that a mistake has been made." *Bertucci Contracting Corp. v. M/V ANTWERPEN*, 465 F.3d 254, 258-59 (5th Cir. 2006) (citation and internal quotation marks omitted). Re-stated, our court may not find clear error "[if] the district court's finding is plausible in light of the record as a whole", even if this court "would have weighed the evidence differently". *Id.* at 258.

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A.

As discussed, Manderson challenges denial of his Jones Act and general-maritime-law claims. He asserts CMC is liable under the Act for violating various regulations, contending these violations constitute negligence *per se*. In seeking relief under general maritime law, he maintains the JILLIAN MORRISON was unseaworthy. Review is for clear error. *E.g.*, *Cenac Towing, Inc.*, 544 F.3d at 303 (Jones Act claims); *Jackson v. OMI Corp.*, 245 F.3d 525, 528 (5th Cir. 2001) (unseaworthiness claim). Based on our review of the record, we are *not* left with requisite “definite and firm conviction that a mistake has been made”. Accordingly, the findings denying these claims are not clearly erroneous.

1.

“The Jones Act allows an injured seaman to sue his employer for personal injuries suffered as a result of the employer’s negligence.” *Park v. Stockstill Boat Rentals, Inc.*, 492 F.3d 600, 602-03 (5th Cir. 2007) (citing 46 U.S.C. § 30104(a)). “Under the doctrine of negligence *per se*, a Jones Act employer may be liable if its violation of a statutory duty causes injury to its seaman-employee.” *Id.* at 603. Manderson sought negligence-*per-se* recovery under the Jones Act, presenting the following claims: (a) CMC failed to provide him with rest periods, as mandated by 46 C.F.R. § 15.1111(a); (b) it failed to provide personnel, qualified under 46 C.F.R. § 15.1103(c), to relieve him from duty and allow him to rest; and (c) it failed to post a watch schedule, in violation of 46 C.F.R. § 15.1111(g).

a.

Regarding the claim that CMC failed to provide Manderson with the rest periods required by 46 C.F.R. § 15.1111(a), that regulation provides:

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Each person assigned duty as officer in charge of a navigational or engineering watch, or duty as a rating forming part of a navigational or engineering watch, on board any vessel that operates beyond the Boundary Line shall receive a minimum of 10 hours of rest in any 24-hour period.

The district court ruled the evidence presented by Manderson not sufficient to find CMC violated 46 C.F.R. § 15.1111(a), stating he “failed to provide [it] with any evidence of [his] work schedule while on board the M/V JILLIAN MORRISON”. First Opinion, 2010 WL 3035491, at *4. The court noted: although Manderson “testified that he worked sixteen to eighteen hours per day, the [court] was not provided any objective evidence regarding his work schedule”. *Id.*

Manderson contends: the court erred because it failed to acknowledge CMC’s testimony, as well as that of former JILLIAN MORRISON personnel Captain Billiot, clerk and engine-room assistant Guiliani, and engineer Leonard, that: CMC worked JILLIAN MORRISON engineers an average of 16-18 or more hours per day, without adequate relief; Manderson worked virtually alone his first five months aboard the vessel and remained on-call 24 hours a day; and, in any event, he could not have offered time records at trial because CMC did not keep them for its engineers.

Among other evidence on this issue, Manderson testified: he never kept a log showing he worked more than 12 hours per shift; he voluntarily worked long hours because he wanted to make more money and improve the vessel; and, when the CMC office instructed him to work a 12-hour shift, with Guiliani working the other 12-hour shift, Manderson refused to do so. Commander Sharpe, CMC’s expert on Coast Guard regulations, testified: as a chief and licensed engineer, Manderson was ultimately responsible for ensuring he got enough rest. And Captain Plain, who served with Manderson aboard the JILLIAN MORRISON, testified: Manderson set his own hours; he never

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observed Manderson working more than 12 hours per shift; and Manderson never complained about his work schedule.

b.

For the claim that CMC failed to provide qualified personnel to relieve Manderson from duty, as mandated by 46 C.F.R. § 15.1103(c), that regulation provides:

[N]o person may employ or engage any person to serve, and no person may serve, in a rating forming part of a watch in a manned engine-room, nor may any person be designated to perform duties in a periodically unmanned engine-room, *except for training or for the performance of duties of an unskilled nature*, unless the person serving holds an appropriate, valid [International Convention on Standards of Training, Certification and Watchkeeping for Seafarers] certificate or endorsement in accordance with part 12 of this chapter.

(Emphasis added.) The district court ruled against this claim because Manderson failed to present evidence of his work schedule but stated, had he done so, “the Court may have found that [CMC] was in violation of this regulation by providing [Manderson] with [able-bodied seamen] instead of skilled help in the engine room”. First Opinion, 2010 WL 3035491, at *5.

Manderson contends the court erred because: proof that CMC violated the regulation is not contingent upon showing excessive work hours; and Manderson, Captain Billiot, and ship’s clerk and engine-room assistant Guiliani testified CMC assigned unskilled deck crew as Manderson’s relief.

The record reflects that, generally, CMC assigned crew to Manderson to perform duties “of an unskilled nature”, *see* 46 C.F.R. § 15.1103(c), such as checking the automated engine room when Manderson was not present. (An automated engine room is one monitored by alarm systems and sensors, so that the vessel can be safely operated without having someone in the engine room at all times.) The only evidence showing the assistants may have done anything

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more than unskilled-nature work was when Manderson trained and assigned them to do so, or when Guiliani, who had experience repairing helicopter motors in the Army, became an oiler and CMC assigned him to split shifts with Manderson. Moreover, Manderson testified: the crew assigned to assist him were “qualified, capable, and competent”; and he would have relieved them of their duties were they otherwise. Additionally, Commander Sharpe—CMC’s expert on vessel operation, manning, and Coast Guard regulations—testified that the JILLIAN MORRISON was properly manned, in accordance with Coast Guard regulations and the vessel’s certificate of inspection (COI).

c.

Regarding the claim that CMC failed to post a watch schedule, in violation of 46 C.F.R. § 15.1111(g), that regulation provides:

The Master shall post watch schedules where they are easily accessible. They must cover each affected member of the crew and must take into account the rest requirements of this section as well as port rotations and changes in the vessel’s itinerary.

The district court found that CMC “fail[ed] to post watch schedules which would have informed [Manderson] of when he was to rest”. First Opinion, 2010 WL 3035491, at *5. Nevertheless, the court found it was not “practical within *this industry* for masters of vessels manned with such a *small crew* to post a rest schedule”. *Id.* (emphasis added).

Manderson contends: the court erred in finding 46 C.F.R. § 15.1111(g) did not apply to Manderson’s vessel; and the regulation does not exempt from its application “this industry”, the dive-vessel industry, or vessels with “small crews”.

The JILLIAN MORRISON’s COI, issued by the Coast Guard, provides the “vessel may operate with: one (1) master, one (1) chief engineer, one (1) able seaman, one (1) licensed mate, [and] one (1) ordinary seaman”. Commander

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Sharpe testified: watch was not required for the JILLIAN MORRISON's engine room because it was an unmanned engine room; rather, the engine room was monitored on an "on-call" basis, a less-demanding status for which there were no Coast Guard regulations; and the vessel was in full compliance with Coast Guard watch requirements.

Moreover, even if this regulation was applicable, the district court found that its violation could not have *caused* the claimed injuries from lack of rest. The court reasoned: "[Because] it was ultimately up to the crew members to rest as they saw needed[,] [t]he Court cannot assume that the posting of a watch schedule would have compelled [Manderson] to rest more". First Opinion, 2010 WL 3035491, at *5.

d.

Regarding his Jones Act claims, Manderson asserts: under the Act, an employee's claimed contributory negligence is disregarded where a safety-statute violation contributes to the employee's injuries; the district court erred in finding Manderson totally responsible for his injuries by negligently remaining on call 24 hours a day; and the court erred in failing to shift to CMC the burden of showing its statutory or regulatory violations could not have caused, or exacerbated, Manderson's medical problems.

As discussed, the district court did not clearly err in finding Manderson did not establish a violation of any statute or Coast Guard regulation. Therefore, it was not necessary to address negligence *per se*, comparative fault, or burden shifting.

2.

In seeking recovery under general maritime law for unseaworthiness, Manderson contests the rejection of his claim that the JILLIAN MORRISON was unseaworthy due to CMC's failure to man it with the crew required by the vessel's COI. (In addition, he makes several references to the vessel's marine

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sanitary device, asserting that it was defective and that he routinely removed overflowed sewage. Although evidence on this point was presented at trial, Manderson does not link this to claimed unseaworthiness. Accordingly, this point is waived for inadequate briefing. FED. R. APP. P. 28(a)(9)(A).)

To be seaworthy, a vessel and its appurtenances must be reasonably fit for their intended uses. *Mitchell v. Trawler Racer, Inc.*, 362 U.S. 539, 550 (1960). Included among the numerous reasons for which a vessel can be unseaworthy is that “her crew [is] unfit” or “[t]he number of men assigned to perform a shipboard task [is] insufficient”. *Usner v. Luckenbach Overseas Corp.*, 400 U.S. 494, 499 (1971). Plaintiff bears the burden of establishing unseaworthiness and that it caused his injuries. *Garcia v. Murphy Pac. Marine Salvaging Co.*, 476 F.2d 303, 305 (5th Cir. 1973).

Manderson contends: the vessel lacked a mate required by its COI, as well as additional qualified engine-room personnel; CMC’s decision to operate its vessel without having a scheduled, licensed, competent person on board who could fully relieve Manderson rendered the vessel unseaworthy; and the district court’s finding it could not find the vessel unseaworthy due to a “minor violation of the COI” is clearly erroneous.

Commander Sharpe testified: even under the most restrictive reading of the JILLIAN MORRISON’s COI, only one chief engineer was required aboard the vessel; the COI did *not* require any other crew for the engine room; and the vessel was manned in accordance with its COI.

When referring to CMC’s “minor violation of the [COI]”, First Opinion, 2010 WL 3035491, at *6, the district court was apparently referring to its earlier finding that the COI required, *inter alia*, two licensed mates, and that there was “evidence to support a finding that [CMC] only equipped its vessel with one mate”. *Id.* The court rejected this violation as a ground for Manderson’s unseaworthiness claim—a finding on causation—because: “[Manderson] claims

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that only the improper manning of the engine room is what caused his alleged injuries, not the manning of the deck”. *Id.* The standard for establishing causation for an unseaworthiness claim is demanding. *Smith v. Trans-World Drilling Co.*, 772 F.2d 157, 162 (5th Cir. 1985) (unseaworthiness claim requires showing “(1) the unseaworthiness played a substantial part in bringing about or actually causing the injury and that (2) the injury was either a direct result or a reasonably probable consequence of the unseaworthiness”). It was plausible for the court to find causation was lacking.

B.

CMC challenges the district court’s application of the collateral-source rule for determining the amount of cure awarded Manderson. Cure is the shipowner’s obligation to pay necessary medical services for seamen injured while in its service. It and its maintenance counterpart have been recognized for centuries. *Hall v. Noble Drilling*, 242 F.3d 582, 586 (5th Cir. 2001) (discussing “venerable history” of maintenance and cure). The cure obligation was first recognized in this country in *Harden v. Gordon*, 11 F. Cas. 480 (C.C.Me. 1823) (No. 6,047) (Story, J.).

In an issue that appears to be of first impression, CMC contends the cure award should not have included the difference between the amount Manderson’s medical providers charged and the lesser amount they accepted from his insurer as full payment. *De novo* review applies. *E.g., Jauch v. Nautical Servs., Inc.*, 470 F.3d 207, 212 (5th Cir. 2006) (findings of fact underlying maintenance-and-cure award reviewed for clear error; conclusions of law, *de novo*).

A shipowner’s obligation to provide cure to an injured seaman is an implied term of a maritime-employment contract and “does not depend on any determination of fault”. *Jauch*, 470 F.3d at 212. “Thus, an owner of a vessel is

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almost automatically liable for the cost of medical treatment . . . when a seaman in its employ is injured.” *Brister v. A.W.I., Inc.*, 946 F.2d 350, 360 (5th Cir. 1991).

The pre-trial order granting Manderson’s motion *in limine* precluded CMC from “referring to or seeking to introduce evidence of payment by [Manderson’s] medical insurers of his medical expenses”. Contrary to Manderson’s assertion here, this does not preclude CMC’s referring to such evidence on appeal. Even assuming, *arguendo*, the order applied to prohibit evidence at trial *and* to calculation of damages, *see Davis v. Odeco, Inc.*, 18 F.3d 1237, 1243 (5th Cir. 1994) (collateral-source rule can apply as evidentiary rule or as substantive rule of damages, or both), Manderson introduced his insurance records at trial, showing both the amounts charged for his medical care and the lesser amounts his insurer paid, and thus waived his objection. *United States v. Truitt*, 440 F.2d 1070 (5th Cir. 1971) (“It is settled law that one waives his right to object to the admission of evidence if he later introduces evidence of the same or similar import himself.”).

The collateral-source rule appears incompatible with maintenance and cure. “The collateral source rule is a substantive rule of law that bars a tortfeasor from reducing the quantum of damages owed to a plaintiff by the amount of recovery the plaintiff receives from other sources of compensation that are independent of (or collateral to) the *tortfeasor*.” *Davis*, 18 F.3d at 1243 (emphasis added). A majority of state courts addressing the matter hold the collateral-source rule prohibits in *tort actions* a reduction of compensatory damages by the difference between the amount billed for medical services and the amount paid. *E.g., Koffman v. Leichtfuss*, 630 N.W.2d 201, 210 (Wis. 2001); *Acuar v. Letourneau*, 531 S.E.2d 316, 322 (Va. 2000). *Contra Hanif v. Housing Authority*, 246 Cal. Rptr. 192, 194-95 (Cal. Ct. App. 1988).

On the other hand, and as discussed above, maintenance and cure is an implied term of contract for maritime employment and is not “predicated on the

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fault or negligence of the shipowner". *Bertram v. Freeport McMoran, Inc.*, 35 F.3d 1008, 1013 (5th Cir. 1994) (citation and internal quotation marks omitted); *Davis*, 18 F.3d at 1246 (shipowner's "duty to pay maintenance and cure . . . is unrelated to any duty of care under tort law"). Accordingly, "[b]ecause of the unique nature of maintenance and cure, normal rules of damages, such as the collateral source rule in tort, are not strictly applied". *Gauthier v. Crosby Marine Serv., Inc.*, 752 F.2d 1085, 1089 (5th Cir. 1985).

Nevertheless, our court has identified an exception to this general rule: "[W]here a seaman has *alone* purchased medical insurance, the shipowner is not entitled to a set-off from the maintenance and cure obligation moneys the seamen receives from his insurer". *Id.* at 1090 (emphasis added). Our court reasoned: "[T]he policy of protecting injured seamen would be hampered if a shipowner, in hopes of reducing his liability, delayed maintenance and cure in order to force seamen to look first to their private insurer". *Id.* Thus, insofar as it can be said the collateral-source rule applies to awards of maintenance and cure, it is in this context.

Manderson was awarded maintenance and cure for the period 24 January 2008-26 January 2009. The court found: between 24 January and 1 March 2008, Manderson was responsible for paying approximately half of his health-insurance premiums; and, for the remaining 11 months of that period, he paid all of them. Having found Manderson purchased his own medical insurance, the court, consistent with our precedent, made no deduction from the cure award for *payments by Manderson's insurer*. But, in doing so, the court found the amount of cure was the greater amount *charged by Manderson's health-care providers*.

CMC contends: the appropriate amount for cure was the lesser amount those *providers accepted as full payment from Manderson's insurer*. We agree.

CMC identifies no caselaw addressing its contention, nor have we found any. On the other hand, our court has repeatedly held an injured seaman may

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recover maintenance and cure only for those expenses "actually incurred". *E.g.*, *Davis*, 18 F.3d at 1246; *Boudreaux v. United States*, 280 F.3d 461, 468 (5th Cir. 2002). Accordingly, the relevant amount is that needed to satisfy the seaman's medical charges. This applies whether the charges are incurred by a seaman's insurer on his behalf and then paid at a written-down rate, or incurred and then paid by the seaman himself, including at a non-discounted rate. Thus, in Manderson's case, regardless of what his medical providers charged, those charges were satisfied by the much lower amount paid by his insurer. Consequently, the district court erred by awarding the higher, charged (but *not* totally paid) amount.

Manderson's payment of health-insurance premiums benefitted CMC. Had he not paid them, it is unlikely Manderson would have been able to negotiate payment of his medical charges as low as his health insurer did, and CMC would have been obligated to pay a higher amount. Although this benefit conferred on CMC may, as discussed above, have presented a problem in the tort context (with CMC paying compensatory damages), it is not a problem here, where fault is not an issue and CMC is liable only for maintenance and cure.

In awarding Manderson the amount equal to what was charged for his medical services, rather than the amount accepted as full payment, the district court went beyond the scope of cure. As a result, the award of cure is modified. The district court arrived at its cure award, \$169,691.06, after deducting amounts charged for medical services outside the appropriate time period and for services unrelated to Manderson's ulcerative colitis and diabetes. Second Opinion, at 2. Based on these findings, which are not challenged here, but using the amount paid by Manderson's health insurer, rather than the amount charged, we hold Manderson is entitled to recover \$71,085.79 for cure.

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C.

Arbitrary-and-capricious denial of a seaman's request for maintenance and cure can result in the employer's being liable for the seaman's attorney's fees. *Morales v. Garijak, Inc.*, 829 F.2d 1355, 1358 (5th Cir. 1987), *abrogated on other grounds by Guevara v. Maritime Overseas Corp.*, 59 F.3d 1496 (5th Cir. 1995). Based upon its finding CMC "acted in an arbitrary and capricious manner in failing to pay maintenance and cure", the district court awarded Manderson "attorney's fees and costs incurred in the prosecution of his claim for maintenance and cure in the amount of \$110,950.00". Second Opinion, at 3.

CMC contests this on several grounds. And, in a related issue, Manderson challenges the denial of his separate motion for costs. We review for abuse of discretion. *Breese v. AWI, Inc.*, 823 F.2d 100, 102-03 (5th Cir. 1987) (arbitrary-and-capricious finding); *Schwarz v. Folloder*, 767 F.2d 125, 131 (5th Cir. 1985) (costs award).

1.

CMC contests the finding that its maintenance-and-cure denial was arbitrary and capricious. CMC contends the court erred because: it made no underlying findings in support of that ultimate finding; and the record does not support it.

To prove an employer's conduct was arbitrary and capricious, a seaman must do more than prove the employer's conduct was unreasonable. *Morales*, 829 F.2d at 1358. Rather, it is only when the employer "has exhibited callousness and indifference to the seaman's plight" that it becomes liable for attorney's fees. *Id.* Our court has described this "higher degree of fault" as "egregiously at fault", "recalcitrant", "willful", and "persistent". *Id.*

In its First Opinion, the court did not find that CMC had been arbitrary and capricious; rather, without explanation, the court awarded Manderson "attorney fees incurred in the pursuit of maintenance and cure". 2010 WL

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3035491, at *8. In its Second Opinion, the court stated only: "This Court finds [CMC] acted in an arbitrary and capricious manner in failing to pay maintenance and cure".

a.

In district court, CMC presented evidence to support its contention that Manderson was not owed maintenance and cure: he had experienced similar flare-ups of his ulcerative colitis before working for CMC; before requesting maintenance and cure, he filed for short-term and long-term disability, claiming his ulcerative colitis was *not* work-related and, in doing so, sent CMC a copy of the claim, which included a form filled out by Manderson's doctor stating the same; the district court had already found Manderson failed to disclose one condition, Hepatitis C, and, thus, was not entitled to maintenance and cure for it; Manderson failed to reveal his pre-existing history of high glucose levels and diabetes at the time he was hired; when he left the CMC vessel in January 2008 and was hospitalized, he failed to file an injury report with the company; and he voluntarily worked long hours. Although the district court ultimately rejected this contention, and CMC does not here challenge the court's awarding maintenance and cure, the supporting evidence for the contention cuts against the related arbitrary-and-capricious finding.

Furthermore, upon receiving a formal demand for maintenance and cure from Manderson's counsel, CMC promptly referred the matter to its underwriter to investigate the claims, and the underwriter did so. Finally, that only approximately two months passed after Manderson requested maintenance and cure before he filed this action also militates against an arbitrary-and-capricious finding.

Therefore, CMC's conduct cannot be found to be "egregiously at fault", "recalcitrant", "willful", "persistent", *etc.* Accordingly, the requisite bases are

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lacking for, and the district court clearly erred in, finding CMC arbitrary and capricious in denying maintenance and cure to Manderson.

b.

Because attorney's fees can be awarded only for an arbitrary-and-capricious denial, *Morales*, 829 F.2d at 1358, the attorney's-fees award is vacated. As a result, we need not reach CMC's challenge to the amount awarded.

2.

In contesting the denial of his Rule 54(d) motion for costs, Manderson contends: that Rule creates a presumption in favor of awarding costs to the prevailing party; Manderson is the prevailing party because the court, *inter alia*, granted maintenance-and-cure claims; the court denied his motion for costs as the prevailing party, stating it already awarded him attorney's fees and costs in connection with his maintenance-and-cure claims, but this was error, because the court awarded attorney's fees but not costs; and the court also erred in providing no reason for its denial of costs.

As Manderson points out, there is a strong presumption under Rule 54(d)(1) that the prevailing party will be awarded costs. *Schwarz*, 767 F.2d at 131. Accordingly, a district court "may neither deny nor reduce a prevailing party's request for cost without first articulating some good reason for doing so". *Id.* (citation and internal quotation marks omitted). The district court denied Manderson's costs request because: Manderson had "already been awarded attorneys fees and costs, on its successful maintenance and cure claims"; and "although [Manderson] is not precluded from moving for costs, he did not prevail on any of his other claims". Third Opinion, at 1.

It is unclear whether Manderson has been awarded any costs. Although the final judgment stated CMC was "liable to [Manderson] for attorney's fees and costs incurred in the prosecution of his claim for maintenance and cure"

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(emphasis added), Manderson's application in that regard included only attorney's fees. Any costs awarded in that instance, however, would relate only to Manderson's maintenance-and-cure claims, whereas an award under Rule 54(d) would cover costs incurred on his other claims.

Nevertheless, the court's explanation that Manderson did "not prevail on any of his other claims", combined with the court's willingness to assume in the same order, *arguendo*, that CMC was the prevailing party, provides sufficient justification for its costs denial. Third Opinion, at 1. See *In re Corrugated Container Antitrust Litigation*, 756 F.2d 411, 418 (5th Cir. 1985) ("The jury found for the plaintiffs in part and for the defendants in part. The trial court acted within its discretion" in denying costs to defendants.). This is even more so, in the light of our vacating or modifying a substantial part of the relief granted by the district court. Accordingly, there was no abuse of discretion.

III.

For the foregoing reasons, the judgment is AFFIRMED in part; MODIFIED in part; and VACATED in part; and this matter is REMANDED for entry of judgment consistent with this opinion.



NMA REPORT #R-344-A, Rev. 1

DATE: July 6, 2010

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

MARINER RIGHTS – MAINTENANCE AND CURE

[Source: By Mark L. Ross, Esq., 600 Jefferson Street, Suite 512, Tel: (337) 266-2345. FAX (337) 266-2346.
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The National Mariners Association wants to keep its membership informed of basic rights under maritime law. From time to time, we will discuss certain legal rights which, although often hundreds of years old, are just as often forgotten by boat companies.

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. 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 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 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 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. NMA 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.

The Townsend Decision: Should Vessel Owners Deny Maintenance and Cure?

[Source: By Lawrence R. DeMarcay, III is a partner at Fowler Rodriguez Valdes-Fauli in the firm's New Orleans, La. office. He can be reached at ldemarcay@frvf-law.com or 504-595-5122.]

Unfortunately, as a vessel owner or operator, you have probably been faced with a situation where one of your crew members have allegedly become sick or injured while in the service of the vessel. As you are aware, once this injury or illness is reported to the company, the duties of providing maintenance and cure under the Jones Act begin. Unfortunately, instances of fraud where the employee may not have suffered the injury or illness that he or she is complaining of seem to be common. In these situations where the alleged injury may not be legitimate, vessel owners have been wrestling with the dilemma as to whether or not to provide the employee with maintenance and cure benefits.

Prior to the summer of 2009, the courts did not allow injured seamen to recover punitive damage awards in cases where a vessel owner refused to provide an injured seaman with maintenance and cure benefits. As such, in cases where there may have been issues relating to the veracity of the seaman's complaint, there was no real penalty for the vessel owner denying such benefits. Although there were several strategic reasons for paying, or not paying, these benefits, punitive damages were not part of the decision making process.

However, the United States Supreme Court, in June of 2009, ruled in Atlantic Sounding Company v. Townsend that a ship owner who willfully or wantonly refuses to provide medical care to a seaman who was injured while in the service of the vessel could be subjected to punitive damages. This Supreme Court ruling has drastically changed the strategies associated with the decision to pay, or not pay, maintenance and cure benefits.

To better understand the issues presented to vessel owners by this recent Supreme Court ruling, it is important to provide a brief analysis of a vessel owner's maintenance and cure obligation. A vessel owner's liability for maintenance and cure is similar to a shore based employer's requirement to supply workers compensation benefits. Essentially, a seaman has a right to recover maintenance and cure as a result of injuries or sickness accruing while he is in the service of the vessel. The right does not depend upon the seaman proving that the vessel owner was negligent or that the vessel was unseaworthy. As such, maintenance and cure should be provided until the employee reaches maximum medical improvement from his illness or injury. The cure obligation includes all nursing, medicines, doctor and hospitalization related to the illness. The maintenance obligation includes the provision of a per diem to compensate the seaman for the room and board that he or she received while aboard the vessel.

The standard of proving a case that a seaman is entitled to maintenance and cure benefits is easy. The employee only has to show that an injury or illness occurred while the employee was in the service of the vessel. It is very difficult for a vessel owner to win a maintenance and cure claim unless it is a clear case of fraud on behalf of the employee.

Although the injured seaman's case is very easy to make, prior to Townsend, there was no real penalty for a vessel owner refusing maintenance and cure. Vessel owners have pursued two different strategies for defending these claims. One, the vessel owner could deny maintenance and cure benefits to the injured seaman and, if it believed that the seaman would retain an attorney and file suit, file a pre-emptive declaratory judgment action in federal court seeking an order from the court stating that the payment of maintenance and cure benefits is not necessary. However, sending this clear message to the employee that the company does not believe that he or she sustained a compensable injury almost always prompts the employee to retain an attorney who will file suit on the worker's behalf. The other option is to pay the costs associated with maintenance and cure while reserving the right to defend any liability based lawsuit filed by the injured worker. Although the second option is far less aggressive with regard to the maintenance and cure claim, it is a much better strategy in the long term when it comes to defending a negligence or unseaworthiness claim brought by the injured worker against the vessel owner. One, a seaman that is receiving benefits is less likely to file suit. Two, courts usually award maintenance and cure to injured workers during trial if the employer is unable to show conclusively that there was no injury or that fraud was involved. Thus, employers taking the high road and paying maintenance and cure, which is usually not very expensive, can minimize the chance of a larger judgment being rendered against the company later.

However, the Supreme Court's ruling in Townsend changed the analysis that vessel owners must make in this situation. Now that the courts can award punitive damages and attorneys' fees against vessel owners for the willful denial of maintenance and cure benefits, injured workers now have leverage that they can use to obtain benefits. It is important to note that the Supreme Court did not rule that vessel owners should be subject to punitive

damages, they only ruled that they could be subjected to punitive damages. This leaves a considerable amount of discretion to the trial courts in determining which situations warrant such an award.

The Townsend court reached its conclusion based upon three theories of admiralty and common law. First, **punitive damages have long been available at common law as a remedy for willful or outrageous conduct.** Second, the general rule that punitive damages were available at common law extends to claims arising under federal maritime law. Finally, nothing in the Jones Act or general maritime law undermines the applicability of punitive damages to the maintenance and cure concepts. As such, a fact finder, whether it be a judge or a jury, can evaluate the facts of each situation and determine (1) whether an employee is entitled to maintenance and cure benefits, (2) whether the employer's denial of benefits was willful, and (3) whether punitive damages and attorneys' fees should be awarded to the seaman for the denial of such benefits. Furthermore, the Townsend court did not rule as to the amount of punitive damages that could be awarded. As such, substantive due process rules apply and the court should look to easily calculable formulas to determine punitive damages.

The Supreme Court, in previous cases, has stated that very few punitive damage awards that exceed a single digit ratio between the punitive and compensatory damages will satisfy substantive due process requirements. Thus, as the courts work out the details surrounding the award of punitive damages for the denial of maintenance and cure benefits, **they will probably be limited to punitive awards that are no more than ten times the compensatory damage award.** Although this limit on the size of the award will keep judges or juries from issuing awards that are beyond the scope of reason, these awards will still be significant. For example, if a court awards an injured seaman a \$300,000 compensatory damage award for serious personal injuries that he suffered, the court could award a punitive damage award of \$3 million dollars.

In addition to evaluating the likelihood and amount of a potential punitive damage award, it is also important to consider that **most insurance policies do not provide a vessel owner insurance coverage for a punitive damage award.** By nature, punitive damage awards are meant to punish the offender. **It is against public policy to have insurance policies that provide coverage for punitive damages.** If covered, the award would no longer serve as a deterrent from the unwanted conduct.

As the courts continue to grapple with the issue of whether to award punitive damages or not, vessel owners are left in a position of uncertainty. Although no appellate level decisions have been rendered, several district courts have evaluated the Townsend language and reached different conclusions. Although all of the courts that have cited Townsend have noted that punitive damages could be awarded, not all of them have decided to do so with others making such an award.

Considering the Supreme Court's ruling in Townsend, it would be prudent for all vessel owners to review their pending personal injury files to determine if proper maintenance and cure has been provided. Furthermore, as new claims are administered, **it makes sense to provide maintenance and cure benefits to all employees that suffer an illness or injury while in the service of the ship unless there is some clear indication of fraud.** Even if you are able to avoid punitive damages for the denial of such benefits, the easy standard applicable to a maintenance and cure claim virtually guarantees that such claims will be paid in the end. As such, there is no need to risk a punitive or attorney's fee award for the denial of benefits that you will ultimately pay in the end.

REPORT ALL INJURIES

United States law, 46 United States Code, 10603, requires each seaman on a fishing vessel, fish processing vessel, or fish harvesting vessel to notify the master or person in charge of the vessel or other agent of the employer regarding any illness, disability, or injury suffered by the seaman when he or she returns to the vessel not later than seven days after the date on which the illness, disability, or injury arose.

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ENCL

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Asserting our right "...to petition the Government for redress of grievances."

Amendment 1, U.S. Constitution, Dec. 15, 1791

ALL UPDATES BEYOND May 22, 2013 APPEAR IN RED

INDEX "R" – RESEARCH REPORTS (R) BIBLIOGRAPHY

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NEW (2013) POLICY ON RESEARCH REPORTS AVAILABILITY

Introduction: The National Mariners Association (NMA) is a non-profit mariner membership organization. You can read about us on our website, www.nationalmariners.us. Our Association gathered and compiled many documents to inform and instruct an estimated 126,000 licensed and unlicensed "limited-tonnage" credentialed merchant mariners. These mariners serve on U.S.-Flag commercial vessels such as tugs, towboats, offshore supply vessels, small passenger vessels, and charter boats.

This collection took place over many years at considerable expense in time and effort. Until we can post the text of these reports on our website, call us at (985-851-2134) and leave a message with your e-mail address and indicate the report(s) you need.

We encourage those who need our Research Reports to become members of the National Mariners Association for \$36.00 per year to support the stated goals of our Association.

We hope the report(s) you read will be helpful. To cover our expenses, we would appreciate a donation of any size. You may use "PayPal" on our website to pay membership dues or to make a donation. All membership dues and donations fund the work of our Association on behalf of limited-tonnage merchant mariners.

[**Editorial note:** The Board of Directors voted to change the legal name of the Association to the National Mariners Association (NMA) from Gulf Coast Mariners Association (GCMA) effective Jan. 1, 2008.]

☐ = Reports that are currently available.

p. = The number of printed pages in a report.

"Congress" = When the word "Congress" appears in bold letters in a report title, or is highlighted, it means that our Association delivered a copy of this report to the appropriate Congressional Committee and/or Subcommittee or staff members.

Hours of Service Issues: [Also see NMA reports #R-302, #R-370, Rev. 4 & entire #R-370 Series; #R-408 & #R-408-A]

☐ R-201. May 2000. Mariners Speak Out on Violation of the 12-Hour Work Day. 200p.

Personal Injury. [Also see #R-205, Issue 7; #R-292, Rev. 1; #R-338; #R-350, Rev. 5, Issue "Y"; #R-429, Rev. 1; #R-429-I]

☐ R-202, Rev. 5. Nov. 1, 2011. Deplorable Treatment of "Limited Tonnage" Mariners. (Don't Count on Corporate Compassion or Coast Guard Concern: True Stories of Our Dead, Injured & Cheated Mariners). 66p.

☐ R-202-B. May 13, 2010. Coast Guard and OSHA Miss the Boat on Maritime Safety and Health Issues. [Contains OSHA Directive CPL 2-1.20, that delineates OSHA/USCG Authority Over Vessels.] 34p.

☐ R-202-C, Rev. 2. July 7, 2010. OSHA Regulates Uninspected Dry Cargo and Work Barge Safety. 18p.

☐ R-202-D, Oct. 15, 2012. Offshore Operation of Unmanned Cargo Barges in the Gulf of Mexico. 72p. [Comments on Petition for Rulemaking Docket USCG-2011-0925.]

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☐ R-203, Aug. 1, 2009. How a "Bill" Becomes a Law. 4p.

- ☐ R-203-A, June 11, 2009. Maritime Workforce Development Act. [H.R. 2651, 111th Congress]
- ☐ R-203-F, Nov. 4, 2010. Coast Guard Authorization Act of 2010 – Important Sections for Our Limited Tonnage Mariners. 7p.
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Coast Guard's Administrative Law System [Also see #R-429 Series Reports.]

- ☐ R-204, Rev. 4. March 29, 2012. The Coast Guard "Injustice" Handbook. A Guide to the Administrative Law System [Also See #R-429-L and R-429-Q.]
- ☐ R-204-A, April 13, 2010. Administrative Law Judges: An Overview. [Reprint of Congressional Research Service Report prepared for members and committees of Congress]. 12p.
- ☐ R-204-B, July 14, 2010. U.S. Coast Guard Prevention Programs – A Tale of Mismanagement. [Includes reprint of Dep't of Homeland Security report titled: "Independent Evaluation of the U.S. Coast Guard Prevention Program – Marine Safety and Environmental Protection."]
- ☐ R-204-C, Rev. 6. April 25, 2011. Insure Your Credential – Protect Your Career. 12p. [License Defense Insurance]

Mariner Safety, Health & Welfare Issues [Also see major NMA Report #R-370, Rev. 4.]

- ☐ R-205, Rev. 1. April 7, 2012. Report to Congress: Outstanding Failures to Protect the Safety, Health, and Welfare of 126,000 Limited Tonnage Merchant Mariners 37p. [Editorial note: This report updates and utilizes information from the following reports in the #R-370 series listed below and other reports in order to present our case to Congress to protect our mariners' safety, health and welfare. Listed in order of appearance in Report #R-205, Rev. 1.]

- ☐ R-429-I, Rev. 2. Mar. 24, 2007. Investigations: Enforcement of Existing Personal Injury Reporting Requirements (Replaces report #R-291, Rev. 1) 7p.
- ☐ R-395, Rev. 4. Sept. 24, 2012. Report to Congress – Providing Safe Potable Water for Merchant Vessels. 10p.
- ☐ R-455, Rev. 6. Mar. 28, 2013. Food Service Aboard Commercial Vessels Served by our Mariners. 3p.
- ☐ R-349. Jan. 20, 2003. Protecting Mariners' Hearing. 8p.
- ☐ R-349-A. Dec. 23, 2009. Supporting Documentation for NMA Report #R-349. 46p.
- ☐ R-341, Rev. 4. June 22, 2011. Petition to Congress: To Curb On-Board Smoking to Promote Merchant Mariner Health. 6p.
- ☐ R-341-A. Jun. 29, 2006. The Health Consequences of Involuntary Exposure to Tobacco Smoke. Executive Summary of 2006 Surgeon General's Report. [Reprint.] 28p.
- ☐ R-440-D. Sept. 11, 2012. Merchant Mariner Medical Issues. 11p.
- ☐ R-445, Rev. 1. Mar. 8, 2012. Report to Congress: Coast Guard Failed to Protect Mariners from Asbestos. 10p.
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- ☐ R-202-B. May 13, 2010. Coast Guard and OSHA Miss the Boat on Maritime Safety and Health Issues. [Contains OSHA Directive CPL 2-1.20, that delineates OSHA/USCG Authority Over Vessels.] 34p.
- ☐ R-202-C, Rev. 2. July 7, 2010. OSHA Regulates Uninspected Dry Cargo and Work Barge Safety. 18p.

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- ☐ R-206. Feb. 22, 2010. If the Question Concerns STCW – Our Answer Remains "NO"! 20p.
- ☐ R-206-A, Rev. 1. Apr. 6, 2010. "NO" to Further Implementation of STCW-95 Amendments. 7p.
- ☐ R-206-B, June 22, 2011. IMO ECDIS Model Course. 2p.
- ☐ R-206-C. Aug. 24, 2011. International Convention on Standards of Training, Certification, and Watchkeeping, 1978, and Changes to Domestic Endorsements. [NMA Comments on STCW Docket #USCG-2004-17914.]. 27p.

Maintaining a Lookout

- ☐ R-207, Rev. 1. Jan. 20, 2010. Training and Posting Lookouts. 15p. [Also see R-275, Rev. 3, Nav. Bridge Visibility]
- ☐ R-207-A. Feb. 6, 2010. Lookout Training. 19p.
- ☐ R-207-B. Apr. 14, 2010. Rule 5 – Maintaining A Proper Lookout. [Contains 2010 Decision by ALJ Bruce T. Smith.] 30p.
- ☐ R-207-C. Nov. 7, 2011. Maintaining a Proper Lookout: The 2010 "Duck Boat" Accident at Philadelphia.

Offshore Supply Vessel (OSV) Issues [Also see Reports #R-207, Rev. 1; #R-230, #R-238, #R-274, #R-299; #R-311.]

- ☐ R-208. Sept. 30, 2010. Lessons from Major Offshore Supply Vessel Accidents. 40p.
- ☐ R-209. Aug. 11, 1999. Offshore Supply Vessels. [Comments submitted to Docket #USCG-1999]. 26p.

Mariner Whistleblower Protection

- ☐ R-210, Rev. 2. Aug. 17, 2011. Whistleblower Protection for Merchant Marine Officers. By Stephen Chouest, LLM Admiralty. 12 pgs.
- ☐ R-210-A. Feb. 6, 2013. Whistleblower Protection for Merchant Marine Officers. Procedures for the Handling of Retaliation Complaints Under the Employee Protection Provision of the Seaman's Protection Act (SPA) as Amended. OSHA Interim Final Rule. 24p.

Mariner Employment Issues. [Also see Reports #R-276-D and #R-350, Rev. 5, Issue "X"]

- R-211. Rev. 1. Mar. 19, 2011. Headhunting – An Illegal Mariner Employment Practice. 8p.
- R-211-A. Jan. 20, 2011. Background Paper on the Maritime Activities of the International Labour Organization. By Bjorn Klerck Nilssen, Chief, Maritime Industries Branch, International Labour Office (ILO), Geneva, Switzerland (Sept. 1998). 13p.

Pilothouse Visibility Issue

- R-212. June 29, 2011. Report to the 112th. Congress – Pilothouse Visibility Issues on Towing Vessels. 8p.]

Mariner Appeals to the Public

- R-213, May 10, 2012. Blood on Brown Water. 74p.

Mariner Medical, Public Health, and Welfare Issues

- R-214. Sept. 24, 2012. Report to Congress on Merchant Mariner Medical Issues. 14p! [Editorial note: This report updates and utilizes information from the following reports cited in enclosures in this report to present our case to Congress to better protect our mariners' safety, health and welfare.]

- R-350-Y. May 1, 2012. Report to Congress: Mariner Indictment of Careless Personal Injury Reporting Practices. 274p.
- R-370, Rev. 4. March 2012. Report to Congress: Abuse of Mariners Under the Two-Watch System. 176p.
- R-349. Jan. 29, 2003. Protecting Mariner Hearing. 8p.
- R-341, Rev. 4. June 22, 2011. Petition to Congress: To Curb On-Board Smoking to Promote Merchant Mariner Health. 6p.
- R-455, Rev. 4. Mar. 6, 2012. Food Service Aboard Commercial Vessels Served by our Mariners. 3p.
- R-445, Rev.1. Mar. 8, 2012. Report to Congress: Coast Guard Failed to Protect Mariners from Asbestos. 10p.
- R-378. Sep. 22, 2003. Hydrogen Sulfide – A Danger to Mariners. 9p.

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- R-215, Rev. 1, Mar. 24, 2011. How to Contact Members of Congress on Maritime Issues. 5p.
- R-216. Oct. 1, 1999. Defining the Difference Between Lines of Demarcation and Boundary Lines. 2p.
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- R-230. Jan. 17, 2000. Rescue boats and platforms required on Offshore Supply Vessels. [Also see #R-354] 10p.

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- R-233. Dec. 1, 1999. GCMA Comments on Notice of Proposed Rulemaking for Outer Continental Shelf (OCS) Activities. [33 CFR Subchapter N; Docket #USCG-1998-3868] 20p.

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- R-242. Apr. 24, 2000. Gulf Coast Mariners Association's (GCMA) First Year's Accomplishments. 3p.
- R-247. Rev.1, Apr. 26, 2004. Violation of Laws and Regulations. 2p.
- R-253. Sept. 3, 2003. Problems Facing Lower-Level Mariners. 37p.
- R-274. Navigation and Vessel Inspection Circular No. NVIC 1-78 [OSV Engineerroom Automation]. 8p. \$2.60.
- R-275. Rev.3, Aug. 24, 2004. Navigation Bridge Visibility. [By Captain David C. Whitehurst] 11p.

Towing Vessels – Inspection & Employment [Also See #R-212.]

- R-276. Rev. 10. Oct. 5, 2011. Report to Congress: Proposed Towing Vessel Inspection Regulations Missed the Mark. 59p. [Available on the internet at www.regulations.gov as document #USCG-2006-24412-0023, including 211 pages of enclosures. Most enclosures are reports listed in this index.]

- R-276. Rev. 4, Feb 14, 2003. Towing Vessel Regulatory Standards. 204p.
- R-276. Rev. 8, Feb. 1, 2005. Towing Vessels Must Be Regulated Like Every Other Inspected Vessel. 36p.
- R-276. Rev. 9. June 1, 2005. Towing Vessels Must Be Regulated Like Every Other Inspected Vessel. 46p.

- R-276-A. Nov. 9, 2006. Towing Vessel Inspection. Mariner Suggestions & Initiatives Submitted to the TSAC Towing Vessel Inspection & Licensing Work Groups. 36p.
- R-276-C. Jan. 26, 2111. "Examination" of Towing Vessels is not "Inspection" – The Background of the Towing Vessel "Bridging" Program. 7p.
- R-276-D, Rev. 6. March 15, 2012. The Towing Industry is a Poor Career Choice 24p.
- R-276-E. Aug. 15, 2011. Inspection of Towing Vessels. [NPRM of Aug. 11, 2011 + NMA comments] 77p.
- R-276-H. Aug. 20, 2011. Towing Vessel Inspection NPRM – NMA Letter to the Docket. 4p. [Discusses USCG failure to include hours-of service and work performance issues in proposed rulemaking.]

- ☐ R-276-I. Oct. 26, 2011. NMA Comments Submitted to Docket #USCG-2006-24412: Inspection of Towing Vessels. [In the public meeting held on Oct. 26, 2011 in Kenner, LA.] 6p.
- ☐ R-276-J. Nov. 16, 2011. Comments Submitted to Docket #USCG-2006-24412: Inspection of Towing Vessels. By Capt. John R. Sutton, Past President of the American Inland Mariners Association (AIM). 34p.
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- ☐ R-287-B. Nov. 14, 2002. TOAR (Great Lakes/Inland) Performance Assessment Criteria. 10p.
- ☐ R-287-C. Nov. 14, 2002. TOAR (Western Rivers) Performance Assessment Criteria. 11p.
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- ☐ R-293-B. Rev. 7. May 22, 2013. Request for Rulemaking to Address Overhead Clearance Accidents. 17p. [Previously numbered #R-411, Rev. 4 and #R-293-B, Rev. 6.]
- ☐ R-293-C. Apr. 25, 2005. Allision Involving the M/V Brownwater V and the Queen Isabella Causeway Bridge, Port Isabel, Texas Sept. 15, 2001. 37p. [USCG Report Reprint. Also see Report #R-399.]
- ☐ R-300. Jan. 9, 2002. Chao, Secretary of Labor vs. Mallard Bay Drilling, Inc. [Reprint of U.S. Supreme Court Decision] 10p.
- ☐ R-301. Uninspected Towing Vessel Workplace Safety Considerations. 42p.
- ☐ R-302. Guide for Investigating for Fatigue. [Reprint of Transportation Safety Board of Canada report]. 26p.

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- ☐ R-304. Rev.1, June 25, 2006. Small Boat Station Search and Rescue Program. [Reprint: DOT Audit of this USCG program.]

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- ☐ R-305. Rev.1. Oct. 2002! Betrayed – A Call for Increased Congressional Oversight of the United States Coast Guard [S/B Morning Dew Accident] 6p.
- ☐ R-309. Mar. 20, 2002. Stacked Deck: Death on the High Seas. 3p.
- ☐ R-310. April 5, 2002. Response to OMSA's Report on Crew Alertness in the Offshore Industry. 49p.

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- ☐ R-315-B. Dec. 27, 2004. Drug Testing: Refusal to Test. 9p.
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- ☐ R-315-F, Rev. 1. Aug. 2009. Marine Employers Drug Testing Guidance. [Reprint of USCG Pamphlet, Aug. 2009.] 62p.
- ☐ R-315-G. Mar. 23, 2012. What Happens When Your Past "Crimes" Return to Haunt You? 16p. [Also see #R-436, Rev. 3 & #R-448, Rev. 1.]

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USCG Assessor's Manual

☐ R-324. Assessor's Manual for Conducting Mariner Assessments. [USCG. DOT, 2000. Reprint. 16p.

☐ R-325. Dec. 2, 2002. Maritime Terrorist Threat Assessment for the New Orleans Area. 11p.

☐ R-326. Rev. 1, Jan. 14, 2005. Autopilots, Watchkeeping, and Voyage Planning. 6p.

☐ R-334. Rev.2. Dec. 27, 2005. Foreign Seamen on U.S.-Flag Vessels 11p.

☐ R-338. Nov. 11, 2002. Which Agency Regulates Uninspected Towing Vessels? [Also see #R-202-B.] 5p.

Maritime Accidents: Oversize and Overloaded Tows.

☐ R-340. Rev.9. Feb. 20, 2008. NMA Report to Congress: Safety Problems With Oversize and Overloaded Tows. 37p.

☐ R-340-A. Apr. 5, 2007. Oversize and Overloaded Tow Accident: The "Elizabeth M" Case. 7p.

☐ R-340-B. Feb. 18, 2008. U.S. Court of Appeals, Seventh Circuit. Larry Gwin v. American River Transportation Co. (ARTCO) 7p.

☐ R-343. Dec. 23, 2002. Forgotten Safety Issues on Small Passenger Vessels. 7p.

Mariner Rights

☐ R-344. Rev.2. Oct. 25, 2008. Mariner Rights. 16p.

☐ R-344-A. Rev. 1. July 6, 2008. Mariner Rights: Maintenance and Cure 3p.

☐ R-344-B. July 3, 2010. Identifying Jones Act Claims by Lee J. Bloomfield, Esq. 5p.

☐ R-349. Rev. 1. Sept. 24, 2012. Report to Congress – Protecting Mariner Hearing. 8p.]

☐ R-349-A. Dec. 23, 2009. Supporting Documentation for NMA Report #R-349. 46p.

Mariners Request Congressional Assistance

☐ R-350. Rev. 7, April 5, 2013. Limited Tonnage Mariners Seek Congressional Assistance Marine Safety, Health, and Work-Related Issues. 32p.]

☐ R-350-A. Sept. 16, 2008. NMA Testimony Before House Subcommittee on Coast Guard and Maritime Transportation RE: Mississippi River Oil Spill, July 23, 2008. 2p.

☐ R-350-B. Mar. 14, 2011. Meet Our Mariners and Consider Our "Limited Tonnage" Mariners' Viewpoints. 10p.

☐ R-350-Y. Rev. 1. July 4, 2013. Report to the 113th. Congress: Coast Guard Careless Personal Injury Reporting & Enforcement Practices. ___ pgs.

Towing Industry. [Also see Reports #R-366; #R-401-A; #R-426; #R-427.]

☐ R-351. Rev.1. Oct. 24, 2006. How Safe Is The Towing Industry? 20p.

☐ R-351-A. Rev.1. Oct. 28, 2010. Safety Issues on Towing Vessels. 13p.

☐ R-352. Mar. 17, 2003. Unfair Labor Practices in the River Industry. 3p.

☐ R-353. Rev.2. July 3, 2006. Lower-Level Mariners Are a Majority of U.S. Merchant Mariners. 7p.

Lifesaving and Firefighting Issues

☐ R-354. Rev. 4. (Series). Mar. 21, 2009. An Appeal to the 111th. Congress on Lifesaving Issues that Affect Our Limited Tonnage Mariners. 41p.

☐ R-354-A. (Series) Jan. 8, 2008. Basic Survival: The Regulatory Struggle for "Out-of-Water" Lifesaving Equipment. [Contains detailed Correspondence with NTSB] 42p.

☐ R-354-C. Mar. 4, 2010. "Ring Buoys, Regulators and Other Marine Hazards – What You Don't Know Can Kill You." By Paul Driscoll. 7p.

☐ R-355. Rev. 1. Feb. 17, 2003. Maritime Security Issues. [Also see R-325]. 12p.

☐ R-356. Mar. 28, 2003. Detained on Board [Apostleship of the Sea Newsletter reprint.] 10p.

☐ R-357. Rev., May 23, 2001. The Prestige's Oozing Sparks Debate [Article, *Insight Magazine*.- Pollution and Revolving Door Policy] 2p.

☐ R-361. Rev. 1. June 1, 2006. Gulf Intracoastal Waterway, Morgan City – Port Allen Alternate Route, and the Bayou Sorrel Bridge & Lock. 9p.

- ☐ R-363. Apr. 3, 2003. Report From the Subcommittee on Lifboat Operations to the National Offshore Safety Advisory Committee of the U.S. Coast Guard. [Reprint of NOSAC Report.] 12p.
- ☐ R-364. Apr. 3, 2003. Remarks of Captain Roland Rodney to NOSAC. 2p.
- ☐ R-366. May 1, 2003. The Plight of Towing Vessel Personnel. 5p.
- ☐ R-368. Rev.1. June 6, 2006. Controversial Rulemaking: Fire Suppression Systems and Voyage Planning for Towing Vessels. 15p.

R-370 (Series) – 12-Hour Rule Violations

- ☐ R-370, Rev. 4. March 2012. Report to Congress: Abuse of Mariners Under the Two-Watch System. 176p. *[Editorial note: This report updates and utilizes information from the remaining reports in the #R-370 series listed below and other reports in order to present our case for improved Hours-of-Service legislation from Congress. A list of other reports cited in this report, request a copy of NMA File # GCM-313. Includes USCG Policy Letter G-MOC-04-00 Rev. 1]*

- ☐ R-370-A, Rev. 2. (Series). May 19, 2007.. Report to Congress: Fifth Anniversary of the Webbers Falls I-40 Fatal Bridge Accident! Unresolved Issues Revisited. 12p..
- ☐ R-370-B, Rev.4. June 1, 2006. Violation of the 12-Hour Rules: The Tug Chinook Strikes & Damages The Lake Washington Bridge. 14p.
- ☐ R-370-D. Rev. 6. June 18, 2009. Whistleblower Protection, Work-Hour Abuse, and “Deadhead Transportation.” 16p. *[Key words: Feemster v. Titan; Garrie v. James L. Gray; Meaige v. Hartley cases]*
- ☐ R-370-E. July 6, 2006. Crew Endurance: Work-Hour Laws and Regulations Need Review. 8p.
- ☐ R-370-F July 6, 2006. Crew Endurance Management Systems. *[Renumbered – formerly #R-362]* 9p.
- ☐ R-370-G Rev. 1. Jan.25, 2012. Crew Endurance: The Call Watch Cover-up. *[Renumbered from #R-375.]* 14p.
- ☐ R-370-H. Mar. 14, 2006. 12-Hour Rule Violations: Harbor Tugs and The “One-Watch” System. 4p.
- ☐ R-370-I. Apr. 19, 2008. Safe Management of Crew Travel Time.
- ☐ R-370-K. June 16, 2003. 12-Hour Rule Violations: The Verret Case. 12 p.
- ☐ R-370-L, Rev. 1. Nov. 18, 2009 The National Transportation Safety Board Views on Fatigue and Hours of Service Regulations. 21p.
- ☐ R-370-M. Aug. 12, 2010. The Miss Amanda Incident: Overworked, Undermanned and Violating the 12-Hour Rule. 2p.
- ☐ R-370-N. Oct. 11, 2012. CG-CVC Policy Letter #12-05. Hours of Rest – Implementation of the 2010 Amendments to the International Convention on Standards of Training, Certification, and Watchkeeping for Seafarers, 1978. 9p.

- ☐ R-372. Rev.1. June 25, 2003. Questions About Towing Vessel Officer Licensing and Manning. 16p. *[Provides useful background material but is not current.]*
- ☐ R-376. EEOC. Federal Laws Prohibiting Job Discrimination. Questions and Answers. 12p.

Administrative Clemency

- ☐ R-377. Rev. 3. Oct. 16, 2012. Administrative Clemency. 17p.
- ☐ R-378. Sep. 22, 2003. Hydrogen Sulfide – A Danger to Mariners. 9p.

- ☐ R-381. Nov. 23, 2003. Extinguishing the Federal Right of Way- A Mariner Issue *[Gassoway Lake Case.]* 3p.
- ☐ R-382. Dec. 8, 2003. Why Our Mariners Don’t Get the Message, 4p.
- ☐ R-383. Rev.3. Nov 18, 2006. Designated Examiner Qualifications: The Good, The Bad, and The Ugly. 14p.
- ☐ R-386. Jan. 18, 2004. Comparative Report: Towboats in Canada and the United States. 3p.
- ☐ R-389. Jan. 18, 2004. The Notice of Violation (NOV) Program. 4p.

Maritime Accident – Towing Vessels *[Also see #R-340-A; #e-429-D; #R-433; #R-433-A]*

- ☐ R-390. Feb. 14, 2004. Loss of the Tug Thomas Hebert off the New Jersey Coast Fails to Bring Needed Changes. [“Tripping”] 7p.
- ☐ R-390-A. Mar. 5, 2010. Sinking of the M/V Elizabeth M and 6 Barges with Four Fatalities on Jan. 9, 2005 at the Montgomery Locks & Dam, Ohio River Mile Marker 31.7. 60p. *[Also See Report #R-340-A.]*
- ☐ R-393. Mar. 11, 2004. USCG Licensing Procedures: An Affront to Lower-Level Mariners. 16p. *[Provides useful background material but is not current.]*

Potable Water and Food Service.

- ☐ R-395, Rev. 4. Sept. 24, 2012. Report to Congress – Providing Safe Potable Water for Merchant Vessels. 14p.
- ☐ R-395-A, Dec. 23, 2009. Supporting Documentation for NMA Report #R-395 (Food Service). 133p. *(See #R-455, Rev. 4)*
- ☐ R-395-B, Dec. 23, 2009. Supporting Documentation for NMA Report #R-395 (Potable Water). 64p.
- ☐ R-396. May 1, 2004. How Western Rivers Mariners Lost Their Administrative Law Judge. 4p.
- ☐ R-397. May 8, 2004. Father Sinclair Oubre Speaks for All Mariners on Elimination of Crew List Visa. 3p.
- ☐ R-398. Dec. 1, 2005. Crew Van – Death Van? *[By Captain David C. Whitehurst.]* 5p.

Maritime Accident – Oversize and Overloaded Tow. [Also see #R-390A-; #R-42; #R-427.]

- R-399. Jun. 14, 2004. Danger on the Illinois Waterway: Towboat Pilot Loses License After He Accepts High Risk Assignment. 10p.
- R-400, Rev.8. Aug. 12, 2004. Oversize and Overloaded Tows: Towing Vessel Horsepower. 18p.

Historical Documents (Series). [Also see #R-428-C; #R-429-B; #429-F; #428-A; #428-B; #428-C.]

- R-401, Rev. 1. Mar. 8, 2005. Crew Endurance and the Towing Vessel Engineers – A Direct Appeal to Congress. 30p.
- R-401-A. Uninspected Towing Vessels: An Analysis of the Historical and Contemporary Issue of Their Regulation. July 1980 [By Thomas Alegretti. Formerly #R-231, Rev. 1]. 86p. [Key Words: Pilothouse Licensing Act.]
- R-401-B. Jan. 8, 2007. Finally Answered: How Bureaucracy Wrecked the Coast Guard Merchant Marine Licensing and Documentation Computer System. [Information from a 1998 FOIA Request.] 4p.
- R-401-C. Dec. 2005. Acquisition of the National Security Cutter. [Reprint of Department of Homeland Security, Office of the Inspector General, Report #OIG-07-23.] 140p.
- R-401-D. Mar. 21, 2006. U.S. Coast Guard. Report on Demonstration Project: Implementing the Crew Endurance Management System (CEMS) on Towing Vessels. 98p.
- R-401-E. Feb. 12, 2008. Marine Safety: Where the Coast Guard Went Wrong. 36p. [Reprint of a report by VADM James C. Card (USCG, Ret'd) titled "Coast Guard Marine Safety Analysis: An Independent Assessment and Suggestions for Improvement" dated 16 Nov. 2007 with NMA commentary.] [Also see #R-442]
- R-401-F. Feb. 2007. 110'/123' Maritime Patrol Boat Modernization Project. [Reprint of Department of Homeland Security, Office of the Inspector General, Report #OIG-07-27]. 34p.
- R-401-G. Feb. 29, 2008. Renewed Efforts in the Marine Safety Program. 7p. [Reprint of ALCOAST messages from the Commandant and Assistant Commandant for Marine Safety, Security, and Stewardship.]
- R-401-H. Jan. 6, 2009. Coast Guard Issues Marine Safety Performance Plan (2009-2014).
- R-401-I. Dec. 5, 2009. The Posse Comitatus Act and Homeland Security. By John R. Brinkerhoff (Feb. 2002). 6p.
- R-401-J. Sept. 2000. Offshore Accountability Watch. 16p.
- R-401-K. May 16, 2011. HR-1288 – World War II Merchant Marine Service Act. 20p. [By Don Horton, Coastwise Merchant Seaman's Association.]
- R-401-L. July 7, 2011. Problems in Coast Guard Licensing: 1986-1999. 11p.
- R-401-M. Apr. 15, 1999. Review of Working Conditions in the Offshore Oil Industry - 1999. 10p.
- R-401-N. Jan. 19, 1999. The 12/24 Hour Rule by LCDR Tom Beistle. 18p.
- R-401-P. Nov. 7, 2012. A Report to Congress Concerning the Need for Engineers on Uninspected Towing Vessels. 58p. (Reprint, U.S. Department of Transportation, May 1973).
- R-402. July 14, 2004. Ballast Water Management. 20p.
- R-403. Sept. 19, 2004. Stress and the Licensed Mariner. 20p.
- R-404. Oct. 19, 2004. Substance Abuse: Employee Assistance Programs. 4p.
- R-405. Rev. 1, June 13, 2013. Relinquishing Control of Your Vessel. [Formerly #R-204.] 8p.

Fatigue. [Also see #R-401-; #R-403]

- R-408. 2004. MAIB Bridge Watchkeeping Safety Study. [Reprint of UK Gov't Report] 52p.
- R-408-A. Oct. 24, 2008. Seafarer Fatigue: Wake Up to the Dangers. [Reprint of Report by International Transport Workers Federation]. 9p.
- R-409. Feb. 13, 2005. What is a Safety Management System for Towing Vessels? 10p.

Vessel Engineers Injuries & Fatalities.

- R-412, Rev. 1 March 21, 2013 Report to Congress: Towboat Engineer's Death Points to Vessel Manning Issues. 21p.
[Note: For other fatalities related to American Commercial Lines (ACL) see NMA Reports #R-293-C, #R-433, #R-433-A.]
- R-412-A. Rev. 1. Mar. 14, 2012. In Search of Justice for Chief Engineer Leon Manderson. 36p.
- R-413. Rev. 1, Feb. 11, 2006. A Direct Appeal to Congress to Reform the Two-Watch System. 21p.

Coast Guard Mismanagement of Limited Tonnage Mariners. [Also see #R-324; #372; #R-383; #R-393]

- R-415. Rev. 2. (Series) Nov. 25, 2006. Coast Guard Mis-management of Lower Level Merchant Marine Personnel: Training and Licensing Problems for Towing Vessel Officers. 12p.
- R-415-B. Rev. 1. (Series) Nov. 27, 2006. Medical & Physical Evaluation Guidelines for Merchant Mariner Credentials. 62p.
- R-415-C. Jan. 1, 2009. Our Association Petitions the Coast Guard to Relax Restrictions on 100-Ton Towing Officer Licenses and Endorsements. 10p.

Towing Safety Advisory Committee. [Also see #R-384, Rev. 1; #R-417, Rev. 2; #R-421]

- R-417. Rev. 1, Feb. 25, 2007. Report to the 110th Congress: Request for Congressional Oversight on the Towing Safety Advisory Committee. (TSAC). 11p.
- R-417. Rev. 2, Oct. 10, 2011. Report to the 112th Congress: Request for Continued Congressional Oversight on the Towing

- Safety Advisory Committee (TSAC). 10p.
- R-417-A. Rev. 1, Aug. 27, 2008. Comments on Revising NVIC 4-01, "Licensing and Manning for Officers of Towing Vessels" to the Towing Safety Advisory Committee. 9p.
 - R-417-B. June 16, 2011. NMA Comments to the Towing Safety Advisory Committee Meeting, June 16, 2011. Docket #USCG-2011-0144, 12p.

Charts and Publications:

- R-420. Rev. 1. Nov. 24, 2005. Correcting and Maintaining Your Nautical Charts and Publications. 8p.
- R-420-A. June 25, 2008. Nautical Charts and Coast Guard Inspections. 5p.
- R-421. Nov. 22, 2005. GCMA Suggestions for an Apprentice Mate/Steersman Model Training Course. [Suggestions presented to TSAC]. 4p.
- R-426. Rev. 1. Aug. 27, 2007. Report to Congress: Challenges Facing the Coast Guard's Marine Safety Program - Effectively Regulating the Towing Industry. 14p. [Key Words: Dry Cargo Barges; Construction Barges; OSHA]
- R-427. Mar. 24, 2005. ARTCO-Six Mariners Stand Up Against Intimidation to Move Oversize & Overloaded Tows. 16p.

Maritime Education and Training. [Also see #R-415-A; #R-415-B]

- R-428. Rev. 1. Oct. 23, 2006. Report to Congress: The Forgotten Mariners. Maritime Education & Training for Entry-Level Deck & Engine Personnel. [By Richard A. Block & Glenn L. Pigott.] 30p.
- R-428-A. Oct. 28, 2006. Maritime Education & Training for Lower-Level Mariners. The Newman Report. [Includes complete reprint of 1973 Government Report on the status of maritime education and training in the Gulf Coast area that led to major licensing changes.]
- R-428-B. Rev. 1. Dec. 30, 1996. Report of the Coast Guard-AWO Quality Action Team on Towing Vessel Crew Fatalities. [Reprint of 1996 AWO/Coast Guard Report.] 78p.
- R-428-C. Oct. 29, 2006. Maritime Education and Training: Functional Job Analysis (FJA) of Maritime Personnel. [Includes reprint of 1982 Government Report on vessels in the offshore oil industry.] 55p.
- R-428-D. Feb. 13, 2007. Report to the 110th Congress: Substandard Coast Guard Merchant Marine Personnel Services. 55p.
- R-428-D, Rev. 1. May 1, 2009. Report to the 111th Congress: Substandard Coast Guard Merchant Mariner Personnel Services. 21p.
- R-428-H. Apr. 15, 2007. Maritime Education & Training: Lower-Level Engineering Programs. 23p.
- R-428-I. July 9, 2009. Congressional Hearing Testimony on the National Maritime Center and Mariner Credentialing Subcommittee on Coast Guard and Maritime Transportation. 55p.
- R-428-K. Rev. 6. Feb. 21, 2013. Report to The Secretary of Homeland Security: Request for Audit to Define and Reaffirm the Public's Right to Access the Coast Guard's Professional Examination Question & Answer Database. 49p. [Key word: Q&A]
- R-428-L. Mar. 7, 2011. Milner v. Department of the Navy. 36p. [Key Word: Q&A]. U.S. Supreme Court decision on the meaning of the Freedom of Information Act. Cited in NMA Report #R-428-K (above).

R-429 (Series) Coast Guard Investigations and Administrative Law. [Also see Report #R-389; #R-396; #R-204, Rev. 1]

- R-429. Rev. 1, Sept. 5, 2010. NMA Report to Congress: Shortcomings in Marine Safety Investigations. 51p]
- R-429-A. Rev. 1. Mar. 20, 2007. U.S. Coast Guard Marine Casualty Investigations and Reporting: Analysis and Recommendations for Improvement By James G. Byers, Susan G. Hill, & Anita Rothblum. Interim Report, August 1994. [Reprint of the 1994 Coast Guard R&D Report.] 66p. [Gov't Report]
- R-429-B. Rev. 1. July 26, 1996. Report of the USCG Quality Action Team on Marine Safety Investigations 78p. [Gov't Report.]
- R-429-C. Rev. 1. Aug. 30, 2010. Coast Guard Marine Casualty Investigations. 12p.
- R-429-D. (Series) Oct. 8, 2006. Coast Guard Investigations: Buzzard's Bay Tank Barge Grounding and Oil Spill, April 27, 2003. 12p.
- R-429-E. Nov. 20, 2006. Accident Investigations: If You Are Involved in an Accident, Don't Expect to be Read Your Rights. [Formerly #R-374.] 2p.
- R-429-G. Rev. 2. Feb. 24, 2007. Report to Congress: Sharpening Accident Investigation Tools By Establishing Logbook Standards for Lower-Level Mariners. (Replaces Report #R-291, Rev. 1). 11p.
- R-429-I. Rev. 2. Mar. 24, 2007. Investigations: Enforcement of Existing Personal Injury Reporting Requirements. 7p.
- R-429-J. July 4, 2007. Investigations: Report to Congress - Coast Guard Abuses of the Administrative Law System. 28p.
- R-429-K. Aug. 8, 2007. Congressional Subcommittee Hears About Coast Guard Abuse of the Administrative Law System [Report on Congressional Hearing held July 31, 2007] 52p.
- R-429-M. May 9, 2008. United States Coast Guard's Management of the Marine Casualty Investigations Program. [Contains reprint of Department of Homeland Security Report #OIG-08-51 + a separate NMA introduction] 48p. [Gov't Report]
- R-429-N. July 28, 2008. Report to the 110th Congress: Maritime Towing Accidents Involving Apprentice Mates/Steersmen 24p.
- R-429-O. Aug. 11, 2008. NMA Petitions the Coast Guard to Change the ALJ System. 10p.

- R-429-P, Rev. 1. Jan. 1, 2010. Mariners Drown When "Justice Capsizes"– The Murray Rogers Case. 9p.
- R-429-Q. Mar. 21, 2009. U.S. Coast Guard versus Lt. Eric N. Shine. 34p. [Also see our reports #R-204, Rev. 1, #R-210, Rev. 2, #R-462, Rev. 3 and R-462 (Supplement)]
- R-429-S. June 26, 2009. NMA Letter to Congressional Requesters on the Government Accountability Office (GAO) Report #09-498 on the Coast Guard's Administrative Law System. 12p.
- R-429-T. Apr. 30, 2010. Geneva Conventions Re-defined by Eric N. Shine. 12p. [Also see our reports # R-204, Rev. 1, R-429-L and R-429-Q.]
- R-429-V. Aug. 20, 2010. NMA Report to Congress on DHS "Recommendations to Improve the Coast Guard's System for Adjudicating Suspension and Revocation Matters." 46p. [Includes Reprints of DHS Report #OIG-10-107.]
- R-429-W. Oct. 5, 2010. Allegations of Misconduct Within the Coast Guard Administrative Law Judge Program (Redacted). 54 p., [Reprint of DHS OIG Report #R-OIG-10-108]
- R-429-X, Rev. 1. Mar. 10, 2011. The Coast Guard Abused Captain Rogers Just Because They Could. 8p. By Capt. Murray Rogers.

Tonnage Issues

- R-430. Rev.2. June 25, 2006. What is an OSV? [ITC Tonnage vs GRT tonnage. Formerly #R-167.] 3p.

Small Passenger Vessel Casualties. [Also see #R-441]

- R-432. Aug. 15, 2006. Coast Guard Inspection SNAFU Leaves Four Dead and Many Injured and Hundreds of Boat Owners Affected. [Lady D Accident in Baltimore Harbor.] 47p.

Towing Vessel Fatalities

- R-433. Sept. 17, 2006. Towing Vessel Fatalities. GCMA Coverage of Two Accidents on TSAC Sept. 2006 Agenda. [Fatal accidents, Death of Joseph Hulen on M/V Wally Roller and the M/V A.V. Kastner accident]. 12p.
- R-436. Rev. 3, Mar. 5, 2009. The Coast Guard Appeals Process. 10p.
- R-437. Nov. 28, 2006. Ways to Retain New Crewmembers and Keep Seasoned Crews. [By Capt. David C. Whitehurst] 2p.
- R-438, Rev. 1. Mar. 12, 2008. Criminalization of Mariners. 10p.

Mariner Health & Medical Issues:

- R-440-A, Rev. 1. Sept 30, 2008. Mariner Health and the New Medical NVIC. 79p.
- R-440-B. April 13, 2009. Abuses of the Medical NVIC: An Assault on Our Mariners. 16p. [Key Words: Body Mass Index]
- R-440-C. Rev. 1. Jan. 25, 2012. Obstructive Sleep Apnea. 9p.
- R-440-D. Sept. 11, 2012. Merchant Mariner Medical Issues. 11p.
- R-441, July 21, 2007, Coast Guard Obstructs Preventive Maintenance – NTSB. 4p.
- R-442, Aug. 2, 2007, Hearing on Challenges Facing the Coast Guard's Marine Safety Program. 105p. [GCMA testified in the hearing on Aug. 2, 2007. See #R-350, Rev. 3 for our prepared testimony.]
- R-443. Aug. 13, 2004. Black Listing and the Fair Credit Reporting Act (FCRA). 8p.

Pollution Prevention & Environmental Crimes:

- R-444. Jan. 20, 2006. Bilge Water Processing Equipment: Comments to the Docket. 31p. [By Glenn L. Pigott & Richard A. Block]
- R-444-A, Rev. 1. Feb. 21, 2008. Coast Guard Environmental Crime Disclosure Policy. 12p.
- R-444-B. National Pollutant Discharge Elimination System (NPDES) – [Vessel General Permit Regulations Eff. Feb. 6, 2008.] 6p.
- R-444-C. May 24, 2010. Investigative Report on Minerals Management Service by the Department of the Interior Inspector General. 12p. [Govt Report]
- R-445, Rev.1. Mar. 8, 2012. Report to Congress: Coast Guard Failed to Protect Mariners from Asbestos. 10p.
- R-446. Rev.1. Feb. 25, 2008 Proposed Rule Changes Affect Towing Vessel Officers. 19p.
- R-447. Nov. 6, 2007, "Sailor Tax" Fraud." 24p.
- R-448. Rev. 1, July 9, 2011 Reconsider the Use of Assessment Periods in Merchant Mariner Credentialing. 11p.
- R-450. July 15, 2008. Maritime Confined Space Fatalities. [Includes MAIB report on M/V Viking Islay fatalities in OSV Chain Locker.]
- R-451. Dec. 5, 2008. Towing Vessel Officers Need Stability Training. 17p.
- R-452. Dec. 9, 2008. Towing Industry Statistics. 7p.
- R-453. Oct. 9, 2009. Seafarer Shoreside Access. 5p.

International Labour Organisation:

- R-454. July 2, 2006. International Labour Organisation (ILO) Maritime Labour Convention, 2006. 105p.
- R-454-A. April 1, 2013. Guidance Implementing the Maritime Labour Convention, 2006 (Draft NVIC)

☐ R-455, Rev. 6. Mar. 28, 2013. Food Service Aboard Limited Tonnage Commercial Vessels. 8p.

Commercial Vessel Theft

☐ R-456, Rev. 1. Dec. 1, 2010. The Krutko Case: Commercial Boat Theft, Government Corruption, and False Imprisonment In the Sunshine State. 20p.

☐ R-457. Dec. 8, 2010. Information on the EPA Marine Engine Remanufacture Program. 15p.

☐ R-458. June 30, 2011. Federal Advisory Committees: An Overview. By Wendy S. Ginsberg, Congressional Research Service. 23 pgs.

☐ R-459. April 2011. Report and Recommendation of the Special Master Concerning NOAA Enforcement Action of Certain Designated Cases. By Hon. Charles B. Swartwood, III (ret.), Special Master, JAMS, and Assistants Petia I. Loukova Iannicelli, Esq. and Tony K. Lu, Esq. [This report is now included in NMA Report #R-204, Rev. 4.]

☐ R-460. Nov. 10, 2011. New Focus on Regulating Offshore Drilling and Production. [Address by BSEE Director Bromwich to IADC] 6p.

☐ R-461. Mar. 7, 2013. Problems With Limited Tonnage/Horsepower Engineer Examinations Electrical Questions, Answers & Illustrations – A Report to Our Mariners. 21p.

Mariner Whistleblower Protection. (46 U.S. Code §2114)

☐ R-462, Rev. 3. May 15, 2013. The Coast Guard's War on Whistleblowers: The Eric Shine Story. 19pgs. [Also refer to NMA Report #R-210, Rev. 2]

☐ R-462-A. May 15, 2003. The Coast Guard's War on Whistleblowers: The Eric Shine Story. [Limited Distribution Supplement. Appellant's Opening Brief. U.S. Court of Appeals for the Ninth Circuit, #11-72740.] 114 p.

CONSOLIDATED LIST OF NMA/GCMA REPORTS WITHDRAWN OR RE-NUMBERED

☐ R-200. [Renumbered as R-370-L, 11/18/09.]

☐ R-202-A. [Renumbered as #R-276-K, Rev. 3. Contents used in #R-370, Rev. 4, Chapter 15.]

☐ R-203-B. ☐ R-203-D. ☐ R-203-E. Withdrawn.

☐ R-204. Renumbered as R-405, Rev. 1.

☐ R-223-A, Rev. 1. Re-numbered as R-215

☐ R-239. [Replaced by Report #R-279, Rev. 8]

☐ R-254. [Revised, re-numbered and replaced by #R-276-D.]

☐ R-258. [Revised and Renumbered as #R-370, Rev. 4, Mar. 14, 2012. Contained USCG Policy Letter #G-MOC-04-00, Change 1]

☐ R-261. [Renumbered as #R-401-J]

☐ R-267. [Revised and renumbered as NMA Report #R-351-A]

☐ R-272. [Canceled: 6/2/11]

☐ R-276-B. [Canceled 10/24/11]

☐ R-281. [Renumbered as #R-290-A]

☐ R-282, Rev. 1. [Renumbered and replaced by #R-276-C, Rev. 2.]

☐ R-291, Rev. 1. [Replaced by #R-429-I]

☐ R-294. [Renumbered and revised as R-207, Rev. 1]

☐ R-299, Rev. 1 [Moved to #R-202, Rev. 5 as Case #12]

☐ R-308. [Moved to #R-370, Rev. 4 as Chapter 13, Example 6]

☐ R-311, Rev. 2. Replaced with NMA Report #R-208.

☐ R-328. Replaced by NMA Report #R-208.

☐ R-332, Rev. 3. [Withdrawn. Replaced by #R-350, Rev. 5]

☐ R-333, Rev. 3. [Renumbered as R-202, Rev. 4.]

☐ R-342

☐ R-347, Rev. 1. [Cancelled. Revised, updated & renumbered as #R-202-B.]

☐ R-348. [Revised, updated, & re-numbered as Report #R-211.]

☐ R-350, Rev. 5, "Issue L" Renumbered as #R-210, Rev. 1

☐ R-354-B. [Reserved]

☐ R-370 (Series) Information in most of this series was updated and consolidated into #R-370, Rev. 4 (3/20/12)

☐ R-370-C Rev. 2. [Withdrawn 6/09; Content merged with #R-370-D, Rev. 6]

☐ R-370-K. [Merged into R-202, Rev. 5, Case #1]

☐ R-370-J. [Renumbered as #R-401-N as a document of possible "Historical" interest.]

☐ R-375. [Revised and renumbered R-370-G, Rev. 1]

☐ R-377-A & B-B [Withdrawn. 10/16/12. See R-377, Rev. 3.]

☐ R-384, Rev. 1. [Withdrawn. See Newsletter #78]

☐ R-388. [Withdrawn.]

☐ R-407. [Withdrawn. N/L #82]

☐ R-410. [Withdrawn]

☐ R-411. [Revised and re-numbered as #R-293-B, Rev. 5]

☐ R-415-A. [Revised, updated, and re-numbered as Report #R-211.]

☐ R-418. [Renumbered as R-315-G.]

☐ R-422. [Renumbered as #R-223, Rev. 1]

☐ R-428-E. [Withdrawn and replaced with R# 203-A.]

☐ R-428-J. [Withdrawn. Replaced by #R-428-K, Rev. 1.]

☐ R-429-F. [Replaced by R-428-B, Rev. 1.]

☐ R-429-L. [Replaced by R-462, Rev. 3.]

☐ R-429-R. [Replaced by R-429-P, Rev. 1]

☐ R-433-A. Merged into R-202, Rev. 5 as Case #14]

☐ R-439. [Cancelled - Outdated.] [For TWIC information go to www.tsa.gov/twic]

☐ R-449, Rev. 1. Replaced by R-202-C, Rev. 2.

☐ R-429-U. Canceled. Replaced by R-459. See File #GCM-304.

☐ R-440, Rev. 1. Moved to #R-202, Rev. 5 as Cases #2 & 10.]

☐ R-440-D. Rev. 2. Revised and updated edition was renumbered as #R-214]

☐ R-459. This report is also used in NMA Report #R-204, Rev. 4.