Log M-336A

National Transportation Safety Board

Washington, D.C. 20594

Safety Recommendation

Date: March 1, 1988

In reply refer to: M-88-2 through -8

Honorable Buddy Roemer
Governor of Louisiana
Baton Rouge, Louisiana 70804

About 1920 central standard time on October 28, 1986, the 615-foot-long Hong Kong bulk carrier PETERSFIELD and a tow of eight tank barges, which were being pushed by the U.S. towboat BAYOU BOEUF, collided on the Mississippi River in Avondale Bend at Twelve Mile Point near New Orleans, Louisiana. At the time, both vessels were proceeding upriver and the PETERSFIELD was overtaking the BAYOU BOEUF tow. The overall length of the towboat and barges was about 1,140 feet. The small U.S. towboat, the HARRY MCNEAL, and a fuel barge, the S-20, were secured on the port side of the tow, and diesel oil was being transferred to barges in the tow. The PETERSFIELD sustained damage to its starboard bow and port side. One tank barge sank, two tank barges capsized and were pushed ashore, and four other tank barges and the S-20 sustained damage. The BAYOU BOEUF and the HARRY MCNEAL were not damaged. Total damage resulting from the accident was estimated to be $3 million. No one was injured. 1/

Since 1981, the State-licensed pilot who was piloting the PETERSFIELD at the time of the accident has been involved in five other accidents. In four of the accidents, the pilot's performance either caused or contributed to the cause of each accident. The pilot failed to reduce his speed in view of reduced visibility conditions (APHRODITE) and traffic congestion (RAYNA/BEKER and PALM PRIDE), and he failed to provide adequate separation while overtaking another vessel (ARKAS). Further, it is clear that the pilot failed to recognize the danger of collision in time to take action. In one accident, the master of the vessel involved testified that he took over conning the vessel when the pilot ordered hard right rudder shortly before colliding with barges on the vessel's starboard side while the vessel was supposed to be negotiating a left turn in the river (PALM PRIDE). The Safety Board believes that the pilot's accident record clearly indicates a lack of adequate diligence or competence, or both, to pilot seagoing vessels on the Mississippi River.

Early during the investigation, the Safety Board determined that the president of the Board of New Orleans-Baton Rouge Steamship Pilot Commissioners (BOC) was not aware that the accident pilot had been involved in five other accidents since 1981. The apparent lack of knowledge of the pilot's accident history suggests that oversight by the State of Louisiana over the performance of its State pilots was ineffective or nonexistent. The Safety Board believes that if the State oversight system had functioned effectively, the pilot would have been removed from service or action would have been taken to correct his deficiencies, and the collision between the PETERSFIELD and the BAYOU BOEUF would have been avoided.

1/ For more detailed information, read Marine Accident Report--"Collision Between the the Hong Kong Flag Bulk Carrier PETERSFIELD and the U.S. Towboat BAYOU BOEUF and Tow, New Orleans, Louisiana, October 28, 1986" (NTSB/MAR-88/01).

By law, the BOC must inform the governor whenever a pilot's performance involves incompetence, carelessness, habitual drunkenness or neglect of duty. The governor is required to refer the matter back to the BOC to conduct a formal investigation and then to make a report to the governor with a recommendation for a penalty, if justified. Conducting a formal hearing procedure is time-consuming and exposes to public scrutiny the BOC oversight of a pilot; this procedure appears to be used rarely and only in "serious" cases. The Safety Board is unaware of anything in the State legislation that requires that only "serious" cases be sent to the governor. More importantly, the Board believes that four of the other five accidents involving the accident pilot were serious and involved carelessness or incompetence, or both, and should have been reported to the governor.

The ultimate decision confronting the BOC is whether an accident involving a pilot due to improper performance should be referred to the governor for possible reprimand or suspension or revocation of the pilot's commission. If the BOC decides to not refer the case to the governor, no action will be taken against the pilot because the BOC is not empowered to do so. Although the Safety Board does not believe that the BOC as it is presently constituted would necessarily have taken any action against the accident pilot even if it had such authority, the BOC should be empowered to take some corrective action against pilots when their performance warrants action. The Safety Board believes the BOC should be authorized to take corrective and/or punitive action when a pilot contributes to the cause of an accident or is involved in an infraction of regulations but when the failure does not warrant being referred to the governor for suspension or revocation of the pilot's State commission.

The functioning of the BOC and how it conducts its investigations, except possibly for its quarterly meetings, is not readily accessible to public scrutiny. The only information about the BOC that is available to the public is contained in the sections of State law concerning the New Orleans-Baton Rouge pilots. These sections of the State law provide a limited amount of information, are difficult to read, and are subject to misinterpretation. For example, Section 1042 of the State law requires that a BOC be appointed by the governor with the advice and consent of the senate; however, the law does not define clearly the functions of the BOC. Section 1045 requires the BOC to examine pilot apprentices; however, the responsibility for training apprentices to become pilots is not specifically assigned to the BOC. Applicants are required to serve a 6-month apprenticeship, but the BOC is not specifically assigned responsibility for supervising the apprentice program. Section 1049, which provides authority for the BOC to investigate the performance of pilots involved in accidents also is unclear. The term "sit as investigator" is not explained.

The commissioners' rules, which are supposed to implement the laws applicable to the BOC, were not available to the public and had to be obtained by the Safety Board through the subpoena process. A review of the rules revealed that they were out of date (citing an outdated Section 1049 of the State law), were very brief, and amplified the meaning of the law only slightly. The Louisiana law applicable to pilotage on the Mississippi River between New Orleans and Baton Rouge should be clarified. Further, the Safety Board believes that the BOC should develop and publish clearly written, comprehensive commissioners' rules and that these rules should be made available to the public.

According to its previous president, the BOC conducted preliminary investigations in approximately 30 accidents in a 2-year period ending December 1986. Two of these accidents--the RAYNA/BEKER and the PALM PRIDE--involved vessels piloted by the accident pilot. The accident investigation file pertaining to the RAYNA/BEKER contained the Coast Guard report of the investigation, dated August 15, 1986, and a

cassette recording and transcript of the Vessel Traffic Service (VTS) recording. There was no written statement from the pilot, although the commissioners' rules require a pilot in an accident to submit a written statement within 5 days of an accident, or as soon as possible. The BOC preliminary investigation was dated April 9, 1986. Therefore, the Coast Guard report was not available to the BOC in its decisionmaking. Accordingly, the commissioners must have based their investigation solely on the VTS recording and transcripts. The Safety Board considers the pilot of a ship to be a key person in an accident investigation. Commissioners ought to follow their own rules by requiring the pilot to provide a comprehensive factual statement describing the accident and explaining what the pilot believes caused it.

The commissioners' accident file on the PALM PRIDE collision contained more items than the other file; however, except for the two cassette recordings and transcript of the VTS radiotelephone transmissions, these items were of very limited value in determining the circumstances of the accident. The pilot's written statement, dated July 21, 1986, 28 days after the accident, merely stated that he was piloting the PALM PRIDE when it collided with certain moored barges on the morning of June 23, 1986. The written statement did not give a description of the accident, nor did it provide any information on how or why the accident occurred. Acceptance of such a statement by the BOC indicates that the BOC is not strongly motivated to conduct a reasonably effective investigation. An extract from the PALM PRIDE log attributing blame for the accident to the pilot should have been thoroughly investigated. The PALM PRIDE was in New Orleans for a protracted time as a result of the collision, and its officers were on board for several days; hence, there should have been ample time for the commissioners to obtain crew statements and learn that the master took away the conn of the vessel from the pilot.

The previous president of the BOC conducted the investigations of these two accidents. He stated that he reached his finding that the pilot's performance did not warrant further investigation after carefully reviewing the VTS recordings of the radiotelephone transmissions. The lack of witness statements except for the uninformative statement by the accident pilot and the very limited information in the RAYNA-BEKER file suggests that the investigations of these two accidents were only cursory and that the commissioners did not abide by their own rules. The lack of witness statements in the PALM PRIDE accident suggests that the BOC may have been satisfied with hearing essentially one side of the story. The Safety Board believes that the BOC in conducting these limited investigations provided no effective oversight of pilot performance.

The practice by the BOC of not keeping a file on each pilot which provides details of the accidents involving the pilot and the action taken by the BOC limits the commissioners' ability to recognize when certain pilots are having a high number of accidents. Such records are routinely kept by other State pilotage commissions so that pilots having problems can be identified as early as possible. The practice of considering only the facts of the case at hand without regard for previous accidents renders less likely the detection of a trend toward frequent accident involvement or other problems. Also, the practice of not keeping accident investigation files longer than 3 years prevents any long-range assessment of pilotage safety. This practice limits the ability of the commissioners to recognize safety problems or to maintain continuity of oversight when the commissioners are changed. The lack of records on each pilot and the practice of disposing of files after 3 years insulates poor-performing pilots from proper oversight and permits poor performers to remain on the job with no action taken to improve their performance. Public safety requires that this situation be corrected. The Safety Board

believes that the BOC should maintain on each pilot a service record or personnel file containing information about each accident or infraction involving the pilot and the action taken by the pilot commissioners. The BOC should maintain all accident investigation files as long as the pilot continues to pilot.

Statements by the commissioners show that the BOC does become concerned whenever a pilot is incapacitated through drunkenness. According to the commissioners, the main reason for taking a pilot "off the books" before conducting a preliminary investigation is drunkenness; however, the BOC does not have a drug and alcohol testing program. There is no indication that the accident pilot was incapacitated, and he appears to have met the PETERSFIELD on time. The accident history of the pilot shows that a pilot can be involved in a substantial number of accidents without causing the BOC to take any more action than if he had been in a single accident. The fact that the pilot's record of five accidents (one not caused or contributed to by his actions) in the 5-year period before this accident had not yet caused the commissioners to conduct an in-depth inquiry raises the question of when the commissioners would be motivated to take action. The Safety Board concludes that this situation occurred, in part, because three pilots were detailed to pass judgment on their fellow pilots, and the State law made it an easy matter to avoid making a report to the governor. The situation would be even less likely to occur if a shipping company were permitted to refuse a pilot based on his accident record.

Drug and alcohol testing programs are viewed as an essential part of any oversight program for persons whose performance can directly affect the safety of the public in transportation. The lack of a drug and alcohol testing program demonstrates that the BOC is neglecting to take necessary safeguards against the possibility of substance abuse by the pilots it is charged to monitor. The Safety Board believes that the State should require the BOC to develop and administer a drug and alcohol testing program that will require pilots involved in an accident to provide specimens for drug and alcohol testing at the earliest feasible time after an accident.

Pilots are rarely financially accountable for their actions. Vessel owners and, ultimately, the public must bear this cost. Since it is the public that pays the cost of pilot-caused accidents, the public should have some voice in who is allowed to pilot vessels in the Nation's foreign commerce. Accordingly, the Safety Board believes that State pilotage commissions must be responsive to the shipping companies they serve and to the public, and they must be open to public scrutiny. This can be accomplished by broadening the BOC to include representatives from steamship companies, shippers, and the public.

The Safety Board also believes that information about the actions of the BOC should be disseminated to the public. Such information could be disseminated by an annual report from the BOC to a State agency, such as the Louisiana Department of Transportation. The annual report should provide a brief description of all accidents involving pilots of the New Orleans-Baton Rouge Steamship Pilots Association, date/time, name of pilot, name of vessel, damage cost to vessel and other property, and a description of commissioners' findings and action.

Although the investigation concerning the PETERSFIELD and the BAYOU BOEUF and tow concentrated primarily on pilotage between New Orleans and Baton Rouge, some of the recommended improvements in pilotage oversight probably are applicable to other pilotage commissions in Louisiana. Therefore, the Safety Board believes the State of Louisiana should review the applicability of the recommendations and institute the provisions of each recommendation, if appropriate, to other Boards of Pilot Commissioners.

Therefore, the National Transportation Safety Board recommends that the State of Louisiana:

> Authorize the Board of New Orleans-Baton Rouge Steamship Pilot Commissioners to take corrective and/or punitive action when a pilot contributes to the cause of an accident or is involved in an infraction of regulations but when the failure or fault does not warrant being referred to the governor for suspension or revocation of the pilot's State commission. (Class II, Priority Action) (M-88-2)
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> Require the Board of New Orleans-Baton Rouge Steamship Pilot Commissioners to develop and publish clearly written, comprehensive commissioner rules, and make these rules available to the public. (Class II, Priority Action) (M-88-3)
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> Require the Board of New Orleans-Baton Rouge Steamship Pilot Commissioners to maintain a service record or personnel file on each pilot containing information about each accident or infraction involving the pilot and the action taken by the pilot commissioners. The Board should maintain the service record and all accident investigation files as long as the pilot continues to pilot. (Class II, Priority Action) (M-88-4)
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> Broaden the Board of Pilot Commissioners for the New Orleans-Baton Rouge Steamship Pilots Association to include representatives of steamship companies, shippers, and the public. (Class II, Priority Action) (M-88-5)
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> Require the Board of New Orleans-Baton Rouge Steamship Pilot Commissioners to compile data on accidents and to submit to the Louisiana Department of Transportation an annual report providing a brief description of all accidents involving pilots of the New Orleans-Baton Rouge Steamship Pilots Association, date/time, name of pilot, name of vessel, damage cost to vessel and other property, and a description of commissioners' findings and actions. (Class II, Priority Action) (M-88-6)
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> Require the Board of New Orleans-Baton Rouge Steamship Pilot Commissioners to develop and administer a drug and alcohol testing program that will require pilots involved in accidents to provide specimens for drug and alcohol testing at the earliest feasible time after an accident. (Class II, Priority Action) (M-88-7)
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> Review the applicability of Safety Recommendations M-88-2 through -7 to the other Boards of Pilot Commissioners within Louisiana and institute the provisions of each recommendation that are appropriate for each Board of Pilot Commissioners. (Class II, Priority Action) (M-88-8)

Also, the Safety Board issued Safety Recommendation M-88-1 to the U.S. Coast Guard.

The National Transportation Safety Board is an independent Federal agency with the statutory responsibility " . . . to promote transportation safety by conducting independent accident investigations and by formulating safety improvement recommendations" (Public Law 93-633). The Safety Board is vitally interested in any action taken as a result of its

safety recommendations. Therefore, it would appreciate a response from you regarding action taken or contemplated with respect to the recommendations in this letter. Please refer to Safety Recommendations M-88-2 through -8 in your reply.

GOLDMAN, Vice Chairman, and LAUBER, NALL, and KOLSTAD, Members, concurred in these recommendations. BURNETT, Chairman, did not participate.

By: Jim Burnett
Chairman