UNITED STATES OF AMERICA

DEPARTMENT OF HOMELAND SECURITY
UNITED STATES COAST GUARD

UNITED STATES COAST GUARD
Complainant

vs.

LOUIS M. CHAMPA, SR.,
Respondent.

Docket Number: CG S& R 03-0219
CG Case No. 1750348

DECISION AND ORDER

Issued: June 23, 2004

Issued by: Honorable Peter A. Fitzpatrick, Administrative Law Judge

APPEARANCES:

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I. SUMMARY OF THE CASE

This case arises from a fire in the engine room of the M/V SSG EDWARD CARTER, JR. ("SSG CARTER") at approximately 1600 on July 14, 2001, which caused fifteen (15) million dollars worth of property damage to the vessel and the death of two crewmembers. In discharge of its duty to promote the safety of life and property at sea, the United States Coast Guard ("Coast Guard" or "Agency") initiated this administrative action seeking revocation of the Merchant Mariner's License ("License") and Merchant Mariner's Document ("Document") issued to Respondent Louis M. Champa, Sr., who served as the Chief Engineer onboard the vessel at the time of the marine casualty. The Coast Guard alleges Respondent committed negligence and misconduct arising from the disconnection of vent piping to the Heavy Fuel Oil ("HFO") Vent Collection Chamber onboard the SSG CARTER. This action was brought pursuant to the legal authority contained in 46 United States Code ("U.S.C.") 7703, and the proceeding was conducted in accordance with the procedural requirements of 5 U.S.C. 551-559, 46 Code of Federal Regulations ("CFR") Part 5, and 33 CFR Part 20.[1] After careful review of the facts of this case, I find that the Coast Guard has proved by a preponderance of the evidence that Respondent committed negligence and misconduct. For reasons stated herein, Respondent's License and Document are revoked.

II. PRELIMINARY STATEMENT

On April 1, 2003, the Coast Guard issued a Complaint alleging Respondent committed one count of Negligence and three counts of Misconduct while acting under the authority of his

[1] While this case was pending, the United States Coast Guard transferred from the Department of Transportation to the Department of Homeland Security. Pursuant to the Savings Provision of HR 5005 § 1512 (PL 107-296), pending proceedings are continued notwithstanding the transfer of the Agency.

License when serving as Chief Engineer onboard the SSG CARTER from July 11, 2001 through, and including, July 14, 2001. The factual allegations read as follows:

FACTUAL ALLEGATIONS – Negligence

1. Respondent was signed on as Chief Engineer onboard the SSG CARTER from July 11, 2001 to July 14, 2001.

2. Respondent ordered, on or about July 11, 2001, the disconnection of the vent piping to the HFO Vent Collection Chamber to facilitate correction of an overpressure problem.

3. Respondent negligently failed to order any action by members of the ship's engine room crew, to clear the vent piping of suspected obstructions and failed to reconnect any of the vent piping between the time of the disconnection of the vent piping on or about July 11, 2001 and 1600 on July 14, 2001.

FACTUAL ALLEGATIONS – Misconduct (First Offense)

1. Respondent, as Chief Engineer, was responsible, under the Maersk Safety Management Plan Section 7.2.4 for the safe operation of SSG CARTER's machinery, specifically including the ship's lockout and tag out procedures.

2. Respondent ordered, on or about July 11, 2001, the disconnection of the vent piping to the HFO Vent Collection Chamber to facilitate correction of an overpressure problem.

3. Respondent did not order that any valve allowing the transfer of fuel to the tanks whose vent piping was disconnected be locked out, tagged out, or otherwise rendered incapable of transferring fuel between the time of the disconnection of the vent piping, on or about July 11, 2001, and 1600 on July 14, 2001.

4. Respondent's failure to ensure the transfer piping valves were locked out, tagged out, or otherwise rendered incapable of allowing the transfer of fuel to the tanks whose vent piping was disconnected violated the Maersk Safety Management Plan.

FACTUAL ALLEGATIONS – Misconduct (Second Offense)

1. Respondent, as Chief Engineer, was responsible, under the Maersk Safety Management Plan Section 7.2.4 for the safe operation of SSG CARTER's machinery, specifically including the ship's lockout and tag out procedures.

2. Respondent ordered, on or about July 11, 2001, the disconnection of the vent piping to the HFO Vent Collection Chamber to facilitate correction of an overpressure problem.

3. Respondent did not order that any fuel transfer pump capable of transferring fuel to the tanks whose vent piping was disconnected be locked out, tagged out, or otherwise rendered incapable of transferring fuel between the time of the disconnection of the vent piping, on or about July 11, 2001, and 1600 on July 14, 2001.

4. Respondent's failure to lockout, tag out, or otherwise render the fuel transfer pumps allowing the transfer of fuel to the tanks whose vent piping was disconnected violated the Maersk Safety Management Plan.

FACTUAL ALLEGATIONS – Misconduct (Third Offense)

1. Respondent ordered, on or about July 11, 2001, the disconnection of the vent piping to the HFO Vent Collection Chamber of the SSG CARTER to facilitate correction of an overpressure problem.

2. The engine room of the SSG CARTER is intermittently manned, with reduced engine room manning, and was so manned in July 2001.

3. The Heavy Fuel Oil transfer pump on the SSG CARTER had an automatic transfer setting.

4. 46 CFR Sections 62.35-40 and 62.35-50 require that fuel piping in intermittently manned engine rooms where the fuel transfer pump is capable of automatic transfer be connected to overflow tanks or have an automatic trip system to shut off the transfer pump.

5. SSG CARTER did not have an automatic overfill trip for the Heavy Fuel Oil transfer pump.

6. Respondent committed misconduct when he ordered the disconnection of the vent piping to the HFO Vent Collection Chamber of the SSG CARTER on or about July 11, 2001, and left the vent piping disconnected until 1600 on July 14, 2001, without taking any action to clear or repair the vent piping.

On June 16, 2003, counsel for Respondent filed an Answer admitting most of the jurisdictional allegations.[2] Respondent also admitted much of the factual allegations. However, Respondent denied that he committed any act of negligence by failing to order any actions by the engine room crew to clear the vent piping to the HFO Vent Collection Chamber of suspected obstructions and by failing to reconnect any of the vent piping between the time of the disconnection of the vent piping on or about July 11, 2001, and 1600 on July 12, 2001. Respondent also denied that he committed misconduct by failing to ensure that the valves and

[2] The jurisdictional allegations included Respondent's contact information, identified the Coast Guard License and Document held by Respondent, and indicated that Respondent was acting under the authority of his License as a Chief Engineer onboard the SSG CARTER.

transfer pump were locked out, tagged, out or otherwise rendered incapable of transferring fuel between the time of the disconnection of the vent piping, on or about July 11, 2001, and 1600 on July 14, 2001 in violation of the Maersk Safety Management Plan. Respondent further denied that he committed misconduct by violating 46 CFR 62.35-40 and 62.35-50 by disconnecting the vent piping to the HFO Vent Collection Chamber of the SSG CARTER on or about July 11, 2001, and leaving the vent piping disconnected until 1600 on July 14, 2001, without taking any action to clear or repair the vent piping.

Respondent also asserted three affirmative defenses. Respondent's counsel argued: 1) that the Investigating Officer ("IO") violated Respondent's due process rights and his right to be represented by counsel by conducting an arbitrary and capricious investigation under 46 CFR Part 4; 2) that the Respondent's acts amounted to an error in judgment - - not negligence as that term is defined in 46 CFR 5.29; and 3) that the Respondents acts amounted to an error in judgment - - not misconduct as that term is defined in 46 CFR 5.27.

A separate administrative action seeking revocation of Coast Guard credentials was filed against Peter R. Donat, Second Assistant Engineer, onboard the SSG CARTER. See USCG v. Donat, Docket Number CG S&R 03-0243. On July 3, 2003, the Champa case and the Donat case were consolidated. In mid-October 2003, the undersigned Administrative Law Judge approved a settlement agreement between the Coast Guard and Mr. Donat, which effectively resolved the case against Mr. Donat. However, the settlement did not resolve the case against Mr. Champa.

An evidentiary hearing was held in Wilmington, North Carolina ("NC") before this Judge beginning on October 29, 2003 and ending on October 31, 2003. Prior to commencement of the hearing, the Coast Guard and Mr. Champa, by and through counsel, entered into Stipulations

pursuant to 33 CFR 20.809. The Stipulations are contained in Attachment A. At the hearing, the Coast Guard offered the testimony of five (5) witnesses and sixty (60) exhibits were admitted into evidence. Respondent's counsel defended by offering the testimony of four (4) witnesses and introduced seven (7) exhibits, which were all admitted into evidence. The list of witnesses and exhibits is contained in Attachment B. Following the conclusion of the hearing, the parties filed post-hearing briefs, including proposed findings of fact and conclusions of law. Rulings on the proposed findings of fact and conclusions of law are contained in Attachment C. This case is now ripe for decision.

III. FINDINGS OF FACT[3]

A. Background: The M/V SSG EDWARD A CARTER, JR.

1. The M/V SSG EDWARD A CARTER, JR. (Official No. 66578) is a 940-foot U.S. flagged containership owned by Maersk Line, Ltd and chartered by the Military Sea Lift Command to carry military ammunition as part of the Navy's prepositioned fleet. *(Gov't Ex. 1; Tr. Vol. I at 85-86).*[4]

2. The SSG CARTER is a Coast Guard inspected vessel approved by the Coast Guard to carry explosives. *(Stipulation 1; Gov't Ex. 1).*

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[3] The Findings of Fact are based on the documentary evidence, witness testimony, and transcripts, including those transcripts from the investigation conducted under 46 CFR Part 4 ("Part 4 Investigation"). Generally, admissions by a person in a Part 4 Investigation are only used against the individual for impeachment in a suspension and revocation proceeding conducted under 46 CFR Part 5. See 46 CFR 5.101(b)). However, I find that an exception exists in this case based on the stipulations of the parties to include the transcript and exhibits from the Part 4 Investigation in this proceeding. Consequently, pursuant to 33 CFR 20.809, the stipulations made in this case are binding on all parties.

[4] The citations to the record are as follows: Transcript for hearing conducted on October 29, 2003 will be Transcript Volume I followed by the page number (*Tr. Vol. I at* ___); Transcript for hearing conducted on October 30, 2003 will be Transcript Volume II followed by the page number (*Tr. Vol. II at* ___); Transcript for hearing conducted on October 31, 2003 will be Transcript Volume III followed by the page number (*Tr. Vol. III at* ___); Agency Exhibit followed by number (*Gov't Ex.* ___); Respondent Exhibits followed by a letter (*Resp Ex.* ___); and Stipulation followed by the paragraph number (*Stipulation* ____).

3. The SSG CARTER is equipped with an HFO Transfer Pump located on the forepart of the engine room on the second platform ("02") level. (*Tr. Vol. I at 91, 100; Gov't Ex. 8*).

4. The HFO Transfer Pump has an automatic transfer setting that allows the pump to be turned on automatically when the level of fuel in the HFO Settling Tank goes below a pre-set level. (*Stipulation 12*).

5. For intermittently manned engine rooms, 46 CFR 62.35-40 and 62.35-50 require fuel oil day tanks, settling tanks, or other service tanks that are filled automatically or by remote control to be equipped with a high level alarm and an automatic safety trip control or an overflow arrangement that serves as an extra layer of protection in the event an oil tank overfills. (*Stipulation 13; Tr. Vol. I at 70-75*).

6. Title 46 CFR 62.35-40 and 62.35-50 is a construction or design requirement that is imposed on ship designers or vessel owners. The Coast Guard reviews the plans to determine whether the naval architects have satisfied the regulations preferably before the vessel is built if the plan concerns an initial construction. The plans are also reviewed when the vessel is modified or undergoes a major repair that is deemed a significant change to the system. (*Tr. Vol. I at 76-77*).

7. The SSG CARTER is equipped with port and starboard overflow tanks. Each tank is approximately 160 cubic meters. (*Stipulation 6; Tr. Vol. I at 101, 126-31, I 57-58, 165; Gov't Ex. 8, 25, 26, 29; Gov't Ex. 33 at 519*).

B. The SSG CARTER at Dry Dock in Norfolk, VA

8. While the SSG CARTER was at dry dock in Norfolk, Virginia ("VA"), the port and overflow tanks had heavy fuel oil in them, which remained in the tank through July

2001. (*Gov't Ex. 35 at 975-76, 979-80, 988-90*). Since the overflow tanks are not intended for storage, the 2nd Assistant Engineer was concerned about emptying the tanks. (*Id. at 988-89; Tr. Vol. II at 44-46*).

9. Between the end of February 2001 through June 2001, the SSG CARTER was dry docked at Norshipco Shipyard in Norfolk, VA where the vessel underwent repairs and conversion. (*Gov't Ex. 31 at 21-27, 71-74, 80, 82-83; Gov't Ex. 32 at 90, 99-106, 115-17, 135, 142-44, 245*).

10. The SSG CARTER passed American Bureau of Shipping ("ABS") inspection in a report written on June 25, 2001. (*Gov't Ex. 32 at 177-89, 210-11, 215, 230-31, 237*).

11. On June 12, 2001, the Coast Guard issued a Certificate of Inspection ("COI") for the SSG CARTER. (*Gov't Ex. 1; Gov't Ex. 32 at 90, 251*).

12. After receiving its COI, the SSG CARTER departed Norfolk, VA and headed to Sunny Point, NC for an ammunition load-out. Mr. Elmer Lawrence Gustafson served as Chief Engineer onboard the SSG CARTER and was the Chief Engineer while the vessel was in dry dock. (*Gov't Ex. 32 at 90-91, 141*).

C. Respondent Joined the SSG CARTER and Became Aware of the Vessel's Mechanical Problems

13. Respondent Louis M. Champa is the holder of a Coast Guard issued Document and License. The License authorizes Respondent to serve as an engineer onboard steam and motor vessels. He has over 20 years of experience as a Chief Engineer in the marine industry. (*Tr. Vol. I at 218-19*).

14. On June 19, 2001, Respondent joined the crew of the SSG CARTER. (*Stipulation 2; Gov't Ex. 11*).

15. Upon boarding the SSG CARTER, the crew familiarized Respondent with the vessel, described the work performed on the vessel while it was at dry dock in Norfolk, VA, and briefed Respondent on some of the mechanical problems experienced onboard the SSG CARTER. (*Tr. Vol. I at 224, 251*).

16. Although the SSG CARTER underwent conversion, passed ABS inspection, and received a COI from the Coast Guard, the vessel suffered numerous mechanical problems. For instance, Mr. Gustafson and Respondent discovered a major fuel leak from one of the tanks that had been bunkered while the SSG CARTER was in dry dock. (*Id. at 221*). It took approximate three to four days to repair the tank. (*Id. at 222, 224*). Furthermore, problems existed with the engine lube oil filter, the coolers had not been cleaned, the bilge and ballast valves were leaking, and the alarms on the cargo bilge systems were not functioning properly. (*Id. at 251-52*).

17. The tank level indicators ("TLI") also required over $100,000 in repairs because the system kept sending nuisance or false alarms. As such, the TLIs were not considered reliable at the time of the marine casualty here. To prevent nuisance alarms, a pencil was wedged in the acknowledge toggle switch of the TLI. This prevented audible alarms from sounding in the event a tank overflowed. (*Tr. Vol. I at 108, 263-64, 271; Tr. Vol. II at 35-44, 120-24; Gov't Ex. 6, 8, 27; Gov't Ex. 40 at 2567-74, 2814-15*).

18. Respondent knew there might be a problem with the TLI and he knew a pencil had been wedged in the TLI acknowledge switch by the 2nd Assistant Engineer to prevent audible nuisance or false alarms. (*Tr. Vol. I at 263-64, 271; Gov't Ex. 35 at 864-69*). However, the TLI were not tagged to indicate that they were not functioning properly. (*Tr. 274*).

D. Respondent Assumed the Position of Chief Engineer on the SSG CARTER from June 22, 2001 through July 14, 2001

19. On June 22, 2001, Respondent Champa relieved Mr. Gustafson and assumed the position of Chief Engineer onboard the SSG CARTER. Respondent served as Chief Engineer onboard the vessel through July 14, 2001. (*Stipulation 2; Tr. Vol. I at 228, 250; Gov't Ex. 32 at 91*).

20. Respondent did not have a full compliment of engine room personnel onboard the SSG CARTER: he was one man short. (*Tr. Vol. I at 265*). As such, the engine room was, at all relevant times, including specifically on July 14, 2001, considered minimally manned. (*Stipulation 3*).

21. In addition to Respondent, the engine room staff was comprised of: a) George M. Howard, who served as the 1st Assistant Engineer; b) Peter Donat, who served as the 2nd Assistant Engineer; c) Paul C. Powell, who served as the 3rd Assistant Engineer; d) Donald E. Hastings, who doubled as the Electrician and Qualified Man in the Engine Department ("QMED"); and e) Horace C. Beasly, who served as the Wiper. (*Gov't Ex. 11; Tr. Vol. II at 159-60, 185-86, 214*).

E. Respondent's Responsibilities onboard the SSG CARTER

22. Although the SSG CARTER was not subject to the International Safety Management Code, the crew was subject to a Safety Management Plan issued by Maersk Line, Ltd. ("Safety Management Plan"). (*Tr. Vol. I at 91-93; Gov't Ex. 4; Contra Stipulation 10*[5]).

[5] The parties stipulated in paragraph 10 that the SSG CARTER was subject to the International Safety Management Code ("ISM Code"). However, the testimony of LCDR Rick Raksnis reveals that at the time particularly relevant in this case, the vessel was not subject to the ISM Code. (*Tr. Vol. I at 91-93).*

23. Pursuant to Section 3.2.2 of the Safety Management Plan, as the Chief Engineer onboard the SSG CARTER, Respondent's responsibilities were as follows:

> B. Chief Engineer. The Chief Engineer reports to the Master and is responsible for ensuring that the vessel and its equipment is maintained in good working order and for making the appropriate reports when it is not. Ensures that all machinery is operated safely and all pollution prevention equipment is properly operated. The Chief Engineer is responsible for complying with all applicable USCG regulations when loading, discharging, or transferring hazardous material which could damage the marine environment. This material includes, but is not limited to, fuel, lube oil, hydraulic oil, and chemical products. The Chief Engineer is also responsible for ensuring that all engine department members work in accordance with the guidelines specified in the Safety Management Plan.

(*Gov't Ex. 4 at 11*).

24. Pursuant to Section 7.2.4 of the Safety Management Plan, the Chief Engineer "is responsible for ensuring that all Engine Department personnel are familiar with Engineering practices which allow for the safe operation of the vessel's machinery . . . [including] reviewing confined space and lockout/tagout procedures." (*Id. at 22; Stipulation 11*).

25. Lockout/tagout procedures are personal safety mechanisms employed onboard a vessel. The lockout procedure requires the motor controller of a particular equipment or system to be "locked" at the breaker to prevent the equipment or system from being operated while it is undergoing repairs; whereas a tagout procedure is the simple placement of a tag on a switch, pump start button, or valve that contains a date and a message such as: "Danger men operating. Do not remove" or provide some other similar warning to prevent equipment or system from being operated. (*Tr. Vol. II at 72-74, 92, 100, 103-04, 194; see also Gov't Ex. 40, at 2834-35 (describing the Maersk tagout procedure)*).

26. As Chief Engineer, Respondent knew he was responsible for: a) maintenance and repair of the mechanical devices on the SSG CARTER; and b) ensuring the safe operation of the engine. (*Tr. Vol. I at 246-47*).

F. On July 11, 2001, Respondent Ordered that the Vent Piping to the HFO Vent Collection Chamber be Disconnected and the Piping Remained Disconnected through July 14, 2001

27. On July 11, 2001, while the vessel was moored at Military Ocean Terminal Sunny Point ("MOTSU"), NC taking on cargo, Mr. Donat, the 2nd Assistant Engineer, advised Respondent of over pressure problems with the HFO Settling Tank that was noticed during routine heavy fuel oil transfers. (*Tr. Vol. I at 254-56; Gov't Ex. 35 at 824, 994-95*).

28. Because Respondent knew the vents were previously cleaned in dry dock, Mr. Hastings, was directed to disconnect the vent piping to the HFO Vent Collection Chamber (also known as the HFO "Christmas Tree") to determine whether the lines to the HFO Settling Tank were clogged. (*Stipulation 4; Tr. Vol. I at 275, 279; Gov't Ex. 33 at 506-15; Gov't Ex. 34 at 771-75; Gov't Ex. 35 at 998-1007*).

29. Respondent also knew that a similar problem had occurred with the diesel fuel oil vent system while the vessel was at dry dock in Norfolk, VA and the over pressurization problem was remedied by disconnecting system and cleaning the vents. (*Tr. Vol. II at 168, 177, 186, 188-90, 213, 215-16; Gov't Ex. 34 at 755-57; Gov't Ex. 35 at 996-97*). The lines to the diesel fuel oil vent system were disconnected in May 2001 while the SSG CARTER was cold plant without any machinery running. (*Tr. Vol. II at 177-78; Gov't Ex. 34 at 755-58).*

30. The HFO Vent Collection Chamber is located on the 01 level aft and outboard of the incinerators stack inside the engineering space casing called the Fidley. It is located

approximately three levels above the HFO Settling Tank. The HFO Vent Collection Chamber is a cylindrical tank that serves as a centralized manifold connecting a number of vent lines. (*Stipulation 5; Tr. Vol. I at 103-05, 116, 119, 176-77; Gov't Ex. 2, 3, 5-8; Gov't Ex. 35 at 915*).

31. Mr. Hastings disconnected the flanges connecting the HFO Vent Collection Chamber to the HFO Service Tank, the Fuel Oil Drain Tank, the Vent Box Drain from the 02 level, the HFO Settling Tank, Main Engine Fuel Oil Mixing Tank/HFO Settling Tank joint vent line, the drain to the Starboard Overflow Tank, and the IFO Diesel Fuel Oil Collection Chamber. (*Stipulation 6*). However, the bolts that secured the vent piping were left near the HFO Vent Collection Chamber so that the bolts could easily be refastened in case of an emergency. (*Tr. Vol. II at 217, 220, 253-54; Gov't Ex. 20, 21, 23*).

32. When the HFO Vent System was disconnected, the engine room personnel onboard the SSG CARTER, including Respondent, did not know where all the vent lines ran or to what they were connected because Mr. Howard, the 1st Assistant Engineer, and Mr. Donat had not completed tracing all the vent lines on the vessel in July 2001. (*Tr. Vol. I at 256-57, 281; Gov't Ex. 35 at 1026-27*).

33. All of the flanges were disconnected while the HFO system was still operating and supplying fuel to the ship's service generators. (*Tr. Vol. I at 283; Tr. Vol. II at 189).*

34. When the lines to the HFO Vent Collection Chamber were first disconnected, rust fell out. Rust was also observed in the vent line connecting the HFO Settling Tank to the HFO Vent Collection Chamber. (*Tr. Vol. I at 276-77; Tr. Vol. II at 216; Gov't Ex. 33*

at 505-06, 11-13; Gov't Ex. 34 at 772-73; Gov't Ex. 35 at 999-1000; Respondent Ex. D at 366).

35. Since nothing could be seen, except rust, when the vent lines were opened, Respondent directed Mr. Donat to conduct a fuel transfer to the HFO Settling Tank while the main vent line to the HFO Settling Tank was disconnected at the HFO Vent Collection Chamber. During the course of the fuel transfer, Respondent placed his hand over the open vent line leading from the HFO Settling Tank to ascertain whether there was a transfer of air. He could not feel any air and concluded that the line leading directly from the HFO Settling Tank to the HFO Vent Collection Chamber was clogged. (*Stipulation 7; Tr. Vol. I at 277-78, 282; Gov't Ex. 33 at 507-08, 14; Gov't Ex. 35 at 902, 1022-23*).

36. Prior to the fuel transfer, the fuel level in the HFO Settling Tank was approximately 43.6 tons. After the fuel transfer, the fuel level in the HFO Settling Tank was approximately 51.7 tons, which is well beyond the 95 percent capacity for the Settling Tank. The level of fuel in the HFO Settling Tank would have triggered the TLI alarm had a pencil not been wedged in the acknowledge switch. (*Gov't Ex. 35 at 939-47; contra Id. at 865-69, 923-24, 960-61*). The HFO Settling Tank's full capacity was approximately 55 tons. (*Gov't Ex. 35 at 983; Respondent's Ex. E*).

37. At the time the fuel transfer occurred, Respondent was not fully aware of the level of fuel in the HFO Settling Tank. (*Tr. Vol. II at 231-32*).

38. To eliminate the blockage in the HFO Settling Tank, "Dresser couplings" were ordered from a commercial service off the base. The engine room staff planned to cut out a section of the horizontal pipe leading directly from the HFO Settling Tank to the HFO

Vent Collection Chamber, to pull down and clean the HFO Vent Collection Chamber, and to back flush the pipe leading directly from the HFO Settling Tank. (*Tr. Vol. I at 279-80, 283-84; Tr. Vol. II at 190, 202-07; Gov't Ex. 33 at 508-09, 13*).

39. Respondent did not know how long it would take for the ordered Dresser couplings to arrive. (*Tr. Vol. I at 284; Tr. Vol. II at 202-07*).

40. After the vent lines were disconnected on July 11, 2001, they remained disconnected through and including July 14, 2001 while the engine room staff and Respondent waited for the Dresser couplings. Respondent viewed temporarily reconnecting the HFO System and disconnecting it again once the Dresser couplings arrived as a "lot of busy work" that was not necessary since there was plenty of fuel in the HFO Service Tank and there was no reason to run the HFO Transfer Pump. (*Tr. Vol. I at 280, 282-85, 297-98; Gov't Ex. 12-15;Gov't Ex. 35 at 1026*).

41. After the vent lines were disconnected, no further tests were performed on the HFO Settling Tank or any of the disconnected lines associated with the HFO Vent Collection Chamber. (*Tr. Vol. I at 299; Tr. Vol. II at 190-91, 217; Gov't Ex. 35 at 1023-26*).

42. The daily log did not contain notes from Respondent or crewmembers concerning the disconnection of the vent piping to the HFO Vent Collection Chamber. Furthermore, the status board was void of any warning containing that information. (*Tr. Vol. II at 251-52*).

43. The HFO Transfer Pump and the associated valves were not locked out or tagged out because Respondent did not believe it was necessary since Mr. Donat was the only individual who performed all the fuel transfers onboard the SSG CARTER. (*Stipulation 8; Tr. Vol. I at 90-91, 273, 284, 297; Tr. Vol. II at 219-21*). Mr. Donat

performed all the fuel transfers manually every third or fourth day. (*Tr. Vol. I at 236, 273; Tr. Vol. II at 247-48; Gov't Ex. 35 at 515, 844-85, 927*).

G. The Engine Room Fire onboard the SSG CARTER on July 14, 2001

44. On the early morning of July 14, 2001, the HFO Settling Tank held approximately 50.3 tons of fuel. (*Gov't Ex. 35 at 939, 943, 949; Respondent's Ex. E*). Based on the level of fuel existing in the tank after the fuel transfer, to fill the HFO Settling Tank to full capacity would take less than fifteen minutes. (*Gov't Ex. 35 at 983*).

45. The starboard overflow tank held approximately 62.7 tons of fuel on the morning of July 14, 2001. (*Id.*).

46. Around 1530 on July 14, 2001, before concluding his assignment for the day, Respondent directed Mr. Donat to check the incinerator which was burning sludge, and which had just been shut down and was cooling. Generally, it takes several hours for the incinerator to cool down. (*Tr. Vol I at 290-91*).

47. Respondent and Mr. Donat inspected the incinerator, which is located on the starboard side of the vessel between the engine room and the generator room. At that point engine room conditions were normal. After showing Mr. Donat the incinerator and satisfying himself that everything was under control, Respondent disembarked the vessel. (*Tr. Vol. I at 291-92, 296*).

48. The SSG CARTER was moored at MOTSU, NC loaded with five (5) million pounds of high appointment explosives bound for Diago Garcia in the Indian Ocean as part of the Military Sealift Command pre-positioned fleet when a fire broke out in the engine room at approximately 1600 hours on July 14, 2001. (*Stipulation 16, 17; Tr. Vol. I at 85-86, 226, 295*).

49. At the time of the fire, the generators were operating on diesel fuel and the oil-fired boiler, which maintains heat in the HFO Vent System and the HFO Settling Tank, was running. (*Tr. Vol. I at 230*). The LT cooling water system and the piston cooling water pump were also operating on the day of the fire. (*Gov't Ex. 33 at 539-40, 541*). Furthermore, the Number 1 and 3 generators, the auxiliary boiler, the main engine jacket water pump, and regular "hotel" equipment such as the Air Conditioning plants and the potable water system, were on line. (*Id. at 554*).

50. Mr. Howard was on watch duty when the fire occurred. (*Id. at 515, 527*). He was in the engine control room with the electrician, Mr. Hastings, when the fire alarm sounded. (*Id. at 563, 573-74; Gov't Ex. 35 at 1028*). Mr. Howard and Mr. Hastings both noticed that five engine room zones on the fire detection panel lit up. (*Gov't Ex. 33 at 574, 632; Gov't Ex. 35 at 1028*).

51. Mr. Howard and Mr. Hastings exited the control room and entered the generator room, where they observed light smoke. Mr. Howard and Mr. Hastings then proceeded through the double doors on the port side of the generator room and entered the main engine room where they observed heavy black smoke and saw flames in the vicinity of the auxiliary boiler. (*Gov't Ex. 33 at 564, 567, 569-70, 628-30*).

52. At that point, Mr. Howard returned to the control room where he telephoned Captain Robert A. Vranish, Master onboard the SSG CARTER, and advised him that there was a fire in the engine room. (*Id. at 564-65, 630*; *Gov't Ex. 11; Gov't Ex. 35 at 1028*). Mr. Donat observed Mr. Howard in the engine control room calling the Captain. (*Gov't Ex. 33 at 565, 572-73; Gov't Ex. 35 at 871-72*).

53. As engine room personnel were exiting the engine control room, they observed burning fuel cascading down as "balls of fire" from the upper level of the engine control room. (*Gov't Ex. 33 at 565-73, 630-31; Gov't Ex. 35 at 877, 963*).

54. Mr. Donat, Mr. Hastings, and Mr. Howard survived the fire. (*Gov't Ex. 33 at 565-69, 572*). However, two men died. (*Tr. Vol. I at 189-90*). Mr. Powell died of smoke inhalation and his body was found on the 03 level of the Fidley approximately 12 feet from the exit. (*Id.*; *Stipulation 18; Gov't Ex. 33 at 546-52, 561*). Mr. Beasley jumped overboard from the open port door in the engine room and he eventually drowned after attempts to rescue him proved unsuccessful. (*Gov't Ex. 33 at 582-88*). The vessel sustained 15 million dollars worth in property damage. (*Tr. Vol. II at 66*).

55. No alarms sounded that would have alerted the engine room personnel that a fuel tank had an overflow. (*Gov't Ex. 33 at 521*).

56. Respondent did not return to the SSG CARTER until 1900 on July 14, 2001, at which time, he learned a fire occurred. The fire onboard the SSG CARTER was not fully extinguished until approximately 2300 or 2400. (*Tr. Vol. I at 292-95*).

57. After the fire, substantial amounts of heavy fuel oil were observed on the 01 level of the engine room where the HFO Vent Collection Chamber is located. (*Stipulation 21; Tr. Vol. I at 116, 285; Gov't Ex. 34 at 806; Gov't Ex. 37 at 1360-61; Gov't Ex. 38 at 1915*). Furthermore, the engine room was covered with soot. (*Tr. Vol. I at 109; Gov't Ex. 6; Gov't Ex. 34 at 806*). The fire did not cause any damage to the HFO transfer manifold, located in forepart of the engine room, or the HFO transfer pumps and the controllers for that pump. (*Tr. Vol. I at 91, 100*). The fire was contained in the aft end of the

engine room involving a number of levels, where heavy damage was observed. (*Id. at 91, 109, 114, 189*).

58. A sounding of the starboard overflow tank indicates that the level of fuel increased from 62.7 tons before the fire to 65.7 tons of fuel after the fire. The only way that the starboard overflow tank could get additional fuel would be by overflow from the HFO Settling Tank. Similarly, a sounding of the port overflow tank indicates that the level of fuel decreased from 49 tons before the fire to 29.6 tons after the fire. (*Tr. Vol. III at 118-21; Gov't Ex. 34 at 777-85; Gov't Ex. 35 at 980; Gov't Ex. 39 at 2295-99, 2304; Respondent's Ex. E*).

59. Sometime after 1800 on July 14, 2001, Lieutenant Commander ("LCDR") Rick Raksnis of the Coast Guard conducted a marine casualty investigation. He directed several members of the crew of the SSG CARTER to undergo drug testing at the local hospital since the fire was deemed a serious marine casualty. (*Tr. Vol. I at 89-90*). LCDR Raksnis also boarded the vessel and noticed that none of the valves connected to the HFO transfer system were tagged out, nor had the valves been tagged out at the time of the fire. (*Id. at 90-91*).

60. LCDR Raksnis and his investigation team observed that the middle valve on the HFO transfer manifold, the suction valve, and the discharge valve were open. (*Id. at 101*).

61. After the fuel transfer on July 11, 2001, the valves and the transfer system should have been closed. Respondent believed the valves were closed and he was surprised to learn that the valves and transfer system had not been closed for three days, through July 14, 2001. (*Tr. Vol. II at 232-34*).

62. The suction valve goes through a strainer to the HFO transfer pump and then is discharged out. (*Id.; Gov't Ex. 6*).

63. The discharge pipe runs from the HFO transfer pump back to the aft part of the engine room underneath the deck at plate level. (*Tr. Vol. I at 102; Gov't Ex. 6*).

64. The HFO transfer pump is located on the platform level forward in the engine. (*Tr. Vol. I at 119; Gov't Ex. 2*). After oil leaves the HFO transfer pump it runs down the second platform level back aft to the settling tank, which is located in the after part of the engine room on the starboard side. (*Tr. Vol. I at 102*).

65. The HFO settling tank sounding tube is located on top of the HFO settling tank on the third platform level. (*Tr. Vol. I at 103, 120; Gov't Ex. 2, 6*).

66. The Fidley is the exhaust tank for the engine room where LCDR Raksnis noticed black smoke emitting when he first arrived on the pier. (*Tr. Vol. I at 96-97, 103-04; Gov't Ex. 6*). He also observed that several flanges of the HFO vent collection chamber were disconnected. (*Tr. Vol. I at 105, 125-29; Gov't Ex. 12, 25*).

67. After the fire, a test established that the Main Engine Mixing Tank contained a combination of diesel fuel and heavy fuel oil. (*Stipulation 23; Gov't Ex. 40 at 2476-79*). The Main Engine ran entirely on diesel fuel prior to the fire. As such heavy fuel oil should not have been in the Main Engine Mixing Tank. (*Tr. Vol. I at 241; Gov't Ex. 41 at 2797*).

IV. ULTIMATE FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Respondent and the subject matter of this hearing are properly within the jurisdiction vested in the United States Coast Guard under 46 USC 7703; 46 CFR Parts 5; and 33 CFR Part 20.

2. Respondent Champa admits that he is the holder of a Coast Guard License and Document.

3. Respondent Champa admits that on July 14, 2001, he acted under the authority of his license while serving as the Chief Engineer onboard the SSG CARTER as required by 46 CFR 15.501.

4. A reasonable and prudent Chief Engineer, under the same circumstances established in this case, would not have disconnected the vent lines of the HFO Vent Collection Chamber without knowing where all the vent lines ran or to what they were connected. (*Tr. Vol. II at 289-94*).

5. A reasonable and prudent Chief Engineer would have notified everyone that the vent piping to the HFO system was disassembled by recording the information on the status board. (Gov't Ex. 37 at 1522-23, 1526)

6. A reasonable and prudent Chief Engineer, under the same circumstances, would have recognized the safety risks associated with leaving the HFO System disconnected and would have reconnected the vent piping. (*Tr. Vol. II at 102-03*).

7. The Coast Guard proved Respondent committed acts of **NEGLIGENCE** on or about July 11, 2001 through 1600 on July 14, 2001 by disconnecting the vent piping to the HFO Vent Collection Chamber, failing to order any action by members of the ship's engine room crew to clear the vent piping of suspected obstructions, and failing to reconnect the vent piping after its disconnection on July 11, 2001.

8. The first and second counts of **MISCONDUCT** are merged together.

9. A reasonable and prudent person would have locked or tagged out the motor controller to the disconnected heavy fuel oil transfer pump and its associated valves to place personnel

on notice that the system had been disassembled. (Tr. Vol. III at 118; Gov't Ex. 36 at 1314; Gov't Ex. 37 at 1522-23; Gov't Ex. 40 at 2835).

10. The Coast Guard proved Respondent committed acts of **MISCONDUCT** by failing to ensure that the transfer piping valves whose vent piping had been disconnected and the transfer pump were locked out, tagged out, or otherwise rendered incapable of transferring fuel to or from the affected tanks between July 11, 2001 and 1600 on July 14, 2001 in accordance with Section 7.2.4 of the Maersk Safety Management Plan.
11. The third count of **MISCONDUCT** is dismissed because 46 CFR 62.35-40 and 62.35-50 are construction or design requirements imposed on ship designers or vessel owners. Those sections do not impose standards or requirements on Respondent serving as a Chief Engineer onboard the SSG CARTER.

V. DISCUSSION

The purpose of Coast Guard suspension and revocation ("S&R") proceedings is to promote safety at sea. 46 U.S.C. 7701. Administrative Law Judges have the authority to suspend or revoke a license, certificate, or merchant mariner's document whenever it is established that a mariner committed an act of negligence or misconduct. See 46 U.S.C. 7703(1)(B); 46 CFR 5.19. The burden of proof is on the Coast Guard Investigating Officer to establish negligence and misconduct by a preponderance of the evidence. 33 CFR 20.701, 20.702(a). The term "preponderance of the evidence" is synonymous with substantial evidence. Appeal Decision 2477 (TOMBARI) (1988). Preponderance of the evidence is the standard of proof enunciated in the Administrative Procedure Act ("APA"), 5 U.S.C. 551-59 and is the

standard of proof which governs this proceeding. See 46 U.S.C. 7702(a) (adopting the APA for Coast Guard suspension and revocation hearings).

Under the APA, sanctions may only be imposed if upon consideration of the record as a whole the allegations are supported by "reliable, probative, and substantial evidence." 5 U.S.C. 556(d). This simply requires the Coast Guard to establish to the trier of fact "that the existence of a fact is more probable than its nonexistence . . . " Concrete Pipe and Products of California, Inc. v. Construction Laborers Pension Trust for Southern California, 508 U.S. 602, 622 (1993) (citing In re Winship, 397 U.S. 358, 371-372 (1970). (Harlan, J., concurring) (brackets in original)). In doing so, the Coast Guard may rely on either direct or circumstantial evidence, or both. See Simkins v. R.L. Morrison & Sons, 107 F.2d 121, 122 (5th Cir. 1939) (holding that, in the absence of proof to the contrary, the circumstances show that the fire onboard the tug SALLIE was the result of respondent's negligence); United States v. Bethlehem Steel Co., 302 F. Supp. 600, 604 (D. Md. 1969)(ruling that "the government's case may be proved by circumstantial as well as direct evidence"); Detyens Shipyards, Inc. v. Marine Indus., Inc., 234 F. Supp. 411, 414 (D.C. SC 1964) (finding that the tug captain was negligent even though there was no direct evidence).

A. Respondent Committed Negligence

The complaint alleges that Respondent committed negligence under 46 CFR 5.29 when he "ordered, on or about July 11, 2001, the disconnection of the vent piping to the HFO Vent Collection Chamber to facilitate correction of an overpressure problem [and] . . . [he] failed to order any action by members of the ship's engine room crew to clear the vent piping of suspected obstructions and failed to reconnect any of the vent piping between the time of the disconnection of the vent piping on or about July 11, 2001, and 1600 on July 14, 2001." The

Coast Guard introduced substantial, reliable, and probative evidence to establish that an oil transfer caused the fire onboard the SSG CARTER on July 14, 2001 when the HFO Settling tank overfilled. The Coast Guard's theory is that heavy fuel oil traveled up one of two vent lines - - the other being clogged with debris, and because of the force of the pump transferring the oil there was sufficient energy to cause the oil to rise to the 01 level, where the HFO Vent Collection Chamber is located and where large quantities of oil was released onto the deck on the 01 level from the disconnected piping and came into contact with an ignition source. See Complainant's Written Argument (Jan 15 2004).

The Coast Guard argues that "[i]t is the combination of factors that the Respondent knew or did not know, at the time he ordered the disconnection, what he ordered disconnected, and the failure to do anything else with the vent lines after the initial disconnection and tests that constitutes negligence on the Respondent's part." The Coast Guard points out that Respondent:

1) knew he was the Chief Engineer on a ship loading a significant amount of military ammunition;
2) knew the ship's tank level indicator system was not working properly and had not been fixed;
3) knew the tank level indicator was disabled by the Second Assistant Engineer, who placed a pencil in the alarm acknowledge switch to prevent false alarms;
4) knew there was a potential vent problem with the HFO Settling tank;
5) knew the HFO system was in constant operation supplying fuel to the ship's service generator;
6) did not know which tanks and systems were connected to the HFO Vent Collection Chamber; and

7) was not sure how long it would take for the Dresser couplings to arrive

Respondent argued that the Coast Guard failed to establish that the Respondent failed to act as a reasonable and prudent Chief Engineer by not reconnecting the disconnected vent piping. Respondent introduced the testimony of an expert witness, who offered an alternative theory of causation. Mr. Lipman testified that the most likely cause of the fire was the break of the clamp on the homemade drain, located directly above the auxiliary boiler stack. (*Tr. Vol. III at 15-17, 36, 42-43*). The light diesel fuel from the homemade drain ignited and the 1st Assistant Engineer observed the fuel spewing down from the upper level of the engine room. (*Id. at 16-18, 36*). Mr. Lipman explained that a secondary tertiary fire started in the lower engine room near the HFO Settling Tank, which caused the tank to heat up to 240 degrees and resulted in the thermal expansion and thereby creating the overflow condition that rose to the 01 level. (*Id. at 25-27, 34-45*).

The parties' considerable emphasis on the cause of the fire is misplaced. Whether the fire was caused as a result of a fuel transfer as theorized by the Coast Guard or by the break of the clamp on the homemade drain and thermal expansion as suggested by Respondent is irrelevant in determining whether Mr. Champa committed negligence. While the common law tort of negligence requires proof of causation, in S&R proceedings, a showing of causation is not an integral part of proof. See Appeal Decision 2585 (COULON) (1997) ("Issues of proximate cause . . . are not relevant nor are fault determinations necessary" in deciding whether a respondent was negligent); Appeal Decision 2415 (MARSHBURN) (1985) (causation is not an element of negligence in suspension and revocation proceedings); Appeal Decision 2395 (LAMBERT) (1985) ("Proximate cause, although needed to establish civil liability for damages, is not an element of negligence for purposes of [S&R proceedings]").

Under 46 CFR 5.29, "Negligence" is defined as "the commission of an act which a reasonable and prudent person of the same station, under the same circumstances, would not commit, or the failure to perform an act which a reasonable and prudent person of the same station, under the same circumstances, would not fail to perform." "In proving a negligence case, it is incumbent on the Investigating Officer to establish the standard of care which is relevant to the circumstances involved and to show how that standard has been breached by the respondent." Appeal Decision 2599 (GUEST) (1998); see also Appeal Decision 2100 (COLEMAN) (1977).

Here, the Coast Guard relies on company policy to establish the standard of care and the common law principle that the Chief Engineer is responsible for the operation of the engine room. Under Section 3.2.2 of the Maersk Safety Management Plan, Respondent, as the Chief Engineer of the SSG CARTER had a duty to maintain the vessel, including the components of the engine, in good working order and to make the appropriate reports when the vessel's equipment was not in good working order and to ensure that the machinery was operated in a safe manner. (*Gov't Ex. 4 at 11*). This duty includes safe repair of mechanical devices and components in the engine room. As Chief Engineer, Respondent was aware that he was responsible for: a) maintenance and repair of the mechanical devices on the SSG CARTER; and b) ensuring the safe operation of the engine. (*Tr. Vol. I at 246-47*). The evidence conclusively establishes that Respondent breached the applicable standard of care.

Although it is recognized that the SSG CARTER suffered significant mechanical problems, it should have placed Respondent on notice that extra precautions were necessary since all of the problems on the vessel were not clearly evident. While disconnecting the HFO system was not negligence in itself, leaving the HFO system disconnected for three days from

July 11 through 14, 2001 given Respondent's lack of knowledge concerning the system and its layout was negligence.

When the HFO Vent System was disconnected, the engine room personnel onboard the SSG CARTER, including Respondent, did not know where all the vent lines ran or to what they were connected because Mr. Howard, the 1st Assistant Engineer, and Mr. Donat had not completed tracing all the vent lines on the vessel in July 2001. (*Tr. Vol. I at 256-57, 281; Gov't Ex. 35 at 1026-27*). A reasonable and prudent Chief Engineer, under the same circumstances established in this case, would not have ordered the disconnection of the vent lines of the HFO Vent Collection Chamber without knowing where all the vent lines ran or to what they were connected. (*Tr. Vol. II at 2892-94*).

Furthermore, at the time of the fuel transfer test to determine whether the vent line was clogged on July 11, 2001, Respondent was not aware of the level of fuel in the HFO Settling Tank. (*Tr. Vol. II at 231-32*). After the fuel transfer on July 11, 2001, the fuel level in the HFO Settling Tank was approximately 51.7 tons, which is well beyond the 95 percent capacity for the Settling Tank and would have triggered the TLI alarm had a pencil not been wedged in the acknowledge switch. (*Gov't Ex. 35 at 939-47; contra Id. at 865-69, 923-24, 960-61*). Respondent knew the TLI needed to be repaired. He also knew that a pencil was wedged in the TLI acknowledge switch and thus the TLI could not sound a warning in the event that one of the tanks overflowed. (*Tr. Vol. I. at 263-64; 271; Gov't Ex. 35 at 864-69*).

Yet, Respondent allowed the HFO System to remain disconnected from July 11, 2001 through July 14, 2001, and viewed disconnecting the system and reconnecting it once the Dresser couplings arrived as unnecessary "busy work." (*Tr. Vol I at 280, 282-85, 297-98; Gov't Ex. 12-15; Gov't Ex. 35 at 1026*). Given the fact that Respondent did not know how long it would take

for the ordered Dresser couplings to arrive, his cavalier attitude is unacceptable and imprudent. A reasonable and prudent Chief Engineer, under the same circumstances, would have recognized the safety risks associated with leaving the HFO system disconnected and would have reconnected the vent piping. (*Tr. Vol. II at 102-03*). At the very least, a reasonable and prudent Chief Engineer would have notified everyone that the piping to the HFO system was disassembled by recording the information on the status board and ensuring that the transfer pump and associated valves were locked out and/or tagged out. (*Tr. Vol. III at 118; Gov't Ex. 36 at 1314; Gov't Ex. 37 at 1522-23, 1526; Gov't Ex. 40 at 2835).* Accordingly, negligence is found proved.

B. Respondent Committed Misconduct

1. Respondent Failed to Comply with the Lockout/Tagout Procedures Established in the Maersk Safety Management Plan

Under 46 CFR 5.27, Misconduct is defined as:

> . . . 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 and similar sources. It is an act which is forbidden or a failure to do which is required.

The first count of misconduct alleges that Respondent failed to ensure the transfer piping valves were locked out, tagged out, or otherwise rendered incapable of allowing the transfer of fuel to the tanks whose vent piping was disconnected, which resulted in a violation of section 7.2.4 of the Maersk Safety Management Plan. The second count of misconduct is similar to the first count of misconduct, except it refers to the failure to comply with the lockout and tagout procedures with respect to the fuel transfer pumps. Since the first two counts of misconduct are virtually identical, they have been merged together.

The evidence conclusively establishes that the fuel transfer pumps and the associated valves onboard the SSG CARTER were not locked out or tagged out. (*Stipulation 8; Tr. Vol. I at 90-91, 273, 284, 297; Tr. Vol. II at 219-21, 251-52*). Pursuant to Section 7.2.4 of the Maersk Safety Management Plan, the Chief Engineer "is responsible for ensuring that all Engine Department personnel are familiar with Engineering practices . . . including . . . lockout/tagout procedures." (*Id. at 22; Stipulation 11*). Respondent argues that the plain language of Section 7.2.4 of the Maersk Safety Management Plan does not state that the Chief Engineer is responsible for ensuring that lockout/tagout procedures are followed. Respondent further argues that Maersk's corporate representative had not promulgated lockout/tagout procedures. According to Respondent, such procedures were in the process of being developed. As such, it is Respondent's position that the Coast Guard failed to establish misconduct based on the failure to comply with the lockout/tagout procedures.

Respondent's narrow interpretation of Section 7.2.4 is rejected. Generally, the Chief Engineer maintains continuous responsibility over operations in the engine room. See Appeal Decision 2332 (LORENZ) (1983). Based on the evidence in this case lockout/tagout procedures are industry practice. Lockout/tagout procedures are personal safety mechanisms employed onboard a vessel. The lockout procedure requires the motor controller of a particular equipment or system to be "locked" at the breaker to prevent the equipment or system from being operated while it is undergoing repairs; whereas a tagout procedure is the simple placement of a tag on a switch, pump start button, or valve that contains a date and a message such as: "Danger men operating. Do not remove" or provide some other similar warning to prevent equipment or system from being operated. (*Tr. Vol. II at 72-74, 92, 100, 103-04, 194; see also Gov't Ex. 40, at 2834-35 (describing the Maersk tagout procedure)*).

Based on the general duties of the Chief Engineer, accepted practices in the industry, and the circumstances in this case, Respondent was indeed responsible for ensuring that lockout/tagout procedures were followed. Respondent's failure to utilize lockout/tagout procedures and to ensure that engine room personnel employed such procedures constitutes misconduct.

2. *The Third Misconduct Allegation is Dismissed*

The third count of misconduct charges Respondent with violating 46 CFR 62.35-40 and 62.35-50. For intermittently manned engine rooms, 46 CFR 62.35-40 and 62.35-50 requires fuel oil day tanks, settling tanks, or other service tanks that are filled automatically or by remote control to be equipped with a high level alarm and an automatic safety trip control or an overflow arrangement that serves as an extra layer of protection in the event an oil tank overfills. (*Stipulation 13; Tr. Vol. I at 70-75*). Title 46 CFR 62.35-40 and 62.35-50 are construction or design requirements that are imposed on ship designers or vessel owners. (*Tr. Vol. I at 76-77*). The above referenced code sections are not substantive requirements imposed against Respondent; thus, they cannot form the basis of a misconduct allegation. See generally Appeal Decision 2551 (LEVENE) (1993) (holding that respondent cannot be charged with violating a regulation that establishes an evidentiary standard); Appeal Decision 1574 (STEPKINS) (1966). Accordingly, the third count of misconduct is dismissed.

C. Respondent's Defenses

1. *Respondent's Argument that he was Deprived of Due Process in the Part 4 Investigation is Rejected*

As stated earlier, Respondent asserted three affirmative defenses. Respondent's first affirmative defense is that the IO violated Respondent's due process rights and his right to be

represented by counsel by conducting an arbitrary and capricious investigation under 46 CFR Part 4. This defense is rejected. There is no evidence that Respondent was deprived of due process in the investigation conducted under 46 CFR Part 4. Even assuming arguendo that there was evidence of irregularities in the investigation conducted under 46 CFR Part 4, those irregularities would not serve as a bar to these S&R proceedings conducted under 46 CFR Part 5, and is irrelevant to the resolution of this case. See Appeal Decision 2639 (HAUCK) (2003); Appeal Decision 2418 (DOUGHERTY) (1986). Suspension and revocation proceedings are procedurally distinct from pre-hearing investigations conducted under 46 CFR Part 4. Id.

2. ***Respondent's Actions were not an "Error in Judgment"***

Respondent's second and third defenses are also rejected. In sum, Respondent argues that his acts amounted to an error in judgment - - not negligence as that term is defined in 46 CFR 5.29, nor misconduct as that term is defined in 46 CFR 5.27. An error in judgment is defined as an act or omission over which reasonable mariners would differ. See Appeal Decision 2516 (ESTRADA) (1990); Appeal Decision 2500 (SUBCLEFF) (1990); Appeal Decision 2216 (SORENSEN) (1980). It is an affirmative defense to negligence and misconduct. See (SUBCLEFF) (holding that an error in judgment is an affirmative defense to negligence); Appeal Decision 2613 (SLACK) (1999) (citing Rechany v. Roland, 235 F.Supp. 79 (S.D.N.Y. 1964) for the proposition that an error in judgment does not amount to misconduct).

Contrary to Respondent's contention, the decision to leave the vent piping disconnected from July 11, 2001 through July 14, 2001and the failure to employ lockout/tagout procedures was not a choice between reasonable alternatives constituting an error in judgment. The witness testimony, including the testimony from Respondent's own expert witnesses establishes that Respondent did not act as a reasonable and prudent engineer in this instance. Respondent's

expert witness, Clifford Jayne, testified that it was not reasonable and prudent to disconnect the vent lines of the HFO Vent Collection Chamber without knowing where all the vent lines ran or to what they were connected. (*Tr. Vol. II at 289-94*).[6] Likewise, even though Respondent's expert witness Andrew Lipman, testified that Respondent's actions were not negligent, he stated that if he were in the same position of Respondent, he would have locked out or tagged out the motor controller to the disconnected heavy fuel oil transfer pump and its associated valves. (*Tr. Vol. III at 118*). Furthermore, at the Part 4 investigation, both John Sullivan[7] and Larry Gustafson[8] both testified that the HFO system should have been locked or tagged out since the vent lines for the HFO Vent Collection Chamber had been disconnected. (*Gov't Ex. 36 at 1314; Gov't Ex. 37 at 1522-23; Gov't Ex. 40 at 2835).* Finally, as the Coast Guard's expert witness, Kenneth Olsen, pointed out, a reasonable and prudent Chief Engineer, under the same circumstances, would have recognized the safety risks associated with leaving the HFO System disconnected and would have reconnected the vent piping given the know problems with the system. (*Tr. Vol. II at 102-03*). Thus, based on the weight of the evidence, one cannot conclude that Respondent's actions were mere errors in judgment.

VI. SANCTION

The remaining issue concerns determination of an appropriate order. Under 46 CFR 5.569(a), the selection of an appropriate order is exclusively within the purview of the

[6] Initially, Mr. Jayne testified on direct examination that Respondent's actions were not negligent. However, on cross-examination, by asking hypothetical questions that were factually identical to the facts in this case, the Coast Guard was able to discredit Mr. Jayne's testimony on direct examination. It appears that upon forming his initial opinion, Mr. Jayne was not familiar with all of the facts in this case.

[7] Mr. Sullivan was a Chief Engineer of the SSG CARTER from 1995 through fall 1997 when the vessel was formerly called the Sealand INNOVATION. (*Gov't Ex. 36 at 1299*). Mr. Sullivan assisted the Coast Guard in its casualty investigation following the fire on board the SSG CARTER on July 14, 2001. (*Gov't Ex. 36 at 1299-1300*).

[8] Mr. Gustafson served as Chief Engineer on board the SSG CARTER when the vessel was in dry dock in Norfolk, VA between February through June 2001. (*Gov't Ex. 32 at 90-91, 141*).

Administrative Law Judge. In determining an appropriate order, the ALJ may consider the following factors:

1) Remedial actions which have been undertaken independently by the respondent;
2) Prior record of the respondent, considering the period of time between prior acts and the act or offense for which presently charged is relevant; and
3) Evidence of mitigation or aggravation.

See 46 CFR 5.569(b). The Table of Suggested Range of an Appropriate Order ("Table") set forth in 46 CFR 5.569(d) serves as information and guidance for the ALJ in fashioning an order in a particular case. Appeal Decision 2628 (VILAS) (2003). However, the ALJ is not bound by the Table and may exceed the suggested range or impose a sanction less severe when aggravating or mitigating factors are present. Id.

Here, all of the allegations against Respondent relate to vessel safety. Under the Table, the suggested range of an appropriate order for negligently performing non-navigational duties related to vessel safety is 1-3 months suspension. 46 CFR 5.569(d). The suggested range of an appropriate order for misconduct for failure to perform duties related to vessel safety is 3-6 months. Under 46 CFR 5.567(b), the order is to be directed against "**all** licenses, certificates or documents, **except that in cases of negligence** or professional incompetence, the order is made applicable to the specific licenses." (Emphasis added).

The Coast Guard seeks revocation of Respondent's License and Document. In support of its request for revocation, the Coast Guard points out that the consequence of Respondent's negligence and misconduct are relevant. The Coast Guard cites to Appeal Decision 2243 (TRIGG) (1981). Other cases also support the Coast Guard's contention that the consequences of Respondent's action or the resultant damages may be considered by the ALJ in determining an

appropriate order. See Appeal Decision 2539 (HARRISON) (1992); Appeal Decision 2510 (COUSINS) (1990); Commandant v. Wardell, NTSB Order EM-149 at 9 n. 10 (1988).

The Coast Guard argues that the Respondent's decision to disconnect the HFO Vent Collection Chamber and leave it disconnected for three days is egregious. The Coast Guard points out that Respondent knew the SSG CARTER had approximately 5 million pounds of high appointment explosives on board, Respondent knew the TLIs were not functioning properly, Respondent knew that the fuel and vent lines on the SSG CARTER had not been traced out, and he knew that repair of the HFO Settling Tank would be delayed indefinitely until the Dresser couplings arrived. The Coast Guard points out that the consequences of Respondent's failures resulted in a fire that caused $15 million in property damages and the death of two crewmembers.

The Respondent's relies on Appeal Decision 1470 (CHANDLER) (1964) in support of his argument that a lesser sanction should be issued is misplaced. In CHANDLER, the Commandant reduced the ALJ order to three months suspension where the degree of negligence exhibited by respondent was not gross negligence, but was ordinary negligence. In that case, the Chief Engineer ordered that a boiler tube be plugged at its top and bottom after a leak was discovered while the vessel was anchored. After plugging the tube, the boiler was fired up and the proceeded on its voyage. On the next day, the boiler pressure increased and the lower end of the plugged tube burst injuring several members of the crew and resulting in the death of one crewmember. There were four assistant engineers on board the vessel and all were involved, to some extent, in the process of plugging the tube. However, no one suggested the possibility of venting the tube before firing the boiler. The respondent had never plugged the tube and the first assistant engineer had plugged the tube on several occasions but in every occasion the tube had

already ruptured. The Commandant found that the inattention was produced by the fact that in an ordinary case a tube is secured precisely because it has been ruptured. The Commandant held that while the rupture of the tube was foreseeable, the specific conditions that lead to the fatality was not. As such a lesser sanction was warranted. Id.

In this case, Respondent's actions cannot be deemed ordinary negligence. Respondent was subject to a higher standard of care because he was on board an ammunition ship that had 5 million pounds of explosives on board. Before deciding to disconnect the vent piping to the HFO Vent Collection Chamber and leave the vent piping disconnected from July 11 through July 14, 2001, Respondent failed to make himself aware of all facts necessary to make informed decisions. This is aggravated by the fact that Respondent failed to utilize accepted safety practices necessary to minimize potential risks of harm and property damage. The resulting fatalities and damages were foreseeable in this case.

After careful review of the facts of this case and the applicable law, I find that revocation of Respondent's License is not only appropriate, it is warranted. In so ruling, I am not unmindful of Respondent's exemplary record as a Chief Engineer for over 20 years and his Expeditionary Medal for his service in support of Operations Enduring Freedom and Iraqi Freedom. I am also not unmindful of the fact other persons, including the operator Maersk, Mr. Donat, and the port engineer, may bear some responsibility for the casualty in this case. However, those failures do not excuse Respondent of his broad responsibility as Chief Engineer nor does it justify reducing the order recommended by the Coast Guard.

Further, based on the authority granted to me under 46 CFR 5.567(b), revocation will not extend to Respondent's document.

WHEREFORE,

VII. ORDER

IT IS HEREBY ORDERED that the Merchant Mariner's License issued to Respondent Louis M. Champa is REVOKED. Respondent shall immediately surrender his License to the U.S. Coast Guard Marine Safety Office in Wilmington, NC.

PLEASE TAKE NOTICE that the service of this Decision and Order on the Respondent's counsel serves as notice to the Respondent of his right to appeal, the procedures for which are set forth in 33 CFR 20.1001 through 20.1003 and are located below in Attachment D.

SO ORDERED:

Peter A. Fitzpatrick

PETER A. FITZPATRICK
Administrative Law Judge
United States Coast Guard

Done and Dated: June 23, 2004
Norfolk, Virginia