LAW OFFICES
KEESAL, YOUNG & LOGAN
A PROFESSIONAL CORPORATION
400 OCEANGATE
LONG BEACH, CA 90802
P.O. BOX 1730
LONG BEACH, CA 908011730
(562) 436-2000
FACSIMILE:
(562) 436-7416
www.kyl.com

SAMUEL A. KEESAL, JR.
STEPHEN YOUNG
MICHAEL M. GLESS
PETER R. BOUTIN
SCOTT T. PRATT
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PHILIP R. LEMPRIERE*‡
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STACEY MYERS GARRETT
JON W. ZINKE°
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ELIZABETH H. LINDH
KELLY J. MOYNIHAN
CARA L. MEREDITH
SARAH TONG SANGMEISTER
MARC R. GREENBERG
JULIE A. KOLE
DAVID D. PIPER

OF COUNSEL
ROBERT H. LOGAN
RICHARD A. APPELBAUM+
REAR ADMIRAL, U.S.C.G. (RET.)
ELIZABETH A. KENDRICK
DAVID W. TAYLOR±
NANCY HARRISS†
FRANCES L. KEELER

GLEN R. PIPER
SANDOR X. MAYUGA
ESTHER E. CHO
CHRISTOPHER A. STECHER
AUDETTE PAUL MORALES
SCOTT E. HINSCHE
MELANIE L. RONEN
BENTLEY P. STANSBURY III
ATLANTIS TILLMAN LANGOWSKI
JOHN D. KIMMERLEIN†
EVELYN A. CHRISTENSEN
GARRETT R. WYNNE
JOHN COX
DAVID A. TONG
ANGELIKI J. PAPADAKIS
STEFAN PEROVICH
AILAN LIU
NICOLAS J. VIKSTROM†
JAMES F. KUHNE, JR.
ANNE M. MORIARTY
NICOLE S. BUSSI
JAY S. CARLSON†
NATHAN R. JASKOWIAK
JAMES A. MARISSEN
KENDRA S. CANAPE
JEREMY M. JOSEPH
JENNIFER L. MEEKER
TARA B. VOSS
JENNIFER M. PORTER
MOLLY J. HENRY†

* ADMITTED IN ALASKA
† ADMITTED IN WASHINGTON
‡ ADMITTED IN WASHINGTON & CALIFORNIA
§ ADMITTED IN ALASKA & CALIFORNIA
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ALL OTHERS ADMITTED IN CALIFORNIA

February 25, 2009

The Honorable Debbie Hersman
National Transportation Safety Board
490 L'Enfant Plaza, S.W.
Washington, D.C. 20594-2000

Re: The Allision of the *Cosco Busan* with the San Francisco–Oakland Bay Bridge - November 7, 2007

Dear Ms. Hersman:

We attended the NTSB Hearing on February 18, 2009, and we write to express our appreciation for your efforts to illuminate the responsibility of the U. S. Coast Guard in the unfortunate accident of November 7, 2007. We believe that during the NTSB Public Board Meeting several issues were raised which were not fully addressed. We respectfully provide the following information on those topics with the hope that the information will be of assistance to you, should you decide to issue a dissent to the Board's Findings, Conclusions, and Recommendations.

a. Thirty Years Of NTSB History Should Not Be Disregarded Now

The *Cosco Busan*'s allision with the San Francisco–Oakland Bay Bridge was the result of several related causes, some of which are systemic within the Coast Guard. While drug induced confusion by the pilot was recognized by the NTSB as undoubtedly the direct cause of the accident, there are systemic problems that must be addressed if the goal is to avoid another similar accident by a pilot.

For more than thirty years the NTSB has recommended that the Coast Guard require U.S. pilots to inform a ship's master and crew regarding the pilot's intended navigation. The NTSB has recognized that U.S. pilots have a long track record of not properly advising the crew of the pilots' intended navigation. In the NTSB's proposed findings for this accident, the Board once more cites to the lack of a complete pilot-master exchange regarding the pilot's intentions as a cause of the Cosco Busan accident. However, the Board failed to reiterate its Recommendations from 1974, 1977, 1988, 1991 that the Coast Guard should require that U.S. pilots inform ship captains of the pilots' planned routes.

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Over the course of the past thirty years, the NTSB has investigated no less than nine separate casualties, two of which involved the loss of life, where a U.S. pilot was at the conn and the ship's crew was uncertain as to the pilot's intentions. In each accident, the crew was uncertain as to the pilot's intentions, and, as a result, the crew was unable to act as a safety-net for pilot error.

In 1994, the NTSB wrote to the Coast Guard to express its disappointment in the Coast Guard's unwillingness to place any obligation whatsoever on U.S. pilots:

> The Board is disappointed that the USCG continues to believe that the CFR already sufficiently regulates master and pilot discussions. The Board maintains that the CFR does not require master and pilot discussions, but rather requires only that the crew inform the pilot of the vessel characteristics, peculiarities, and abnormal circumstances. Because the USCG has made clear that it plans no further action, Recommendation M-91-28 has been classified as "Closed—Unacceptable Action."

The label of "Unacceptable" is unfortunately appropriate in view of the *Cosco Busan*'s allision. When the practical realities of maritime shipping are overlaid in a scenario such as that of November 7, 2007, it is clear that the local pilot must be obligated to communicate the pilot's intentions, just as the master is obligated to communicate the characteristics of the ship. Indisputably, the compulsory pilot is hired for his or her expertise of the harbor, and the master is not expected to know the harbor's features and hazards as well as that pilot. Quite simply, if we want the crew to know the pilot's usual and customary practice for navigating out of the bay, we need to require that he disclose it. The NTSB's history with maritime accidents demonstrates that the Coast Guard's decision to leave it optional for the pilot, or worse yet, suggesting that the captain should be expected to extract the information from the pilot, is not only illogical, it has cost lives.

The importance of the NTSB's Recommendations M-74-15, M-77-33, M-88-20, M-91-28, cannot be overstated. Had the Coast Guard heeded the NTSB guidance in 1974, perhaps the twenty-six souls that perished on the *Edgar Queeny* in 1975 would be alive today. Thirty years of NTSB experience has proven that the Coast Guard's refusal to place any duty upon the pilot cannot be justified. The Coast Guard's objective of protecting pilots from liability for the accidents they cause must cease.[1]

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[1] In justifying its refusal to follow the NTSB's Recommendation, in 1993 the US Coast Guard wrote the following to the NTSB: "In this instance, making a high speed transit in relatively shallow water, it would have been prudent for the master and pilot to discuss the proposed route. . . However the USCG

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Since 1974 the NTSB has been a lone voice in the wilderness on this issue, a voice that has been repeatedly unheeded by the Coast Guard. As a result, on the *Cosco Busan*, the pilot felt no obligation to inform the crew of his intentions. In fact, the San Francisco Pilots Association's Pilot Card states that the pilot may discuss his intended plan, but is not required to do. It's not required because the Coast Guard, for thirty years, has refused to require it. As a result, the *Cosco Busan's* pilot did not look at the crew's passage plan as set out on the chart, did not tell anyone of his plan, and did not even explain why he set a VRM at 0.33 mile after leaving the berth. In so doing, the pilot of the *Cosco Busan*, like other pilots, functionally removed the crew as an oversight of his actions. His actions and inactions were, unfortunately, consistent with the actions and inactions of pilots on ships around this country, some of which, regrettably, have been the subject of NTSB investigations since 1974.

For more than thirty years, the NTSB has been shouting into the wind when it comes to these Recommendations to the Coast Guard, but that is no reason to stop shouting now. While the losses to the shipping interests in this case are substantial – clean up costs, damages to the ship, damage claims, environmental claims, and even the threat from the Government of forfeiture of the ship – fortunately, there was no loss of human life, as there was on the *Africa Neptune* and the *Edgar Queeny*. The fact that no lives were lost in this incident should not diminish the point that this accident might have been avoided had the Coast Guard followed the NTSB's previous Recommendations.

b. The Coast Guard's Medical Review Process Should Be Audited By The General Accounting Office

Independent of the pilot's lack of communication, there is the more causative issue of the pilot's medical condition and drug usage. Since at least 1997, after the *Star Princess* accident caused by a pilot with sleep apnea, the NTSB has attempted to advance the quality of the Coast Guard's medical review process.[2] Some eight years later, the NTSB again tried to bring the Coast Guard's medical review process in conformity with other regulatory agencies. In 2005, the NTSB Recommended to the Coast Guard that it "review its medical oversight process" and take actions to address, at a minimum, the lack of tracking of performance examinations and deficiencies in the system. This Recommendation was made as part of the

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remains unconvinced that a more detailed rule would have prevented this failure to communicate. Because there are innumerable variables that potentially could be discussed, such a regulation would serve only as a way to penalize the master and the pilot after a casualty." It is in response to this statement that the Board expressed its "disappointment," quoted above, and closed the Recommendation as "Unacceptable Action."

[2] See: Recommendation M-97-42.

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NTSB's report on the *Staten Island Ferry* accident. In that accident, the pilot also suffered from sleep apnea, one of the ailments noted in Captain Cota's medical evaluation report received by the Coast Guard in 2007. Yet, here we are, years later, once again finding that the Coast Guard did not take the most basic steps to fulfill its fundamental responsibilities to only license medically fit pilots.

Despite the seriousness of the *Staten Island Ferry* accident, and the loss of life that resulted, the Coast Guard, two years later, functionally allowed another pilot with sleep apnea to take the conn of a ship. Like the captain of the *Staten Island Ferry*, the pilot of the Cosco Busan was also under the influence of various pain medications. The difference here was that Captain Cota reported most of those medications to the Coast Guard, and, had the Coast Guard performed even a cursory review of his medical report, it would have realized that he was unfit. As you know, that did not happen until after the accident. The inescapable conclusion is that had the Coast Guard done its job properly this pilot would not have been licensed and this accident would not have happened.[3]

In recognition of the souls lost on the *Africa Neptune,* the *Edgar Queeny*, and the *Staten Island Ferry*, and for the sake of the souls that can be spared the same fate in the future, the NTSB must continue to shout into the wind, even though the Coast Guard shows less than adequate response. We submit that this is, in fact, the mandate of the NTSB, and that this important role should never be diminished or forgotten, particularly when it is a Federal agency that has repeatedly dismissed the same Recommendations, accident after accident.

c. VTS San Francisco's Failures Were A Proximate Cause Of This Accident

As a separate matter, we concur with the concerns that you expressed regarding the failure of the VTS to warn the pilot when the VTS watchstanders saw that the pilot was off course and thereafter, when they saw that he was "standing in danger" of hitting the bridge pier. During the public meeting, you asked the NTSB's staff what the pilot might have done had he been warned that he was heading directly for the Delta tower. Perhaps you could ask the staff whether the ship would have hit the bridge pier if the pilot had maintained his rudder command of "hard starboard" after hearing from VTS.

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[3] It should be noted parenthetically that the Harbor Commissioners, the Port Agent and the Pilots' Association appear to have abdicated their responsibility in the licensing process, or at a minimum, did not aid the process of full disclosure, thorough vetting or a sincere attempt to determine who should pilot vessels in this environmentally sensitive bay.

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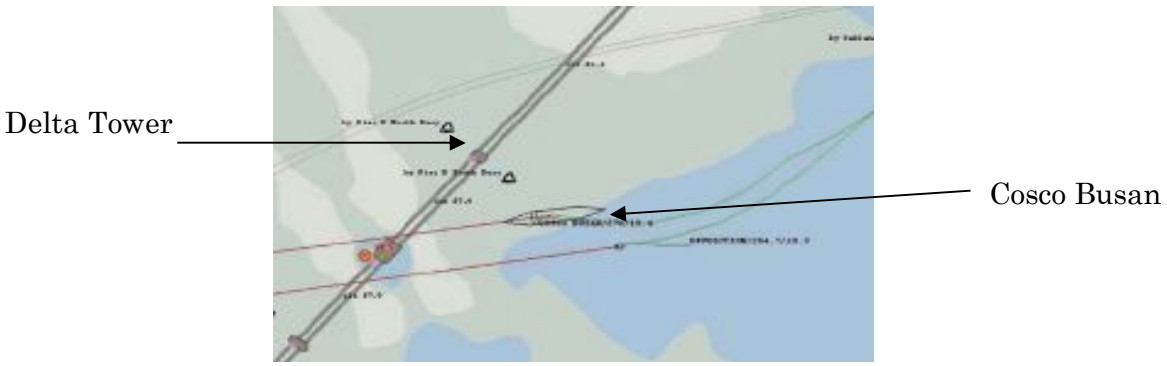
At 8:27:35, the VTS watchstanders called to the pilot ("Romeo") because they recognized that he was out of position to make a turn to the Delta-Echo span.[4] At 8:27:48, the VTS watchstanders mistakenly told "Romeo" that he was heading 235 degrees. At 8:27:57, "Romeo" responded that he was steering 280. At this point, the VTS watchstanders could see that the ship was already southeast of the Delta tower and that the ship would not be able to make the turn, absent a very hard turn to starboard.

VTS Image At 8:28:04



It was after this that the pilot ordered "hard starboard." However, shortly thereafter, the pilot ordered "midships" at 8:28:42, and then issued an order of "starboard 20" at 8:28:51. Had the VTS notified "Romeo" that he was heading directly for the Delta tower, the pilot could have maintained the "hard starboard" command. Moreover, the pilot could have employed the tethered tug, deployed one or both anchors, and used propulsion to avoid the allision (or certainly mitigate the effects of impact).

As you noted during the hearing, the difference between hitting the tower and avoiding it was only eight feet. With the rudders, engines, anchors, and tug available, an experienced licensed pilot had many tools to use. The failure of the VTS to alert the pilot denied him the

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[4] The Admiralty Sailing Directions state that outbound traffic should sail through the South-West side of the Delta-Echo span, not directly under the RACON, as intended by the pilot. A passage directly under the RACON would risk collision with a pilot bringing a ship into an Oakland berth. The pilot that navigated the ship into the harbor traveled directly under the RACON, despite the fact that the Admiralty Sailing Directions counsel against doing so. The pilots in San Francisco apparently disregard the local Admiralty Sailing Directions and VTS makes no effort to correct this error.

opportunity to employ those tools to avoid the allision, and, thus, must be a proximate cause. Doing nothing is outrageous. Doing nothing is a dereliction of the VTS's duties as contained in its published mission "to facilitate the safe and efficient transit of vessel traffic in the waterways of San Francisco Bay. . . in an effort to prevent collisions, rammings, groundings and the associated loss of life and damage to property and the environment." It is ridiculous to suggest that doing nothing was based on concern for distracting the pilot during a complex maneuver. This should not have been a complex maneuver. The fact that it was perceived to have become complex is, in itself, further support for the VTS to clearly communicate its concern.

This is not to diminish the fact that the VTS' first opportunity to prevent the accident was to warn the pilot that the Harbor Safety Plan required at least 0.5 mile visibility. But they chose not to do so. The VTS could have informed the foreign ship captain that the pilot was acting contrary to the Harbor Safety Plan, but they did not. The VTS could have warned the pilot and/or the captain that four other pilots complied with the Harbor Safety Plan and decided not to leave port in the fog, but the VTS chose not to mention this either. Instead, the VTS simply watched as the *Cosco Busan* left the safety of the dock.

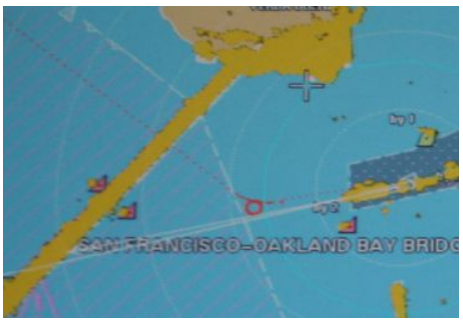
Thereafter, the VTS could have warned the pilot that he was off course when the watchstanders first noticed that the pilot's track was unusual. They had seen thousands of ships travel through the Delta-Echo span and undoubtedly knew that this pilot's course/track was outside the norm. The VTS could have warned the pilot that the ship was southeast of the Delta Tower and that its track over ground indicated that the ship would continue to move further to the Southwest. The VTS could have warned the pilot that he was standing into danger and heading directly for the bridge tower.

Even if the pilot mistakenly thought that the "red triangle" was a "bridge light," as was mentioned by Member Higgins, had VTS warned him that he was heading for the tower, he would have known that he was aiming for the red bridge light on the Delta tower, not the green bridge light at the center of the Delta-Echo span. Instead, the VTS chose not to give any warnings whatsoever. Rather than fulfilling its charter to promote safety, the VTS made the situation worse. Specifically, it falsely reported the ship's heading. Even though during the entire passage the ship's heading was never steady at 235, VTS reported to the pilot that it had the ship heading 235. As recognized by the Board, this only served to further confuse a pilot who was already suffering from a mental fog due to his various medications. Then, when the pilot confirmed that he was still intending to pass through the Delta-Echo span, at 8:28:04, two full minutes before the ship hit the bridge, the VTS responded, "Roger, understand you still intend delta-echo span." In so stating, the VTS validated the pilot's false belief that he was following the usual and customary path. VTS knew better, but they remained silent and simply watched the allision occur, just as others had watched the *Oregon*

and the *Arizona* collide under the Golden Gate Bridge back in 1971. The difference is that, in this case, the VTS had the opportunity, and in fact the duty, to step in and help but chose not to do so.

d. The Red Triangle Appeared On Other Ships Piloted By Cota

As for the pilot's statement to the NTSB that he had never seen an electronic chart with a red triangle prior to the *Cosco Busan* allision, this seems to be simply false. You will recall that you, along with NTSB staff, sailed on the *NKY Atlas* in San Francisco Bay. The photo taken by NTSB staff, shown here, reveals that the ship had an electronic chart with the same red triangle symbols as the *Cosco Busan*. And records of Captain Cota's sailing history show that Captain Cota piloted this same ship, with the same electronic chart, twice before the allision, once only a few weeks before the accident. While there was undoubtedly similar chart software on other ships piloted by Captain Cota, we note this one because you personally sailed on this ship and saw the chart for yourself. As acknowledged by the American Pilots' Association, Captain Cota's claimed lack of understanding of the "red triangle" is inexplicable. It was not unreasonable that the master did not realize that the local expert pilot on his ship would be unfamiliar with the navigational aids in the harbor. Furthermore, there was no way for the master to know that the pilot was under the influence of prescription drugs, only the Coast Guard, the Pilot Association, and the Board of Pilot Commissioners were aware of that fact.



e. The Passage Plan Text versus The Passage Plan On The Paper Chart

We would note concurrence with the NTSB's Captain Rob Jones' point that the written passage plan was not of significance because the passage plan set out on the chart was berth-to-berth, albeit disregarded by the pilot. Crews sail on the basis of the track lines set out on the navigational chart, not on the basis of waypoints listed in a text document. However, given that the pilot, like most pilots, disregarded the crew's passage plan on the chart, the passage plan issue is a "red herring." Moreover, as testified to by the crew, Roy Mathur from California Fish & Game reviewed the original text pilot-to-pilot passage plan on the morning of the accident. The crew testified that the plans created thereafter were for Fleet, not for the government. Again, a ship sails on the basis of the chart, not the text document created on from the information on the chart.

It must be further noted that, without incident, the *Cosco Busan* sailed into Long Beach with a pilot, out of Long Beach with a pilot, and into San Francisco with a pilot. The

key variable in terms of the allision is the Coast Guard and State-licensed pilot, Captain John Cota, not the passage plan paperwork. That which allowed Captain Cota to exercise his license on November 7, 2007, is at the heart of the matter. The only piece of paper that directly caused the allision was Captain Cota's license. But for his license, Captain Cota would have been ashore. But for Captain Cota, the *Cosco Busan* would have been safe.

f. The SMS And Other Ship's Documents Must Be Maintained In English

The NTSB has recommended that Fleet provide copies of its SMS in the language of the ship. Typically, there will be a variety of languages spoken on a ship. The crew may consist of mariners from the Philippines, India, China, and the Ukraine, just to name a few. If ship managers were required to have copies of the ship's documents, manuals, and procedures in every language there would not be enough storage space on the bridges for all the documents. Moreover, mariners are tested for the ability to read English as part of the test to obtain their respective licenses. There is no reason to depart from the long standing, international standard of printing the ship's SMS in English, the *lingua franca* of the ship. Every ship sailing around the world today has an SMS, they are all quite similar since they are all drafted to comply with the same IMO rules, and they are all in English. If it was the intent of the NTSB to suggest that the ship's documents should all be provided in the native language of every mariner, such a recommendation is untenable and is contrary to international policies and practices.

While there were other points of confusion during the public meeting, upon which we could comment, we will keep this brief. We hope that you will issue a dissent and consider the points described above. Our point is that, while the Coast Guard generally executes its extraordinarily broad and challenging missions in exemplary fashion, there is always room for improvement, and those areas, identified herein, need to finally be addressed. If the purpose of the NTSB is to avoid the occurrence of future casualties, we submit that this can only be accomplished if the systemic problems discussed above are addressed and corrected. For more than thirty years, the NTSB has tried to protect mariners and the environment by trying to influence the Coast Guard in these limited areas. Thirty years of unresponsive ("Unacceptable" per the NTSB) action by the Coast Guard is not a reason to abandon the effort.

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We thank you for your efforts to advance the honorable goal that Federal and State agencies, and non-governmental organizations, should learn from the mistakes of the past in order that they may be prevented in the future.

Respectfully submitted,

KEESAL, YOUNG & LOGAN

Marc R. Greenberg

Richard A. Appelbaum
Rear Admiral, U.S. Coast Guard (Retired)
Of counsel

cc: Honorable Mark Rosenker
Honorable Robert Sumwalt
Honorable Kathryn O'Leary Higgins
Honorable Steven R. Chealander
Mr. Tom Roth-Roffy, Group Chairman