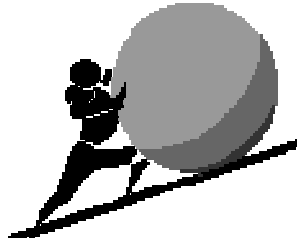




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## TOWING VESSEL HORSEPOWER/BARGE RATIO

*[Letter to the Editor from Captain John R. Sutton dated July 8, 2004 in response to **GCMA Project #R-400**. The GCMA "Project" involved reviewing and commenting upon a 1995 report by the Towing Safety Advisory Committee on towing vessel horsepower. GCMA Report #R-400, the result of our project, was submitted to members of TSAC and will be posted on our internet website. Printed copies are available to mariners without internet access upon request.]*

I appreciate your thinking of me when distributing your latest work on the elusive horsepower to barge ratio for towing vessels.

As you are aware, I have participated in numerous conversations and meetings with industry leaders and mariners alike as the past President of the American Inland Mariner's Association. I would like to start discussion on this topic by saying, all towing vessels are not created equally, and there will never be an all-encompassing ratio that solves all towing vessel accidents.

In reviewing the spreadsheet attachment you forwarded me, I can say its drafters were headed in the right direction with the recommended horsepower per barge. However, I would argue that the horsepower selected for some of the less used tributary rivers is questionable at best.

The bottom line is my personal experience as a river mariner leads me to state, that at no time should the horsepower-to-barge ratio fall below 150 horsepower per 2,000-ton barge and only then during extreme slack current periods.

Real world experience tells me, the more realistic horsepower to barge ratio for each 2,000 ton barge lies somewhere between 175 and 240 horsepower per barge during normal to medium high river conditions. While arguably this is a large variance of horsepower, inside this variance lies the most important factor in determining the appropriate horsepower to barge ratio for any given towing vessel, the experience of the individual standing at the helm of the vessel and the conditional shape of that horsepower, (i.e., does the vessel have kort nozzles?, are the wheels in good shape?, are the engines actually performing at peak performance?).

The bottom line is that many of the towing vessels operating today are overloaded first at the helm and secondly at the shaft. Many of the mariners working onboard towing vessels today lack the experience to safely navigate their vessels onboard when they are faced with adverse river conditions and/or vessel performance problems. Because these individuals have either been rushed into service as river pilots and/or these individual mariners lack the ability to perform at the level they are attempting to work at.

On a closing note, the USCG and the AWO are often quick to cite statistics from the Coast Guard's database because it favors their argument. However, the statistics are

flawed because what we discovered long ago at AIM was that the USCG 2692's fail to collect the adequate data to prove what all rivermen already know, "that boats are being overloaded on a daily basis."

It may seem simplistic, but what needs to be done first is the USCG 2692 (accident report form) needs to be changed to collect such data as, total barges in tow, total tonnage of the tow and the "documented" horsepower of the towing vessel. These three key pieces of data are capable of giving the industry and Coast Guard alike, the clearest picture of the appropriate vessel horsepower to barge ratio (and) where accidents are more likely to occur.

In addition, to better hone this information, one could include the river stage of the nearest river gage, in addition to key river ports such as Cairo, Memphis, or New Orleans, etc.

Once again, many thanks for thinking of me, till the next time we speak, take care!

Respectfully,

s/Captain John R. Sutton, Master of Any Gross Tons for Great Lakes and Inland Waters, Master of Towing Vessels for Great Lakes, Inland Waters and Western Rivers, First Class Pilot for the Mississippi River, Radar Observer (Unlimited).

*[Editorial note: In a subsequent telephone call, Captain Sutton pointed out that one of the most important factors in preventing towing vessel accidents is to assure the proper "posting" of river pilots. Posting is the process where a Pilot who has not worked on a particular river or waterway is given the opportunity to make one or more familiarization trips on that waterway before being placed in charge of a watch on that waterway. The practice of using pilots that are not "posted" on their routes is a dangerous practice yet is widespread.]*

**[GCMA Comment: The report on GCMA [Project #400](#) was prepared by a committee of seven licensed merchant marine officers with a total of 278 years experience.]**

#### **FORMER POLICE OFFICER INDICTED IN PILOT'S DEATH**

*[Source: [Waterways Journal](#) July 26, 2004, p. 6]*

A former Grand Isle, La., police officer is free on \$100,000 bond posted following his indictment on a charge of second degree murder in the June 2, 2003 shooting of Bret J. Lemoine, a former Canal Barge Company, Inc., towboat pilot.

Keeland Cheramie Jr., 24 was a sergeant on the Grand Isle Police Department when Lemoine was shot during an incident that Grand Isle Police said at the time began as a traffic stop. (WJ, July 14, 2003).

Cheramie resigned from the Grand Isle Police Department July 1, 2004 after a change of the department's administration.

A Jefferson Parish (La.) grand jury returned the second degree murder indictment July 15. If convicted on the charge, Cheramie could face life imprisonment.

Cheramie and Grand Isle police said the shooting was justified and done in self defense after Lemoine allegedly gunned his pickup truck in Cheramie's direction. An investigation by the Jefferson Parish Sheriffs Office backed the Grand Isle Police version of the

incident.

Lemoine's family has a distinctly different view of the incident, accusing Cheramie of carrying out a vendetta against Lemoine, who was a 33 year-old Grand Isle resident at the time of his death.

### **RUNAWAY BARGE BLAMED ON VANDALISM**

Police in Webbers Falls, OK, site of a fatal barge allision in May 2002 that killed 14 people, said a runaway barge on July 13, 2004 near the Interstate 40 bridge in Webbers Falls may have been untied from its dock by vandals. Officials were able to stop the barge about a mile away from the bridge after it broke loose.

A U.S. Coast Guard and FBI investigation shows someone may have purposely untied the barge from the dock.

The same Interstate 40 bridge collapsed two years ago when a barge under tow by the M/V ROBERT Y. LOVE hit one of the structure's support columns.

**[GCMA Comment: Aside from vandalism, the cause of many breakaways leads back to old, worn and generally inadequate mooring lines on barges that have never been subject to regulatory oversight. Any proposed Safety Management System should establish guidelines for a corporate policy addressing this neglected area.]**



### **BATHROOM BREAK MAY HAVE CAUSED TUGBOAT CRASH**

A tugboat captain's bathroom break reportedly led to a crash into a St. Clair County, Michigan marina Saturday July 10, 2004.

The operator left the controls for a few minutes and when he returned, the tugboat veered off course and was headed toward several docks, according to the St. Clair County Sheriff's Department. The U.S. Coast Guard said the M/V EVANS McKIEL was pulling a barge in the St. Clair River, near Roberts Landing, around 7 a.m. when the crash occurred.

Cpl. Don Berg of the St. Clair County Sheriff's Department called the crash a "pilot error." "The pilot went to the washroom for a quick second, took his eyes off the controls," Berg said.

A new boat and hoist were destroyed in the crash, Local 4 reported. No injuries were reported.

The captain was arrested and a breathalyzer test was performed, but the St. Clair County Sheriff's Department confirmed that alcohol was not a factor in the crash.

**[GCMA Comment: Adequate "bathroom breaks" need to be spelled out in conjunction with watchkeeping and vessel manning requirements.]**

## DECKHANDS WON'T STAND WATCH

A frustrated towboat Pilot who wanted to be known only as "Another Towboater" recently made a complaint on the internet that we edited below. While GCMA does not (and will not) sponsor a "chat board," this matter deserves a comment.

**The problem:** "As I said before, I have been tripping for them for a few months now, and honestly, I have a problem and don't think I will do another trip for them.

They only run a four-man boat (in 24-hour service) with two men in the wheelhouse and two men on the deck. The problem I am having is of all their boats I have been on, I am the only person up at night. Both the deckhands sleep at night even if there is tow work to do or locks to make.

"I have brought this to all the captains' attention, and was told on numerous occasions that is the way they run their boats. One Captain even got very nasty with me and told me if I did not like the way he ran his boat "You can get your (expletives) off my boat!" Needless to say, I was off the very next afternoon.

"I have shown the Captains in the company policy in the procedure manual that states there will be one deckhand and one wheelman awake and alert at all times. I have even brought it to the attention of the Company Safety Manager at (an AWO Responsible Carrier Company) but it seems to have fallen on deaf ears.

"I recall a movie a few years ago where Bruce Willis played a cop working Harbor Patrol in the Pittsburgh Harbor, and some hijackers took over a towboat and crew as it was going thru the harbor.

"Now, let's look into this scenario. The Pilot is the only person awake and on watch, going up the Houston Ship Channel. He has in tow six loads of assorted chemicals (gasoline, diesel, naphtha, methanol, caustic, benzene). It is 3:00 AM. There is a lil' skiff that quietly comes alongside the tow. Three armed men come onboard, make their way to the wheelhouse and subdue the Pilot. The other (crewmembers) are awoken from their sleep and gathered in the wheelhouse, and are then shot and killed. The armed men then go out on the tow and place explosives on the barges.

"Now, if something like that should happen, and the barges should explode, what would become of the Houston, Texas City or any other city for that matter?"

"It seems as if the company is only doing what they have to do on paperwork and not in real life.

"Could this have been prevented if there has been someone up other than the pilot? I don't (know) the answers to these questions, but it seems to me as if someone else was up with the pilot, things may be different."

"My question is...is there a policy in the AWO Responsible Carrier Program that states there must be one Pilot and at least one deckhand up on watch at all times?"

## GCMA LOOKS AT THE PROBLEM

The Responsible Carrier Program is a safety program established by the American Waterways Operators, an industry trade association, to establish the "best practices" within the towing industry. It has no "enforcement" powers that a mariner can count on. This is exactly why GCMA fought to have the Coast Guard regulate uninspected towing vessels in the same way they regulate small passenger vessels, offshore supply vessels, cargo ships, and tank ships to name only 4 of the 14 other classes of "inspected" vessels.

While the Responsible Carrier Program shows willingness by industry to comply with existing laws and regulations and to uphold high standards, the AWO has no enforcement powers over its members. However, they can plead with their members to live up to the standards they agree to follow as a condition of their membership in AWO.

A member of the GCMA Board of Directors contacted the AWO by mail and asked them to look into this situation with the company named in this particular internet article.

As GCMA pointed out in previous newsletters, if you as a licensed or documented mariner violate a company regulation (for example, one that might also happen to be part of the company's RCP commitment to AWO), the Coast Guard can proceed against your license or document under 46 CFR 5.27 for misconduct. Misconduct (defined) is human behavior which violates some formal, duly established rule. Such rules are found in, among other places, statutes, regulations, the common law, the general maritime law, a ship's regulation or order, or shipping articles or similar sources. It is an act which is forbidden or a failure to do that which is required.". GCMA has witnessed USCG enforcement of "company rules" several times in the past year!

Having a minimum of two people "on watch," especially at night and certainly in the Houston Ship Channel scenario is certainly a "best practice." Even if it is not listed specifically in the RCP, as long as the company has this policy published in "...the company policy and procedure manual" as stated on the internet, and if the Pilot were to have an accident while

both his deckhands were asleep, the Coast Guard could and would proceed against your license if they found out about it. In a formal setting before an Administrative Law Judge or when trying to reach a "settlement agreement" with a Coast Guard officer, any attempt on the part of the Pilot to shift the blame to an off-duty officer, a deckhand, or a personnel manager would probably be unsuccessful.

GCMA also discovered that the 12-hour rule simply does not apply to unlicensed crewmembers on inland towboats. GCMA Report #R-375, Crew Endurance, the Call Watch Cover-Up blows the lid off one of the towing industry's dirtiest secrets. This is one reason why one of our first petitions to the Coast Guard in 2000 was to establish uniform logbook standards that would call for accounting for "on-duty" time. Actually, it was a Coast Guard investigator who first expressed his frustration to GCMA Directors about the poor quality of the logbooks maintained on towing vessels that first propelled us into action. We later found that we were in substantial agreement with the AWO Responsible Carrier Program in its approach to logbook entries and adopted it as part of our presentation to the Coast Guard and Congress.<sup>(1)</sup> [<sup>(1)</sup> Refer to GCMA Report #R-350, Issue #5.]

**[GCMA QUESTION: Where was the deckhand that was supposed to be on watch serving as lookout when Captain Collins Verret suffered a stroke with his tug underway on autopilot in the Gulf of Mexico? (GCMA Report #R-370). In his bunk! Where was the lookout on the M/V ROBERT Y LOVE when it demolished the Interstate 40 bridge at Webbers Falls, OK.]**

## **FIGHTING FIRES ON TOWBOATS: REPORT ON THE M/V KAY A. ECKSTEIN FIRE**

*[Source: Edited from USCG Investigation]*

**[Preamble:** 46 U.S. Code §6305(b) states in part that "Reports of investigations conducted under this part shall be made available to the public." GCMA comments upon this report with knowledge of the regulatory changes that occurred since 1999.]

On May 23, 1999 the river towboat M/V KAY A ECKSTEIN, a 148 foot long, 691 Gross Register Ton, 7,300 horsepower push boat, was underway northbound on the Lower Mississippi River near St. Francisville, LA pushing a tow of 28 barges. At approximately 1800, a fire was discovered in the engine room. The fire quickly escalated beyond the crew's control and their limited onboard firefighting equipment.

Forced by the rapidly advancing flames and intermittent explosions the Captain ordered the crew to abandon the vessel.

The Louisiana Department of Transportation and Development's passenger ferry M/V ACADIA based in St. Francisville arrived on the scene about an hour after the fire started with a fire truck and ambulance on board, retrieved the crew, and held position so that the local firefighting crew could attempt to extinguish the fire. Their efforts were unsuccessful, and the towboat sank at approximately 0730 the following morning thereby extinguishing the fire.

Although the cook was treated with oxygen by the ambulance on board the M/V ACADIA, fortunately no other injuries occurred. The towboat was scrapped and a new vessel was given her name. The vessel, that had recently been renovated during a lengthy shipyard visit, was declared a total constructive loss valued at **\$2,500,000**.<sup>(1)</sup> [<sup>(1)</sup> *Ibid*, p.3]

In this incident, a towing vessel used exclusively in inland rivers service caught fire. The fire quickly got out of control forcing the crew to abandon the vessel. The vessel eventually sank after it was filled with firefighting water by the nearby city fire department.

The subsequent investigation found that the crewmembers, including the Captain, had never received any formal firefighting training. Nevertheless, the company, Marquette Towing, made the Captain responsible for ensuring that his crew was adequately trained and drilled.

While there were other factors that contributed to the severity of the fire in this incident, this casualty was the only one that was not addressed in changes to towing vessel fire regulatory changes made since 1999.

In the MSU Baton Rouge area of responsibility that includes the Lower Mississippi River from mile 167 to mile 507, there are no land-based fire departments adequately trained and prepared to fight fires on vessels. Therefore, it is critical that the towing vessels transiting this area are prepared and equipped to fight most fires aboard their vessel. In this accident, this was clearly not the case.

**Fire Drills and Firefighting Training.** The Captain stated he normally ran his crew through fire and other emergency drills once per month while underway. Fire drills were normally announced in advance and involved starting the main fire pump and testing the fire hoses. Occasionally the Captain would have the crew practice fighting a fire on the stern or in the

galley.<sup>(1)</sup> Captain ■ ■ ■ stated that he had never conducted a fire drill with the location of the fire being designated as the engineroom.

**[GCMA Comment: The engineroom with its huge supply of fuel, low and high pressure fuel lines and available sources of ignition is a logical place to practice a fire drill.]**

Captain ■ ■ ■ also stated that he could not recall whether he held a fire drill between 15 April and 23 May, the day the vessel caught fire. The fire drills would be conducted as follows:

- The Captain would tell the crew that there would be a fire drill conducted at 1200.
- At 1200, the Captain would sound the general alarm briefly, signaling the crew to muster to their fire stations. The deck crew was assigned fire stations based on their bunk numbers.
- There were five fire stations (which involved hoses on reels on/off valves placed around outside of the superstructure with one on the bow and two on either side.
- The Captain would radio to the First Mate the location of the fire if the crew were to practice fighting a fire.

**[GCMA Comment: As an uninspected towing vessel, this towboat carried only one licensed (1) mate (called a "Pilot"). 46 CFR 15.810(b)(3) calls for two mates on inspected vessels of 100 or more gross tons but less than 1,000 gross tons. This is another example of the inequalities faced by mariners working on uninspected towing vessels.]**

- The Engineer would energize the main fire pump that fed the hoses.
- After the Captain was satisfied that all systems were operating properly, he would ring the general alarm 3 times to signify the end of the drill.

While the Captain of the vessel is responsible for fire safety and training according to company policy, Captain ■ ■ ■ received no company training on how to conduct fire drills or safety meetings. New deckhands on board the vessel were required to watch a video about firefighting. They were also shown the firefighting stations and the station bill during their initial orientation and participated in drills run once monthly on board the vessel. This was the only firefighting training they were provided while on board the vessel. None of the crewmembers reported having any formalized firefighting training.

**[GCMA Comment: This \$2,500,000 loss by fire would pay for a lot of training at a USCG approved fire school.]**

**Fire Fighting Equipment:** The M/V KAY A ECKSTEIN was equipped with several hand held CO<sub>2</sub> fire extinguishers stationed around the vessel. The vessel also had a large semi-portable CO<sub>2</sub> fire extinguisher in the engineroom. The main electric fire pump was located in the generator room forward of the main engine room on the aft bulkhead. The main fire pump could be activated by pressing the buttons located just inside the engineroom next to sliding doors on each side or by going to the fire pump itself. There were five firefighting stations with fire hoses fed by the main fire pump. There were also five portable water pumps stowed in the lower deck locker and fire axes located on the bow. There were smoke detectors located in the lounge, galley, dining area, each passageway, and in each stateroom.

**[GCMA Comment: New firefighting regulations call for a Class V semi-portable dry chemical fire extinguisher in the engineroom.]**

**Layout of Engine Room.** The engine room occupied two levels. The lower level was divided into an engineroom aft and a generator room forward. There were three main diesel engines, two diesel powered generators. The main engines were Caterpillar model 3606 while Detroit Diesels powered the two generators. The fire pump was located near the aft bulkhead of the generator room. The shutdown solenoids for the port and center main diesel engines were located on a station between the port and center engines. The emergency shutdown solenoid for the starboard main engine was located on a station between the center and starboard engines. These solenoids were the only method of shutting down the engines whether during routine operations or in an emergency. According to the Captain, there was no method of shutting down the engines in the pilothouse. If he wanted the engines shut down or powered up, he would call down to the engineroom and have the duty engineer do it.

**[GCMA Comment: Inspected vessels require engine shutdown controls in the pilothouse. This is another reason why GCMA has called for the Coast Guard to adequately regulate towing vessels. Refer to 46 CFR 184.620(b).]**

The upper engine room had catwalks, that allowed the crew to walk over the engines and look down on them. The engine control room was an enclosed room with glass windows located on the port side of the upper engine room. The generator day tank was located in the upper engineroom starboard side. Crewmembers would have to walk through the upper engineroom and through the engine control room to transit from aft berthing areas to the galley. The upper engineroom at

the same level as the vessel's main deck.

**Discovering the fire.** At approximately 1800, the Call Watchman, noticed an orange reflection on the bulkhead opposite the engineroom on the mess deck. He turned around and saw that there was a fire in the engineroom and notified other crewmembers. The deck crew awoke the off-watch crewmembers and they all reported to their fire stations. Someone in the deck crew phoned the Captain in the pilothouse to alert him to the fire. The Chief Engineer described his actions:

"Ran back to the office [control room] and looked, I seen fire – as I was going back I seen fire coming up from the glass in front of the center engine. And I started to open up the office door, and I hurried up and shut it because I didn't want to open it up all the way up. It might have a back draft come through there. And I went back through the galley, I went through the deck locker, went around the starboard side of the boat, and I went in the engineroom – down the stairwell to the lower engineroom on the starboard side. I looked, seen where the fire was at, came back up the stairs and went across the engineroom went down the stairs to the center and port engine, and I noticed there was fire across there. So I came back up and got a fire hose on the port side and got it going."

At some point while running through the engineroom, the Chief Engineer activated the main fire pump.

While these events were taking place, the Oiler was sitting on his rack in his bunkroom. He stated he smelled something odd and heard a crackling sound outside of his room. He opened the door leading to the passageway aft of the engineroom, and saw thick, black smoke. He stated that the smoke was so dark he could not see the bulkhead on the opposite side of the passageway. He closed the door, put on some slip-on shoes and, wearing no shirt, exited through the door leading to the weather deck. He entered the galley and met the Chief Engineer. Together they went forward to the deck locker and retrieved one of the vessel's portable dewatering/firefighting pumps. They went out on the weather deck on the starboard side of the vessel where the Oiler and the Mate, set up the portable pump and began putting water on the fire in the engine room from outside the forward starboard door.

**[GCMA Comments: Most barge dewatering pumps, although they can pump sizeable quantities of water, are neither designed nor equipped as true fire pumps.]**

When the Chief Engineer initially entered the engine control room and then the engineroom, he saw the fire concentrated mainly in the forward center of the lower engineroom. The fire very quickly spread to where the crew could see flames by looking in the doors on the starboard side of the upper engine room.

Captain ■ ■ ■ had assumed his watch at 1730. He had the towboat KAY A ECKSTEIN and her tow of 28 barges moving northbound enroute to St. Louis, Missouri on the Lower Mississippi River with all three engines full ahead. Ten of the barges were loaded – 5 with granular urea in bulk, 4 with salt, and 1 with molasses. The loaded barges were made up in the center of the tow 2 wide by 5 long. A deckhand in the galley notified him of the fire using the intercom at approximately 1800. He instructed the deckhand to muster the crew at their fire stations and send the pilot and the cook to the tow for safety. He looked out the portside pilothouse window and saw smoke. He then sounded the general alarm and contacted the Coast Guard on VHF channel 16.

After notifying the Coast Guard, the Captain attempted to land the tow on the bank. While attempting to maneuver from the center of the river to the left descending bank, the generators and engines began to lose power. When the engines finally died at approximately 1815, the tow was very close to the left descending bank, but had not pushed up on ground.

Consequently, the vessel began to drift slowly downbound along the left descending bank. The Captain looked out the portside pilothouse window again and saw paint on the main deck melting and bubbling. He grabbed a fire extinguisher that was located in the pilothouse and descended to the main deck to attempt to fight the fire on the deck. The ladder from the pilothouse to the main deck is on the aft side of the pilothouse. After a short while, the Captain saw that his fire fighting efforts were fruitless and returned to the pilothouse.

Back inside the pilothouse, the Captain contacted the Coast Guard again at approximately 1820. Then he gathered a hand-held VHF radio, a cell phone, and a bag with his license and other documents inside. He attempted to climb down the stairs to the main deck but was unable to do so because of the fire. At this time the tow was near mile 271 of the Lower Mississippi River, just north of the St. Francisville ferry crossing.

While the pilot and at least two other members of the deck crew were using fire extinguishers and portable pumps to fight the fire through the forward engineroom door on the starboard side, the oiler and another deckhand went forward to help the Captain climb over the front rail of the pilothouse. They led the Captain back to starboard side where the crew was fighting the fire. Here the Chief Engineer told him that the fire pump had operated briefly, but that it ceased operating when the generators caught fire. Although two portable pumps were being operated, the Captain decided that the fire was out of their control and that it was time to prepare to abandon the vessel. He was also concerned about the barges in his tow and

wanted to get them tied off to the bank somehow.

The crew began to attempt to manually lower the tug's small boat, or "yawl," so that some of the deckhands could run a line from the bow of the tow to a tree on the bank. According to an eyewitness recreational boater in the vicinity the yawl fell into the water bow first and took on some water. A deckhand entered the yawl and began bailing the water while another deckhand on the deck of the towboat led the yawl forward with a line. Then an explosion occurred in the engineroom. The explosion rocked the vessel knocking the deckhand leading the yawl from the deck of the towboat into the river. When he fell, he caused the yawl to overturn spilling the other deckhand into the river. Fortunately, the two deckhands were able to swim to the bow of the towboat and climb on board. They then climbed over to the barges, joining the pilot and the cook. The yawl apparently drifted away.

The explosion also caused excessive flames to begin coming out of the port and starboard engineroom doors. Both doors were left open while the crew attempted to fight the fire. The fire was now too strong for anyone to get close enough to close them. As a result, the Captain and four crewmembers that remained on the towboat were forced to retreat to the vessel's stern. As they considered jumping into the river, a boater brought his recreational pontoon-type boat up to the stern of the towboat and rescued the stranded Captain and his four crewmembers...

The boater was on the river going southbound when he saw smoke. He turned to look up river and observed black smoke coming from the towboat. He went up toward the tug and saw that it was on fire. He then went southbound towards the ferry crossing to attempt to get help. His mother, who was on board, called 911 on her cell phone, but lost reception near the ferry crossing. They found some other people on a small recreational boat fishing and asked them to go to the ferry crossing to get help for the towboat.

The Captain asked the boater to take his boat up to the tow so that the remainder of the crew could escape. He had difficulty doing this, however, because the towboat and her tow were still drifting down river with the current. The crew on the tow also stated that they would prefer to stay on the tow in order to attempt to keep the barges together. At one point the towboat struck the bank causing the barges to shift out of alignment, but none of them broke away.

Soon afterward a Sheriff's boat and the passenger ferry, M/V ACADIA, with a fire truck and EMS truck on board, arrived on scene: The Sheriff's boat took the Captain aboard. The M/V ACADIA pushed up to the tow and rescued the crew from the barges. The Sheriff's boat then came back to the pontoon boat for the remainder of the crew and placed all of them aboard the M/V ACADIA. The paramedics aboard the M/V ACADIA treated the cook for smoke inhalation. No other member of the crew received any medical attention.

The M/V ACADIA remained pushed up to the side of the towboat so that the fire crew could put water on the fire. Two assist tugs, SEPCO 1 and SEPCO 2, arrived on scene shortly after and held the towboat and her tow against the bank. Small boats brought foam to the M/V ACADIA to apply to the fire. Members of the crew remarked that the foam appeared to bring the fire under control, but the fire department exhausted its supply before the fire was extinguished. After they ran out of foam, they began applying water to the fire again. This continued until the towboat finally sank still tied to her tow, at 0730 the following morning.

**Conclusions.** Coast Guard investigators and inspectors boarded the towboat after she was raised from the bottom and the silt was washed out of her. Because of the amount of damage to the vessel, they were unable to come to any conclusions on what caused the fire. What is known is that the fire was first observed in the engineroom near the Center main diesel engine. There were large amounts of fuel and oil in the engineroom that may have provided additional fuel for the fire as the engineroom burned.

Dr. ■ ■ , a fire investigator with Burgoyne Incorporated, Consulting Scientists and Engineers, was hired by attorneys of the owners, Marquette Towing, to investigate the fire. He investigated the fire by attending the vessel after it was re-floated, visiting with crewmembers in the months following the incident, and reviewing documents pertaining to the vessel.

Dr. ■ ■ stated in his report dated 20 July 2001 that the fire began in the engineroom and spread somewhat into the generator room, but that the generator room was never fully engulfed by the fire. He observed that the fire had also spread aft to the shaft alleys and storerooms behind the engineroom. Dr. ■ ■ also indicated that the fire spread to the engine control room and "other areas of the vessel at the main deck and above."

The most severe fire damage observed by Dr. ■ ■ was in the lower engine room at and below the "floor plates" and was concentrated underneath and forward of the three main engines but not outboard of either the port or starboard engines.

From his observations and interviews, Dr. ■ ■ concluded that the fire originated in the forward portion of the lower engineroom, most likely forward of the center engine. He surmised that loose check valve couplings on the center main engine caused diesel oil to spray from the forward part of the center main engine. Some of the diesel oil pooled on the

engineroom floor in front of the center engine, and some of it sprayed onto the port generator exhaust pipe and lagging forward of the center main engine.

The heat from the port generator exhaust pipe then ignited the diesel oil – probably after several minutes. This fire ignited the diesel oil that had pooled in front of the center engine causing the fire observed by the deckhand and Chief Engineer. Further, while the loose check valve couplings continued to spray diesel oil onto the fire, Dr. ■ ■ theorizes that other lines and fittings on the center engine began failing as a result of the fire, thereby adding more fuel to the fire.

**Contributing Factors.** There were several factors that contributed to the fire.

- No fire detection system in the engineroom. The duty engineer was not required by company or vessel policy to constantly man the engineroom. At the time the fire started, the duty engineer (i.e., the Chief Engineer) was having coffee in the mess deck. Had there been a fire detection system installed in the engineroom, the crew may have been warned before the fire got too intense for the crew to extinguish.

**[GCMA Comment: 46 CFR §27.203 NOW requires a fire detection system certified by a registered Professional Engineer or recognized classification society on ALL towing vessels.]**

- No fixed fire extinguishing system in the engineroom. When the Chief Engineer discovered the fire in the engineroom it was already too intense for any of the crew to get close enough to fight with a hand-held or semi-portable extinguisher. Water proved to be ineffective in fighting the fire throughout the night. A fixed fire extinguishing system capable of fighting Class B fires would have allowed the crew to safely and quickly extinguish the fire.

- No live watch in the engineroom. The Chief Engineer, was in the mess deck making coffee. Company policy did not require him to man the engineroom the entire duration of his watch. All that was required by company policy was that rounds, or checks, of the engineroom be done and logged every two hours.

- No remote engine cutoff. The only method of shutting off the engines was by depressing the three buttons located in the engineroom near the engines. The vessel operator was not even able to shut off the engines from the pilothouse. No regulations in existence at the time of the fire required remote engine cutoffs on uninspected towing vessels.<sup>(1)</sup>

**[GCMA Comment: Although it calls for good common sense, USCG regulations still do not require engine shutdown controls in the pilothouse of uninspected towing vessels.]**

This investigation also revealed that the crew was not fully prepared to respond to the fire for the following reasons:

- It is apparent that the crewmembers were expected to fight fires manually since there was no fixed firefighting system in the engineroom; however, no protective fire fighting equipment such as fire protection suits and self-contained breathing apparatus were ever provided to the crew and none are currently required by existing regulation..

**[GCMA Comment: We are concerned that our mariners will continue to risk their lives to save vessels whose owners fail to equip them with effective fire suppression systems or adequate firefighting equipment and personal protection gear.]**

- Lack of marine firefighting training potentially exposed crew to unsafe conditions and firefighting practices. No formal firefighting training was required for crewmembers prior to joining the vessel. Once they joined the vessel, they were given a video on firefighting to watch and run through the station bill. The Captain conducted once monthly fire drills. The Captain also ran monthly safety meetings that sometimes concerned firefighting.

- PFDs apparently were not located in an area readily accessible to the crew. PFDs are normally stored in bunkrooms and in the pilothouse of a towboat. In this incident, the crew quickly turned their attention to firefighting. When they began preparing to abandon the towboat, the interior of the vessel was engulfed in fire so intense that no one could enter the vessel. Therefore, two members of the crew were thrown in the river with no lifejackets on, and several others considered jumping into the river without them as well. In this situation, the lifejackets were not "readily accessible" as required by 46 CFR 25.25-9.

**New Regulations Promulgated Since this Incident.** Since this fire occurred, there were a series of fire protection regulations promulgated for uninspected towing vessels in 46 CFR Part 27. These regulations include:

- A requirement for a fire detection system in the engine room – even on tugs and towboats built before 2000. This system must be certified by a registered Professional Engineer and installed, tested and maintained in line with its manufacturers design manual. The system must set off alarms in the vessel's pilothouse. [Refer to 46 CFR§27.203.]

- A general alarm system. [Refer to 46 CFR §27.201.]

- A requirement for a remote fuel shut off at a safe place outside of the space in which the valve is located.

- A requirement for firefighting training for crews of uninspected towing vessels. This is limited to drills and instruction rather than attendance at a fire training school as recommended by the Coast Guard in this incident. [Refer to 46 CFR §27.209.]
- By April 28, 2005, in addition to these regulations already in effect, regulations requiring either a fixed fire extinguishing system to protect the engine rooms of uninspected towing vessels in inland (and ocean) service or an approved B-V semi-portable fire extinguishing system. [Refer to 46 CFR §§27.303 and .305]

#### **Important points regarding this incident:**

- The fire was first observed burning on deck plates in front of the center main diesel engine. The fire appears to have started when oil sprayed out of loose couplings onto a heated exhaust plate. A loose coupling on the center main engine is suspected of spraying fuel causing the fire. [Ibid, p. 11]
- A crewman walking through engineroom detected the fire located on engine room deck plates in front of the center main engine. [Ibid, p. 12]
- Application of foam fire extinguishing agent was observed to be effective but was in short supply and had to be brought from shore to the fire. [Ibid, p. 12]
- On board firefighting equipment was not available because it depended on electrical power that was lost as a result of the fire. [Ibid, p. 36]
- About an hour after the fire started (at approximately 1900), the M/V ACADIA came alongside with a fire truck on board.
- M/V ACADIA provided a platform for the municipal fire truck to attempt to fight the fire. The fire truck started out using river water. Foam was carried out to the fire scene by small boats. Observers noted the foam started to control fire but the fire department ran out of foam and resumed fighting the fire with water. The local firefighters fought the fire throughout the night with water. The fire continued to burn until the vessel finally flooded and sank. [Ibid, p. 13]
- While attempting to escape the burning towboat the cook had to pass through areas engulfed in thick black smoke. [Ibid, p. 14]
- Numerous explosions occurred while the towboat burned. [Ibid, p. 14]
- Ten crewmembers abandoned the vessel and two entered the water without any lifesaving equipment but were able to swim back to the tow. Five crewman were rescued off the stern by a good Samaritan, while four crewmen were rescued off the tow by a sheriff's boat. [Ibid, p. 16]
- The crew attempted to lower the rescue boat but could not do so successfully. The men were eventually evacuated from the vessel by a good Samaritan. [Ibid, p. 16]
- Lack of a fixed fire fighting extinguishing system in the engineroom prevented extinguishing the fire early. By the time the crew could set up the portable pumps, the fire grew too big for them to be effective. [Ibid, p. 18]
- The investigators stated the engineroom was not required to be properly manned. [Ibid, p. 19]

**[GCMA Comment: Existing towing vessel manning regulations are a sad joke and have been neglected by the Coast Guard for many years at the expense of our mariners. This needs to change!]**

- Although the defenses were in place, they failed because the crew was not trained adequately in marine firefighting. The firefighting crew based on the M/V ACADIA used land-based firefighting techniques because they, too, lacked training in marine firefighting. [Ibid, p. 19]
- Other defenses that were in place failed because of inadequacy. Improper or inadequate personal protective equipment. Although lifejackets were adequate in number, their stowage inside the vessel prevented their use in this situation. Since the vessel became completely engulfed in flames, the crew could not re-enter when they realized they needed the lifejackets. As a result, two crewmembers fell into the Mississippi River without any lifesaving gear.
- Active human failures included execution errors, attention failures, mistiming errors and omissions: The crew did not don lifejackets before fighting the fire. As a result, when the time came to abandon the vessel, no one in the crew was able to don their lifejackets because they could not re-enter the vessel to retrieve them.

**The Coast Guard Ignored Its Own Safety Recommendation #5452.** As a result of the fire, the Coast Guard investigator recommended that 46 CFR 10.205(g)(3) be amended to require masters and mate/pilots of all towing vessels, including those operating exclusively on the Western Rivers, to attend a firefighting course of instruction approved by the Commandant before receiving their Coast Guard licenses.

Nothing in this report leads us to believe that this recommendation was ever acted upon in light of the "Low" priority assigned to the recommendation.<sup>(1)</sup> [ <sup>(1)</sup> *Ibid*, p.3

At present, only the applicants for the licenses listed below must present a Certificate of Completion from a firefighting course of instruction approved by the Commandant:

- Master's licenses for service on vessels of 200 gross tons or less in ocean service.
- All master or mate's licenses for over 200 gross tons except towing vessels.
- All licenses for master or mate (pilot) of towing vessels, except apprentice mate (steersman) of such vessels on oceans.



- All engineer's licenses.<sup>(1)</sup> [ <sup>(1)</sup> *Most towboat engineers, even on the largest river towboats do not hold USCG Engineer's licenses.*]

### **GCMA CALLS ON COAST GUARD TO CHANGE ONE CONTROVERSIAL POLICY IN LIGHT OF WEBBER FALLS DISASTER**

In a letter dated August 29, 2004 addressed to the Chief, USCG Office of Compliance, GCMA formally requested the Coast Guard to either update or revise controversial portions of G-MOC Policy [Letter #4-00](#), Rev.1. We seek a substantial change in policy in light of the Coast Guard's investigation of the M/V ROBERT Y. LOVE allision with the Interstate 40 bridge at Webbers Falls, OK, that took 14 lives in May 2002. The letter states in part:

"The Gulf Coast Mariners Association is a mariner advocacy group that urged the Coast Guard, and in particular, RADM Robert North while serving as (Chief, Marine Safety, Security and Environmental Protection) to publish the document that became G-MOC Policy Letter #4-00 on September 11, 2000. Your office subsequently revised this document on April 26, 2001.

"While our Association was pleased with this document in general, we noted problems with your office's definition of "Travel Time" in ¶2.d. Your office defined "Travel Time" as follows: "Travel time to a vessel is considered to be neutral time as it is normally NOT considered to be "rest", "off-duty", or "work" time, but all relevant circumstances should be considered in evaluating whether a mariner complies with the applicable "rest" required by STCW or "off-duty" requirements specified in 46 USC §8104(a)."

"The purpose of this letter is to ask you to change your policy in light of the fact that:

- Plain reading will show that "neutral time" was given a negative definition in the policy letter, and
- Publication of a recent accident investigation with multiple fatalities shows that the Coast Guard accident investigation team considers travel time to the vessel to be "on-duty" time. We believe this reflects a "de facto" policy change that needs

to be incorporated in a future edition of your policy letter. **[Enclosure #1]**.

**"The Webbers Falls Accident:** On May 26, 2002 the tow of the M/V ROBERT Y. LOVE demolished the Interstate 40 bridge at Webbers Falls, Oklahoma, killing 14 innocent motorists. The Coast Guard report estimated the monetary cost of the accident at \$60,000,000. The Coast Guard released the accident report to us on August 17, 2004 under our FOIA Request #04-1430. The U.S. Coast Guard and the National Transportation Safety Board jointly investigated the accident.

"In the Coast Guard report (p.2) the scope of the U.S. Coast Guard portion of the joint USCG/NTSB activity was to "determine whether there was any violation of law or regulation associated with this casualty and prosecute enforcement activities accordingly. Hence, the purpose of this factual narrative and the supporting evidence contained in this activity is simply to provide a factual basis to determine whether there was any violation of law or regulation..."

"We enclose pages 22-27 of the Coast Guard accident report as **[Enclosure #1]**. This report states (bottom of p.23): "Mr. ■ ■ ■ (i.e., the master of the vessel) had over 8 hours of work just prior to his arrival at the vessel. The vessel got underway immediately after he got on board; and Mr. ■ ■ ■ stood the first watch after the vessel got underway. In consideration of all relevant circumstances, it appears that there was a violation of 46 USC §8104(a) by Mr. ■ ■ ■ ."

"GCMA notes that Mr. ■ ■ ■ was driving to work during this eight-hour period. We believe that the significance is that the Coast Guard investigators, "after consideration of all relevant circumstances" were convinced that this drive to work was, in effect, "on-duty" time and constituted a violation of law. Additional details appear (top of p.25) where the master's time driving from his home to the company office as well as from the company office to the jobsite counts as "on-duty" time rather than the "neutral time" your existing policy states.

"According to Coast Guard investigators, the employer also shares responsibility for violating 46 USC §8104(a), (center, P.24): "In consideration of all relevant circumstances, it appears that there was a violation of 46 USC 8104(a) by the owner/operator of the M/V ROBERT Y. LOVE."

"The investigators also discovered a clear violation of the 12-hour rule. (P.26, top) "46 USC §8104(h) prohibits a mariner from working more than 12 hours in a 24 hour period. During the 24 hour period immediately preceding the casualty, Mr. ■ ■ ■ was working for approximately 14 hours and 35 minutes. In consideration of all relevant circumstances, it appears that there was a violation of 46 USC 8104(h) by the owner/ managing operator of the M/V ROBERT Y. LOVE."

"Our Association wishes to commend your office for publishing G-MOC Policy Letter #04-00 to clarify the watchkeeping and work-hour limitations on towing vessels, offshore supply vessels and crewboats utilizing a two watch system. Our mariners serve on all these vessels. We needed this clarification years before its publication in 2000. However, in light of the Webbers Falls accident investigation, the "neutral time" reference and other items need revision.

"We now direct your attention to **all** the material we filed in Docket #USCG-2002-13594 on April 18, 2002 (a month before the Webbers Falls accident) where we requested "that the wording in the FRA (Federal Railroad Administration) regulation at 49 CFR §228.7(a)(4) be adopted by the Coast Guard for the protection and welfare of mariners." Our GCMA rulemaking petition pointed to the need for a clear and unequivocal regulation not just a "policy letter." The FRA, like the Coast Guard (at the time), was a separate modal administration within the Department of Transportation. FRA specifies "deadhead time" en route to work be counted as "on-duty" time. The Marine Safety Council passed this project along to the Towing Safety Advisory Committee (TSAC) where it is now under active consideration. We believe it would be helpful if the TSAC working group dealing with this subject had a clear indication in its September 28-29 meeting whether your office plans to consider revising Policy Letter #4-00 in consideration of the M/V ROBERT Y. LOVE accident.

"The material contained in Docket #USCG-2002-13594 does not represent the first time that a mariner association has explained to high-ranking Coast Guard officials that the statutes at 46 USC §8104(a) and (h) are routinely violated not only on towing vessels but on offshore supply vessels as well. One example for the record is the letter addressed to RADM James Card dated October 22, 1996 while he was Chief of Marine Safety, Security, and Environmental Protection **[Enclosure #2]**. Admiral Card later became the Coast Guard Vice Commandant. We state that this and related manning problems were ignored at the highest command levels.

"In May 2000 our Association informed RADM Paul Pluta of the routine violations of the 12-hour rule in our book titled Mariners Speak Out On Violation Of The 12-Hour Work Day. This warning was widely circulated throughout government and industry; yet the Coast Guard at the highest levels of command ignored it. We watched our valid protest shunted into the NOSAC advisory committee that talked it to death in spite of over a thousand pages of supportive study material and finally allowed it to die.

"We now direct your attention to **all** the material we filed in Docket #USCG-2002-12579 on October 24, 2001 as a "Petition for Rulemaking: Work-Hour Limitations for All Unlicensed Crewmembers on Uninspected Towing Vessels." In further

reference to the Webbers Falls accident, we cite this portion of the narrative summary from page 27: "■ ■ ■ was alone on watch in the pilothouse. He experienced an unwitnessed loss of consciousness (syncope) while on watch..."

"Why was this master left alone in the pilothouse? Why was his loss of consciousness "unwitnessed"? Why are so many masters and pilots left alone for hour after hour both day and night without even a break to answer calls of nature? Why does the Coast Guard rail against one-man watchstanding on large ships in open ocean yet ignore the same practice on smaller vessels on coastwise and river voyages?

"Our Association petitioned the Coast Guard on a number of important safety issues and has seen our material pigeon-holed in a number of dockets such as #USCG-2002-12579 that it clearly has no intention of ever selecting to see the light of day. Perhaps senior Coast Guard officials hope that GCMA will tire of trying to obtain safe working conditions for lower-level mariners and simply go away. However, because the Coast Guard consistently chooses to ignore important safety issues, the federal government (which means the American Taxpayer) had to "eat" most of the \$60,000,000 bill for the Webbers Falls accident. While the Coast Guard can point its finger at a pilot for falling asleep<sup>(1)</sup> when he was clearly overworked or at his employer for violating the law, it is high time that the American public points its finger at the highest levels of the Coast Guard command structure for its abject failure to enforce manning statutes and work-hour regulations. Eighty-four hour work-weeks are part of the nineteenth not the twenty-first century! The Coast Guard clearly failed in its superintendence of the merchant marine especially as regards its duties to our lower-level mariners for at least the last three decades. [<sup>(1)</sup>**Editorial note:** NTSB medical experts believe an undetected heart condition rather than falling asleep was the primary cause of the accident. Nevertheless, both the Coast Guard investigators and GCMA point to the violation of several laws by both the company and the mariner.]

"Congress depends upon the Coast Guard as the experts in the marine field. However, we question the quality of your advice as it affects many lower-level mariner issues. The recent changes reflected by §415 of the Coast Guard and Maritime Transportation Act of 2004 will change the status of towing vessels from "uninspected" to "inspected." This change is long overdue. In 1995 Commandant Robert Kramek advised the Secretary of Transportation that inspecting towing vessels was not the best use of Coast Guard resources. Large segments of the towing industry are 30 years behind the times because it lobbied against and effectively derailed inspection in 1972. Our mariners suffered for three decades. Finally, both industry and the Coast Guard recognize Commandant Kramek's bad advice. We trust that this change will finally cause the Coast Guard to demand adequate manning of towing vessels in terms of both licensed and unlicensed personnel so that accidents of this nature can be prevented.

"In closing, our Association expects the Coast Guard to take the lead in properly manning not only towing vessels but every other class of vessel where our lower-level mariners serve. We have worked in this direction since our founding in 1999 as have predecessor mariner associations. We will continue to work in this direction in the future either through the Coast Guard and its Federal Advisory Committees or directly with Congress if we find it necessary to take that route."

#### DIFFERING VIEWS ON THE WEBBERS FALLS ACCIDENT

The National Transportation Safety Board held a "Sunshine Meeting" on Tuesday August 31, 2004 to discuss the bridge allision accident. GCMA will review the webcast of this meeting and the final report when it is issued. During the public meeting, members of the Board questioned their experts and staff members about all aspects of the accident. Several GCMA member viewing the proceedings on the webcast commented that "the Board asked all the right questions." The following article appeared in the The Waterways Journal of Sept. 6, 2004:

#### NTSB Issues Recommendations On I-40 Bridge Allision

The National Transportation Safety Board (NTSB) last week issued several safety recommendations as part of its report on the May 26, 1992 accident in which barges in tow of the M/V ROBERT Y. LOVE struck the I-40 highway bridge over the McClellan-Kerr Arkansas River Navigation System.

Among the recommendations, NTSB called for the U.S. Coast Guard Research and Development Center to "evaluate the utility effectiveness of wheelhouse alerter systems on inland towing vessels for preventing accidents."

**[GCMA Comment: Inland and International Rule 5 requires "Every vessel shall at all times maintain a proper lookout by sight and hearing as well as by all available means appropriate in the prevailing circumstances and conditions so as to make a full appraisal of the situation and of the risk of collision." Requiring a second man to act as lookout in the pilothouse when a tow is underway is a sensible "human" rather than a "mechanical" approach. Providing adequate manning to make this possible has proven to be an industry shortcoming.]**

NTSB found that the probable cause of the allision was the towboat captain's loss of consciousness, possibly because of an unforeseeable abnormal heart rhythm. A wheelhouse alerter system could possibly have detected the black out and

"might have resulted in timely action that may have prevented this accident," NTSB said.

The ROBERT Y. LOVE was northbound near Webbers Falls, Okla., when the pilot apparently blacked out. The tow suddenly veered off course and struck an unprotected pier of the bridge to fall into the river and onto the barges below. Before highway traffic could be stopped eight passenger vehicles and three tractor-trailers had plunged into the river or onto the collapsed portion of the bridge; 14 people were killed five injured.

In addition to the wheelhouse alerter proposal NTSB made three recommendations:

- that the Federal Highway Administration (FHA) revise its sufficiency rating system to include probability of extreme events such as vessel impact;
- that the FHA develop an effective motorist warning system to stop motor vehicle traffic in the event of a bridge collapse; and
- that once effective motorist warning system is developed, the American Association of State Highway Transportation Officials provide guidance to the states on its use.

"An effective motorist warning system can be a vital tool to prevent tragedies like this from occurring," said NTSB Chairman Ellen Engleman Connors. "With this system in place, the loss of so many lives could have been prevented."

Safety board investigators found that the captain of the towboat was not impaired due to alcohol or illegal drugs. Further, his incapacitation was probably not a result of his falling asleep, NTSB said. However, he experienced a sudden loss of consciousness, possibly as a result of an abnormal heart rhythm; such an incident is consistent with an episode of syncope, in which blood flow to the brain is interrupted for any of a variety of reasons. This interruption results in loss of consciousness and falling.

NTSB said the captain had no apparent symptoms of clinical significance prior to the accident, and a reasonable clinical evaluation before the accident probably wouldn't have detected the medical conditions that were discovered through post accident testing.

Among other findings, NTSB said:

- "neither the weather nor the mechanical condition of the towboat nor the captain's qualifications, experience, familiarity with the river, or workload contributed to the accident;
- a "quick-acting fisherman" who was near the site of the accident probably prevented further loss of life when he fired a warning flare to alert motorists on the bridge;
- because of the cost, it may not be feasible to construct pier-protection systems for every bridge in the nation vulnerable to a vessel allision.

**AWO/CG Work Group.** NTSB said the work of the Coast Guard-American Waterways Operators Bridge Allision Work Group, as well as lessons learned from the ongoing Crew Endurance Management System demonstration project "should both enhance the safety of towing vessel operations and reduce bridge allision accidents."

[GCMA Comment: Refer to GCMA Report #R-293, [Towing Vessel Bridge Allisions and Related Background Issues](#), and GCMA Report #R-373, [GCMA Response to the USCG-AWO Bridge Allision Report for a different mariners' perspective](#).]

In a statement following the release of the NTSB report, AWO President Thomas A. Allegretti called the findings "important information that will help our industry and make the traveling public safer. AWO is a partner with the NTSB and the Coast Guard in improving maritime safety. We are committed to studying, learning from, and applying the lesson of this investigation for our industry. In particular, AWO would be pleased to provide any assistance possible with regard to NTSB recommendation that the Coast Guard evaluate the utility of effectiveness of wheelhouse alerter systems on inland towing vessels for preventing accidents."

[GCMA Comment: GCMA shares the same goals as AWO although our Association, unlike AWO, has no special "partnership" with either the Coast Guard or the NTSB.]

## GCMA PETITIONS COAST GUARD ON NAVIGATION BRIDGE VISIBILITY ISSUES FOR TOWING VESSELS

[Source: File #GCM-53]

**Statement of the problem:** On September 24, 2003 GCMA petitioned the Coast Guard Marine Safety Council under provisions of 33 CFR 1.05-20 as members of the public, and in the interest of public safety and for the health, safety and

welfare of our mariners, that the Coast Guard review the matter of pilothouse visibility as it affects uninspected towing vessels.

We noted that GCMA explored the issue of navigation bridge (i.e., pilothouse) visibility in detail in GCMA Report #R-275, Revision 1. We noted that various classes of inspected vessels have specific regulations regarding navigation bridge visibility whereas towing vessels do not. This makes them vulnerable to causing a number of types of accidents from running down small recreational vessels to bridge and lock allisions. Although we brought the matter of pilothouse visibility before the Towing Safety Advisory Committee (TSAC) on several occasions, we were disappointed that they never initiated any task statement to further study the subject. GCMA last brought up the matter at the last TSAC meeting on September 10, 2003.

We believe this is a significant gap in existing regulations that needs to be studied in detail and remedied.

We next brought to the Coast Guard's attention a GCMA letter to the Commanding Officer of MSO Houston-Galveston that reported the problems faced by a towing vessel officer whose vessel was not equipped with a windshield wiper or clear-vue screen as he crossed the busy Houston Ship Channel and approached the Galveston Causeway Bridge in a heavy rainstorm. GCMA believes that such devices are essential to the safe operation of towing vessels in light of the number of bridge allisions and other accidents involving misjudgment of distances and specifically requested that these devices and any necessary fans or defrosters be required to be installed and maintained in an operable condition in the pilothouse of every commercial towing vessel by a well crafted and enforceable regulations.

**Coast Guard Response:** We received a response to our petition for rulemaking in a letter from Captain David L. Scott, Chief of Operating and Environmental Standards, dated August 2, 2004 quoted in part:

"At this time, the Coast Guard does not have compelling casualty data to support the need for rulemaking requiring equipment such as fans or wipers for uninspected towing vessels. Furthermore, such a rule would impose more stringent requirements on these uninspected vessels than are currently required for inspected vessels of similar size and tonnage. However, your Petition will be held by the Vessel and Facility Standards Division at the Coast Guard Headquarters for consideration within future regulatory projects. A determination as to the Coast Guard's authority to establish visibility standards will be determined as part of any subsequent rulemaking."

**Future action:** Congress recently provided the Coast Guard with the authority to inspect towing vessels. It should not be necessary to remind the Coast Guard's Marine Safety Council that a person's eyes are one of the most basic and essential navigational tools. Without good eyesight (that is well regulated in existing licensing regulations), most of the fancy electronic gadgets in the pilothouse are useless. Placing a translucent or opaque object in front of your eyes (such as a fogged-up pilothouse window) limits a pilot's ability to navigate safely. This is true not only on towing vessels but also on "inspected vessels of similar size and tonnage." It is only common sense that wipers, fans and clear-vue screens should not only be required on tugs and towboats but also on any vessel that has a pilothouse window through which a helmsman must see to properly navigate.

We can only hope that it will not be necessary for the Coast Guard to go to Congress to determine whether they have the authority to establish visibility standards. However, if they don't, we will and we are unlikely to wait another year to do so!

Upon our request, Captain Scott placed this issue on the TSAC agenda for its September 28<sup>th</sup> meeting.

## MISGUIDED SECURITY REGULATIONS

[Source: *The Master, Mate & Pilot, Vol. 40, No. 4, July August 2004, Pgs. 9, 10*]

### MM&P Among Many Opposed to Provisions in USCG Interim Rule

In a joint letter to the U.S. Coast Guard, the MM&P as well as many other maritime organizations have voiced strong opposition to a number of provisions contained in the USCG Interim Rule (Docket #USCG-2003-14500) that place excessive restrictions on the issuance and renewal of Merchant Mariner Documents (MMDs).

The letter stressed from the beginning that, "collectively, our organizations represent the overwhelming majority of United States citizens who work aboard U.S.-flag commercial vessels engaged in all aspects of our nation's foreign and domestic shipping trades. The members of our organizations are directly impacted by this Interim Rule...."

The joint letter emphasized that, "the procedures and requirements governing the issuance and renewal of MMDs determine whether a trained and qualified individual will or will not in fact be able to pursue his or her chosen profession. It is absolutely essential that such procedures and requirements be reasonable, realistic, clear and fair, and that they do not serve to arbitrarily deny qualified persons with the opportunity to work aboard U.S.-flag commercial vessels."

The letter further cites a number of objectionable provisions in the interim rule considered by the MM&P and the other

labor organizations to be excessive, unduly restrictive and arbitrarily made in the name of homeland security. Among the most egregious are the Interim Rule's so-called appropriate "Character and Habits of Life" standards that permit "appropriate Coast Guard official" to determine who is a "safe suitable person" to hold a MMD. The rule provides no defined terms of "safe and suitable" and does not define in any definitive manner the Coast Guard official with such authority.

The letter makes clear that "We seek meaningful improvements in security. The individuals we represent may very well be among the first casualties in the event of an attack on an American port or an American flag vessel. With respect to deep-sea vessels, the vessels posing the least risk to the security of the United States are U.S.-flag ships crewed by the United States citizen licensed and unlicensed merchant mariners.

"American deep-sea merchant mariners (already) undergo background checks and are subject to stringent MMD requirements and procedures to a degree unmatched in flag-of-convenience nations or in other maritime sector operations," the letter explained. MM&P and the other signatories highlighted the disparity this creates. "The Interim Rule only applies to U.S. citizen deep-sea mariners working aboard U.S.-flag vessels who represent a very small proportion of the total number of mariners arriving and departing on vessels in American ports."

Meanwhile, some of the greater and more real risks are rooted in "the flag-of-convenience system that dominates international shipping, the secretive nature of international shipping, and the clandestine behavior of nations that view their shipping registry business as an enterprise and not as a regulatory activity..." These traits make their ships and their crews the real threat to the U.S. security, pointed out the letter. The maritime organizations commended the Coast Guard for the steps it has taken in recent years to regulate foreign-flag vessels but stressed that "far more regulations are needed in this area rather than against U.S.-flag ships."

The letter states that "it is also important to emphasize that to the extent American citizens are denied the chance to pursue a career in the U.S. merchant marine for reasons that have very little if anything to do with their current qualifications and on-the-job-performance, our country will lose a valuable, irreplaceable component of its militarily-useful commercial sealift."

The letter signed by the MM&P and the seagoing unions, the American Maritime Officers, Inlandboatmen's Union of the Pacific/ILWU, Marine Engineers' Beneficial Association, Marine Firemen's Union, Sailors' Union of the Pacific, the Seafarers International Union, and by the AFL-CIO's Maritime Trades Department, also requested a public hearing in order to develop a complete and accurate record regarding the provisions and consequences of the Interim Rule.

**[GCMA Comment: The Coast Guard told us that a comparable rulemaking that applies to LICENSES is "in the works."]**

### **GCMA PETITIONS COAST GUARD TO REGULATE TOWING VESSELS**

**[Background:** *In the Coast Guard and Maritime Transportation Act of 2004, Congress authorized the Coast Guard to inspect towing vessels. To do that, the Coast Guard must create a set of rules to comprehensively regulate towing vessels. After that is done, then towing vessels can be "inspected" to meet the new standards. The question is no longer whether towing vessels will be inspected but rather to what standards will they be inspected and when this will take place. This is the purpose of our petition. Our mariners have issues that we want the Coast Guard to look into...in fact we have at least 74 such issues as covered in GCMA Report #R-276.]*

August 17, 2004

ATTN: Executive Secretary  
Marine Safety and Security Council (G-LRA)  
U.S. Coast Guard Headquarters  
2100 Second Street, SW  
Washington, DC 20593-0001  
Subject: **Petition for Rulemaking**  
Regulatory Reference: 33 CFR §1.05-20.  
Our File #: GCM-100  
Petition Transmitted Via Courier  
Dear Sir or Madam,

Section 415 of the Coast Guard and Maritime Transportation Act of 2004 amends 46 U.S. Code §3301 by adding towing vessels to the list of vessels inspected by the Coast Guard.

In order to inspect towing vessels in the same manner as other inspected vessels, a comprehensive set of regulations setting out inspection standards will need to be adopted.

On May 15, 2001, our Association, working through the Towing Safety Advisory Committee (TSAC), identified many areas where mariners working on uninspected towing vessels were not adequately protected by Coast Guard regulations in comparison to mariners working on inspected vessels of comparable size and horsepower. In making that statement we specifically refer to the regulations for small passenger vessels at 46 CFR Subchapters T and offshore supply vessels at 46 CFR Subchapter L.

Our Association has done considerable work on the project that TSAC identifies as "regulatory review." The work performed by GCMA is presented in GCMA Report #R-276, Revision 7 [**Enclosure #1**]. Revision 7<sup>(1)</sup> is the latest edition of a report we have constantly updated since March 2001 and is the same edition that we distributed to members of the House Committee on Transportation and Infrastructure and the Senate Committee on Commerce, Science and Transportation on March 1, 2004. [<sup>(1)</sup>Revision 7 supersedes all previous editions.]

Our work also included a 204-page report prepared for TSAC's consideration at their March 13-14, 2002 meeting in San Francisco. That report was prepared in response to a TSAC comment that suggested that we compare our list of requested regulations with the existing American Waterways Operators' Responsible Carrier Program. We made that comparison in the colored pages of that book [**Enclosure #2**]. This book as well as the TSAC "regulatory review" task statement should be available in files maintained by G-MSO."

Although TSAC discussed the matter of "regulatory review" for almost three years after GCMA requested that it be placed on the agenda, these discussions were based on the premise that the Coast Guard lacked the authority to inspect towing vessels. That premise was altered in 2004 by the legislation cited above.

Although TSAC considered GCMA Report #R-276 inter alia for three years, no final report was ever submitted by the TSAC regulatory review working group.

Our mariners actively contributed to GCMA Report #R-276 for over four years. For this reason, we are confident that GCMA Report #R-276, Revision 7, dated March 1, 2004 could and should serve as the basis of any future rulemaking activity that leads to the regulation and inspection of towing vessels. This report contains a preamble (pages 1-9) and a listing of 74 safety issues that must be addressed (pages 9-26). We believe that these 74 safety issues, compiled as part of our ongoing project, is quite comprehensive. Regrettably during this four-year time period, the Coast Guard addressed only a few of these issues directly. This is not to say that additional issues do not exist and may be uncovered during the rulemaking process.

Therefore, as permitted under Coast Guard regulations at 33 CFR §1.05-20 the Gulf Coast Mariners Association respectfully petitions the Coast Guard to introduce a comprehensive rulemaking project that provides mariners who work on every uninspected towing vessel over 26 feet in length with exactly the same protections that mariners who work on inspected offshore supply vessels, small passenger vessels, and other inspected vessels of comparable size and horsepower also enjoy as well as such additional protective regulations as may be called for in "...a safety management system appropriate for the characteristics, methods of operation, and nature of service of towing vessels" as mentioned in 46 U.S. Code §3301(j) as amended." Very truly yours, s/Richard A. Block, Master #1014425, Issue #8, Secretary, Gulf Coast Mariners Association.

### **HOURS OF SERVICE REGULATION VIOLATIONS RESULT IN FELONY CONVICTION FOR TRUCKER**

In 1989, the National Transportation Safety Board (NTSB) formally recognized that there were glaring problems with existing "Hours of Service" regulations that adversely affect truckers, mariners as well as airline pilots. Subsequently, serious accidents such as the bridge allision accident at Webbers Falls, OK, on the Arkansas River in May 2002 reported in this Newsletter brought the problem into clear focus for the public on the national television news.

The semi-trailer truck driver that was involved in a deadly Amtrak derailment near Bourbonnais, Illinois that killed 11 people and injured 122 others aboard the City of New Orleans passenger train recently had his day in court.

After a three-year investigation, the National Transportation Safety Board (NTSB) ruled that the truck driver John R. Stokes, 63, caused the accident when he failed to heed railroad crossing signals and gates. He ignored warning lights and bells and drove around lowered crossing gates as he unsuccessfully attempted to cross several tracks with a load of steel. Amtrak's City of New Orleans passenger train was enroute from Chicago to New Orleans at its legal speed limit of 79

miles per hour. The resulting crash derailed both locomotives and 11 of 14 cars.

Federal investigators determined that Stokes had just three to five hours of fragmented sleep in the 38 hours before the accident while the federal rules at the time required an eight-hour break after 10 hours of driving. By comparison, in the Webbers Falls bridge allision the towboat Pilot had only about 9½ hours of sleep in the preceding 46 hours.

Stokes was found guilty by a Circuit Judge in Kankakee County, Illinois of willful violation of the maximum time limit for commercial truckers and willfully violating laws requiring him to keep an accurate logbook. Both charges are felonies, and Stokes faces a possible prison term of one to three years at sentencing on September 22<sup>nd</sup>.

The state Assistant Attorney General said, "The judge found today that he lied about how long he was driving and kept lying about it to the police and the NTSB."<sup>(1)</sup> [<sup>(1)</sup>*Chicago Tribune, Aug. 11, 2004.*]

In both this truck crash and the Webbers Falls accident that demolished the Interstate 40 bridge, the truck driver and the towing vessel master spent far more hours "on duty" than the federal rules permitted.

What is noteworthy, however, is the significant differences in the outcomes for the two individuals who violated the same type of rules. The truck driver is facing jail time for "willful violation" of the rules. As far as we know, no criminal charges were filed against the Pilot of the M/V Robert Y. Love. Within months of the Illinois railway accident, the Federal Highway Administration began to push for stricter work-hour regulations while trucking interests (like towing vessel lobbyists) fought the proposed changes. Similarly, GCMA pushed the Coast Guard for adequate logbook and work-hour reporting regulations over 3 years ago. Failing in that, GCMA brought the matter directly to Congress. The GCMA "Yellow Book" published in May 2000 exposed widespread shortcomings in the existing "two-watch" system. GCMA called for meaningful reforms of the existing 12-hour rule in the hope that this would lead to greater safety afloat and less exploitation of our mariners.

In the Stokes case, when the FHA investigated his trucker's logbook, it found four other incidents in the two months immediately before the deadly crash where Stokes recorded he was either off duty or sleeping at the same time company records showed he was either picking up or hauling loads of steel.

Enforcing "work-hour" rules has never been easy because trucking inspectors rely on the logbooks that truck drivers fill out themselves. In a recent one-year period, three million truck inspections revealed that 18% of drivers violated the rules at least once according to the Federal Motor Carrier Safety Administration. No comparable figures exist for uninspected towing vessels because of lax Coast Guard enforcement of existing work-hour regulations.

While the Coast Guard has enforceable logbook regulations for vessels engaged on an international voyage, the regulations for towing vessels have been a ljoke.

The logbook requirements that are mentioned in the AWO's Responsible Carrier Program, on the other hand, are reasonable and GCMA supports them. However, since they are not a part of federal regulations, they are not enforceable.

## EXPLANATION OF LIFE IN A NUTSHELL.



On the first day God created the dog. God said, "Sit all day by the door of your house and bark at anyone who comes in or walks past. I will give you a life span of twenty years."

The dog said, "That's too long to be barking. Give me ten years, and I'll give you back the other ten." So God agreed.

On the second day God created the monkey. God said, "Entertain people, do monkey tricks, make them laugh. I'll give you a twenty-year life span."

The monkey said, "How boring, monkey tricks for twenty years? I don't think so. Dog gave you back ten, so that's what I'll do too, okay?" And God agreed.

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On the third day God created the cow. God said, "You must go to the field with the farmer all day long and suffer under the sun, have calves and give milk to support the farmer. I will give you a life span of sixty years."

The cow said, "That's kind of a tough life you want me to live for sixty years. Let me have twenty and I'll give back the other forty." And God agreed again.

On the fourth day God created man. God said, "Eat, sleep, play, marry, and enjoy your life. I'll give you twenty years."

Man said, "What? Only twenty years! Tell you what, I'll take my twenty, and the forty the cow gave back and the ten the monkey gave back, and the ten the dog gave back. That makes eighty, okay?"

"Okay," said God, "You've got a deal."

So that is why the first twenty years we eat, sleep, play, and enjoy ourselves; for the next forty years we slave in the sun to support our family; for the next ten years we do monkey tricks to entertain the grandchildren; and for the last ten years we sit on the front porch and bark at everyone.

Life has now been explained to you.

### GCMA EFFORTS TO END BLACK LISTING TO REDOUBLE IN THE NEXT CONGRESS

For almost five years GCMA led the fight against the practice of unfairly "black listing" our lower-level mariners also known as "blackballing." Black listing is still being practiced under auspices of one part of the Fair Credit Reporting Act (FCRA). FCRA is a federal law that denies many of our mariners a fair opportunity to find good jobs in the maritime industry.

Since FCRA is a Federal law, we formally brought the problem to the attention of Congressman "Billy" Tauzin, the Chairman, House Committee on Energy and Commerce in a letter dated September 1, 2003. His committee has oversight in this area. We followed up this letter with a reminder on December 17, 2003. We never received the courtesy of an acknowledgement from Congressman Tauzin on either letter. We now reprint the text of our letter that we believe accurately outlines the problems that face mariners in dealing with the Fair Credit Reporting Act.

**September 1, 2003**

Representative W.J. "Billy" Tauzin

Chairman, House Committee on Energy & Commerce

U.S. House of Representatives

2183 Rayburn House Office Building

Washington, DC 20515

SUBJECT: Fairness and the Fair Credit Reporting Act

Dear Representative Tauzin,

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

**"Employment purposes."** 15 USC §1681b indicates that one of the permissible purposes of a consumer report is for "employment purposes." The Federal Trade Commission further defines these "permissible purposes" relating to employment to include reports used for evaluating a consumer "for employment, promotion, reassignment or retention as an employee." Our request concerns abuse of this provision in a significant, non-unionized portion of the maritime industry for employment purposes.

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

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

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

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

[GCMA Comment: GCMA also contacted every other member of Congressman Tauzin's committee by mail but received no response whatsoever.]

[GCMA Comment: Some companies reportedly use a more direct approach outside the FCRA process. All this activity has discouraged many mariners from remaining in the industry over the years. We are convinced the time is at hand when companies will reap what they sew.]

[GCMA Comment: Congressman Tauzin retires from Congress after representing the 3<sup>rd</sup> Congressional District of Louisiana for the past 24 years. We will keep the issue alive.]

### WORKING BEYOND 12 HOURS

By Richard A. Block

We asked the Coast Guard to reply to a hypothetical question based upon a problem one of our mariners recently presented to us. We were looking for the "straight poop" as to how to deal with this matter so we could publish it.

**First scenario:** You have a Master's license. You are running a vessel in 24-hour operation that requires two licensed officers when you are deprived of the services of the second licensed officer. (For example: Got sick; left the boat; Family emergency; Failed to meet boat at crew change.)

**Second scenario:** You have only a Mate (or Pilot) license. You are on a vessel in 24-hour operation that requires two licensed officers when the Master is no longer available. (For example: Got sick; Left the boat; Medevac; Family emergency; Failed to meet boat at crew change.)

You know that your employer expects you to simply pick up the slack and do the job until he can find a replacement. However, you want to protect your license and realize that you can lose it by violating the 12-hour rule. What does the Coast Guard expect you to do to protect your license?

*[We ask whether a licensed mariner can expect relief from the Coast Guard if he reports the problem immediately and seeks permission to continue beyond 12 hours if necessary to reach a safe place to pull in and stop (or to anchor)? We want to determine the Coast Guard's policy in regard to treating such a request. Would the Coast Guard maintain any record of the (phone or radio) call in case the mariner is later fired and seeks redress?]*

**USCG REPLY:**

Dear Sir:

I am writing in response to your letter of July 14,"2004, in which you requested answers to hypothetical questions regarding the "12-hour rule," as found in Section 8104(h) of Title 46 United States Code (USC) and Part 15.705 of Title 46 Code of Federal Regulations (CFR).

As you have written extensively on the subject, I am sure that you are aware that the "12-hour rule" limits a licensed master or mate (pilot) operating a towing vessel of at least 26 feet in length to work no more than 12 hours in any consecutive 24-hour period, except in an emergency. The Coast Guard has taken a strong enforcement posture regarding "12-hour rule" violations. We will initiate an investigation of all alleged violations and pursue warnings, suspension and revocation actions, and civil penalties against mariners and/or operating companies as appropriate. However, as each scenario involving a potential "12-hour rule" violation is unique, they must be evaluated separately and all facts of the case taken into consideration before determining what enforcement actions, if any, should be taken.

Should a master or mate (pilot) need to exceed the 12-hour limitation in the case of an emergency, I recommend that they search for a safe location to push in or proceed to the nearest safe anchorage/fleeting area and suspend operations until a suitable relief can be obtained or they have satisfied the minimal rest requirements. The master, mate (pilot) or operating company may contact the nearest Coast Guard Marine Safety Office to inform them of the situation and the vessel's intentions, and request that the notification be documented within our Marine Information for Safety and Law Enforcement (MISLE) database.

I encourage you or other persons having knowledge of suspected "12-hour rule" violations to report them to the nearest Coast Guard Marine Safety Office so that we may initiate an investigation and take the appropriate action to eliminate this practice.

Sincerely

A. R. SHEFFIELD

Lieutenant Commander, U.S. Coast Guard Chief, Investigations Department

By direction of the

Officer in Charge, Marine Inspection

(Copy: Commander, Eighth Coast Guard District (m))





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