

SUBMISSION TO ICONS FROM THE NATIONAL TRANSPORTATION SAFETY BOARD, USA.

Honorable Peter Morris
Chairman, International Commission on Shipping
Post Office Box 162, Civic Square
Canberra ACT
Australia 2614

Dear Chairman Morris:

Thank you for your May 29, 2000, invitation to submit comments to the International Commission on Shipping on substandard shipping in the context of the National Transportation Safety Board's mission.

Following the December 14, 1996, ramming of the Hilton Hotel in New Orleans, Louisiana, by the Liberian freighter *Bright Field*, I presented a speech to the Propeller Club of Washington, D.C., on the Safety Board's mission and the safety of international shipping. In this speech, I explained the Board's philosophy on vessel safety, with an emphasis on international ship safety, and I also discussed our unique role in transportation safety. I have attached the speech for your information.

I share your concern about the safety of substandard ships and acknowledge the commission's efforts to raise the overall level of international ship safety. I appreciate your bringing this initiative to the Safety Board's attention.

Sincerely,

Jim Hall
Chairman

► **Attachment**

Remarks of Jim Hall, Chairman
National Transportation Safety Board
before the Propeller Club of Washington, D.C.
March 11, 1998

Thank you. Good Afternoon, President Snow, Vice President Shea, and members of the Propeller Club. I am very pleased to be here this afternoon before this group, which is dedicated to the health and wellbeing of the American Merchant Marine. As Chairman of the National Transportation Safety Board, I welcome this opportunity to discuss the role our agency plays in transportation safety improvements and in the safety of marine transportation particularly.

You know the Safety Board for its high-profile investigations like the crash of TWA flight 800 and the ValuJet accident in Florida. You probably also know that the Board investigates major highway, rail, pipeline and marine accidents.

The NTSB was established in 1967 as an independent agency so that we could conduct objective oversight of the operating practices and regulations of the Department of Transportation. Because DOT is charged with both the regulation and promotion of transportation in the United States, and investigation of accidents may suggest deficiencies in the transportation system, the Safety Board's independence is vital for objective oversight. And because the NTSB neither regulates, funds nor is directly involved with transportation operations, we can take an impartial overview of the transportation system and make objective safety recommendations.

Recommendations are made to the appropriate parties involved in an accident, be they government or private industry. Although these recipients have no obligation to comply with the recommendations, historically, over 82 per cent of our recommendations have been accepted and adopted by the recipients. Because of our high profile, most people are shocked to learn that we have fewer than 400 employees and conduct our work at an annual cost of about 18 cents a citizen.

The Safety Board is in a unique position because for 30 years we have been the eyes and ears of the American people at accident sites. We are a national archive, funded by the taxpayer, of what transportation companies and government regulators should not do, to provide lessons so that the same mistakes are not made over and over again. As the federal government's only multi-modal accident investigation agency, we have worked with industries and regulators covering the entire spectrum of our nation's massive transportation network.

What have the American people gotten for that modest investment? I like to think we've played a major part in the development of the safest transportation system in the world. And we can cite concrete examples of safety improvements that resulted from our recommendations.

NTSB recommendations led to smoke detectors in airplane lavatories, floor level lighting strips to lead passengers to emergency exits, anti-collision systems and ground proximity warning devices.

It was a Safety Board study in late 1996 that began the recent national debate on the safety of air bags for children and small adults.

It was the NTSB that spurred improvements in school bus construction standards.

Board recommendations have improved passenger car safety in the railroad industry by recommending that trains be equipped with emergency signage, safety placards and portable lighting. And,

Recommendations issued in September 1987 as part of the Safety Board's "Uninspected Commercial Fishing Vessel Safety Study" led to new regulations that for the first time required commercial fishing vessels to carry specific life-saving devices. These improvements are having a dramatic impact on the safety of this industry. In Alaska, there was over a 50 percent decline in lives lost in just one year.

The Safety Board's Office of Marine Safety consists of eleven investigators who have extensive experience in the commercial marine industry, U. S. Coast Guard and the U. S. Navy. These investigators include licensed master mariners, licensed engineers, naval architects, and human performance and survival factors specialists.

The Safety Board has the authority to investigate marine accidents involving any commercial vessel in U. S. waters, or U. S. commercial vessels in international waters. We can investigate a marine accident in one of several ways, either independently of the Coast Guard, or jointly with the Coast Guard, or by delegation to the Coast Guard.

Because the Safety Board is a small agency, we use what we call the party system during investigations. Parties are designated because they have special knowledge or provide technical expertise or resources that can assist the Board in the development of factual information. Parties are also encouraged to submit their findings, conclusions and recommendations for the Safety Board's consideration. Party representatives must be suitably qualified technical employees who do not occupy legal positions. By using the party system, we get the benefit of their cumulative expertise and knowledge.

An accident, which represents a major failure of the operating system in which it occurred, often results from a combination of circumstances. These circumstances can range from mechanical failures to environmental conditions to human errors to organizational failings. I would like to talk about just such a marine accident investigation that highlighted each one of these safety issues. I want to make it clear that there is certainly no intent to embarrass anyone in the marine industry by discussing this accident. I only mention it because it is important that we all learn the important lessons provided.

I'm sure you all remember the frightening accident when the Liberian freighter BRIGHT FIELD struck the Poydras Street wharf, Riverwalk Marketplace, and New Orleans Hilton Hotel in New Orleans, Louisiana on December 14, 1996. The BRIGHT FIELD was down bound in the Lower Mississippi River with a cargo of corn enroute for the sea. As the ship passed under the Crescent City Connection Bridges, the vessel pilot began maneuvering the ship toward the left descending bank near the Riverwalk Marketplace shopping mall to facilitate the turn around Algiers Point.

At about this time, the main propulsion engine No. 1 lubricating oil pump lost pressure. When the engine power dropped, the ship lost its ability to maneuver in the river current and continued to veer toward the left descending bank. Because of the time required to restore main engine rpm – about 2 minutes – the

ship could not avoid striking the structures along the riverbank. Sixty-two persons in the Riverwalk complex or on board gaming or excursion vessels moored alongside the wharf sustained injuries.

Two months ago, we issued our final report on this major investigation. The issues addressed in the report included:

- The adequacy of the ship's main engine and automation systems.
- The adequacy of port risk assessment for activities within the Port of New Orleans.
- The adequacy of actions of pilot and crew during the emergency, communications, and toxicological testing of the Bright Field crew.
- The adequacy of the emergency preparedness and evacuation plans of the vessels moored in the Poydras Street wharf area.

The Safety Board concluded that the probable cause of the accident was the failure of the shipping company to adequately manage and oversee the maintenance of the engineering plant aboard the BRIGHT FIELD, with the result that the vessel temporarily lost power while navigating a high-risk area of the Mississippi River. Contributing to the amount of property damage and the number and types of injuries sustained during the accident was the failure of the U. S. Coast Guard, the Board of Commissioners of the Port of New Orleans, and International River Center, Inc., to adequately assess, manage, or mitigate the risks associated with locating unprotected commercial enterprises in areas vulnerable to vessel strikes.

This major Safety Board report resulted in 30 recommendations issued to 10 organizations to make improvements in these areas.

As I mentioned earlier, the severity of this accident was the result of a combination of failures, none of which should have been a surprise. I attended the Second World Safety Congress last month in Delft, Netherlands, where the sinking of the motor vessel ESTONIA was the subject of interest with many of the delegates. Like the BRIGHT FIELD accident, the loss of the ESTONIA was predictable and preventable. Problems with the reliability of the bow loading door on the ESTONIA and her sister vessel, the DIANA II, were known to the owner, class society and the flag state. In both accidents the 'safety culture' of each transportation system was ineffective in preventing or minimizing the associated risks.

The safer carriers that we see across the transportation modes have more effectively committed themselves to controlling the risks that may arise. The possibility of factors such as mechanical failure, hostile environmental conditions, human error and organizational failures affecting safety must be anticipated and safeguards must be systematically developed and implemented. All other things being equal, the better this is done, the safer the carrier will be, and the accident statistics will reflect these conditions.

If you were to look at many of the accidents the Safety Board has investigated lately, their root causes go beyond a mere lack of planning, poor personnel decisions or faulty material. Each of the accidents were set up by one or more of the following characteristics:

- The belief that the absence of accidents is indicative of the presence of safety.
- Futility in the belief in an infallible technology.
- The lack of appreciation for the role of the human in a highly technical system.
- The lack of an avenue for divergent opinions.
- The arrogance of management that believed in its inherent superiority to government regulations and sound operating practices.
- The tradeoff between revenue and safety, to the detriment of safety.
- The establishment of an organizations culture that discouraged communication, divergent opinion, and an appreciation for the importance of safety.
- We and the transportation community have come to recognize that all participants have a responsibility for creating and fostering a climate that encourages safe operations.
- Government is responsible for setting guidelines and standards;
- Management is responsible for enhancing the compliance with those standards while accommodating variations in individual experience, knowledge, and skills; and
- The operator is responsible for using the knowledge, skill and experience to do the job in the safest way possible.

This new emphasis on "corporate culture" in the transportation community prompted me to direct the Board to conduct an international symposium on the subject last year. The two-day conference was attended by hundreds of transportation professionals representing all modes of travel.

In closing, let me state that one of the founders of our nation, Thomas Jefferson, said, "The care of human life and happiness is the first and only legitimate object of good government." I believe it is this simple phrase that describes the mission and goals of the National Transportation Safety Board. But it is the vigilance of regulatory agencies, the commitment of transportation companies, and the dedication of organizations like yours that work hand-in-hand with the Safety Board to make our transportation system the safest in the world.

Thank you for allowing me to share my thoughts with you today.

NTSB Home Page | Speeches and Testimony | Jim Hall's Speeches
<http://www.nts.gov/speeches/jh980311.htm>.