UNITED STATES OF AMERICA

NATIONAL TRANSPORTATION SAFETY BOARD

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In the matter of: *
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MARINE BOARD OF INVESTIGATION *
INTO THE SINKING OF THE *SCANDIES ROSE* *
ON DECEMBER 31, 2019 *
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Edmonds Center for the Arts
Seattle, Washington

Friday,
March 5, 2021

APPEARANCES:

Marine Board of Investigation

CAPT GREGORY CALLAGHAN, Chairman
CDR KAREN DENNY, Member
LCDR MICHAEL COMERFORD, Member

Technical Advisors

LT SHARYL PELS, Attorney Advisor
KEITH FAWCETT, Technical Advisor

National Transportation Safety Board

BARTON BARNUM, Investigator in Charge
PAUL SUFFERN, Meteorologist

Parties in Interest

MICHAEL BARCOTT, Esq.
Holmes Weddle & Barcott
(On behalf of Scandies Rose Fishing Company, LLC)

NIGEL STACEY, Esq.
Stacey & Jacobsen PLC
(On behalf of survivors Dean Gribble and John Lawler)

Also Present

LT IAN McPHILLIPS, Recorder

I N D E X

P R O C E E D I N G S

(8:00 a.m.)

CAPT CALLAGHAN: It is 0800 on March 5, 2021, and this hearing is now in session. Good morning, ladies and gentlemen. I'm Captain Greg Callaghan, United States Coast Guard Chief of Prevention for the 11th Coast Guard District. I'm the chairman of this Coast Guard Marine Board of Investigation, and the presiding officer over these proceedings.

The Marine Board has established a COVID mitigation plan to comply with federal, state, and local requirements. As a result, no members of the public will be permitted to be at this hearing in person. The Board will receive witness testimony through a hybrid of in-person, virtual, and telephonic means. The members of the Board have been spaced out far enough at the main table to remove their masks while seated, to maximize clarity and minimize disruption. Members are to place masks back on at any time when leaving the table, and whenever approached by another person. I would ask that anyone who is unable to maintain social distancing please keep their masks on, unless actively speaking into their microphones.

Due to the extensive technology used to support this hearing, and the potential for unanticipated delays or challenges, I ask that you please be patient with us in the event of any disruption.

The Commandant of the Coast Guard has convened this Board under the Authority of Title 46 U.S.C. Section 6301 and Title 46

C.F.R. Part 4 to investigate the circumstances surrounding the sinking of the commercial fishing vessel *Scandies Rose*, with the loss of five lives, on December 31, 2019, while transiting in the vicinity of Sutwik Island, Alaska. There were two survivors.

I'd like to take this opportunity to express my condolences to the family and friends of the five crew members who were lost at sea. I note that many of you are watching this hearing on livestream due to the COVID restrictions in place, and we appreciate your being with us.

Upon completion of the investigation, this Marine Board will submit its report of findings, conclusions, and recommendations to the Commandant of the United States Coast Guard. Other than myself, the members of this Board include Commander Karen Denny and Lieutenant Commander Michael Comerford. The legal counsel to this Board is Lieutenant Sharyl Pels. The recorder is Lieutenant Ian McPhillips. Coast Guard technical advisors to this Board are Mr. Scott Giard and Mr. Keith Fawcett. The Board's media liaison is Lieutenant Commander Scott McCann.

The National Transportation Safety Board is also participating in this hearing. Mr. Bart Barnum, Investigator in Charge for the NTSB *Scandies Rose* investigation, is here with us.

Witnesses are appearing before the Board to provide valuable information that will assist this investigation. We request that all members of the public be courteous to the witnesses and respect their right to privacy.

The members of the press are welcome to attend virtually, and provisions have been made during these proceedings to allow the media to do so. The news media may question witnesses concerning the testimony they have given after I have released them from these proceedings. I ask that any such interviews be conducted with full consideration of the COVID mitigation procedures that the Marine Board has established.

The investigation will determine as closely as possible the factors that contributed to the incident so that proper recommendations for the prevention of similar casualties may be made; whether it's evidence that any act of misconduct, inattention to duty, negligence, or willful violation of law on the part of any licensed or credentialed person contributed to this casualty; and whether there is evidence that any Coast Guard personnel or any representative or employee of any other government agency or any other person caused or contributed to the casualty.

The Marine Board convened this hearing to examine all events relating to the loss of the *Scandies Rose* and five crew members. This hearing has explored crew member data and qualifications, shore side support operations, vessel stability, weather factors, effects of icing, safety equipment, the operations of the vessel from the past up to and including the accident voyage, and survey imagery of the vessel in its final resting place. The hearing also included a review of industry and regulatory safety programs,

as well as the Coast Guard Search and Rescue activities related to the response phase of the accident, after notification that the *Scandies Rose* was in distress.

The Coast Guard has designated parties in interest to this investigation. In Coast Guard marine casualty investigations, a party in interest is an individual, organization, or other entity that under the existing evidence or because of his or her position may have been responsible for or contributed to the casualty. A party in interest may also be an individual, organization, or other entity having a direct interest in the investigation in demonstrating the potential for contributing significantly to the completeness of the investigation or otherwise enhancing the safety of life and property at sea through participation as a party in interest.

All parties in interest have a statutory right to employ counsel to represent them, to cross-examine witnesses, and have witnesses called on their behalf. Witnesses who are not designated as parties in interest may be assisted by counsel for the purpose of advising them concerning their rights. However, such counsel are not permitted to examine or cross-examine other witnesses or otherwise participate in the investigation.

I will now read the list of those organizations and individuals whom I have previously designated as parties in interest. Scandies Rose Fishing Company, LLC, represented by counsel here with us today; crewpersons Mr. Dean Gribble and

Mr. John Lawler, represented by counsel appearing virtual today; Mr. Bruce Culver, not present at this time.

The Marine Board will place all witnesses under oath. When testifying under oath, the witness is subject to the federal laws and penalties for perjury for making false statements under Title 18 U.S.C. Section 1001. Penalties could include a fine of up to $250,000 or imprisonment up to five years or both.

The sources of information to which this investigation will inquire are many and varied. Since the date of the casualty, the NTSB and Coast Guard have conducted substantial evidence collection activities, and some of that previously collected evidence will be considered during these hearings. Should any person have or believe he or she has information not brought forth but which might be of direct significance, that person is urged to bring that information to my attention by emailing uscg.scandiesrosembi@gmail.com. This email address will be continuously monitored throughout the proceedings.

Mr. Barnum will now say a few words on behalf of the NTSB.

MR. BARNUM: Good morning. I am Bart Barnum, Investigator in Charge for the National Transportation Safety Board's investigation of this accident. The Safety Board is an independent federal agency which under the Independent Safety Board Act of 1974 is required to determine the cause or probable cause of this accident, to issue a report of the facts, conditions, and circumstances related to it, and to make safety

recommendations for measures to prevent similar accidents.

The NTSB has joined this hearing to avoid duplicating the development of facts. Nevertheless, I do wish to point out this does not preclude the NTSB from developing additional information separately from this proceeding if that becomes necessary.

At the conclusion of the hearing, the NTSB will analyze the facts of this accident and determine the probable cause, independent of the Coast Guard. At a future date, a separate report of the NTSB's findings will be issued, which will include our official determination of the probable cause of this accident. If appropriate, the Safety Board will issue recommendations to correct safety problems discovered during this investigation. These recommendations may be made in advance of the report.

In addition, on behalf of the NTSB, I would like to offer my deepest condolences for the families and those affected by this tragic accident. Thank you.

CAPT CALLAGHAN: Thank you, Mr. Barnum.

Today we will hear from the representative from the Coast Guard Office of Investigations and Analysis, followed by closing statements from parties in interest, the National Transportation Safety Board, and the Marine Board. At this time, we will now go to recess and resume at 0815.

(Off the record at 8:07 a.m.)

(On the record at 8:15 a.m.)

CAPT CALLAGHAN: The time now is 0815. This hearing is now

back in session. We'll now hear from Commander Baxter Smoak from Coast Guard Office of Investigations and Analysis.

Commander Smoak, Lieutenant McPhillips will now administer the oath and ask you a few preliminary questions.

Lieutenant McPhillips?

LT McPHILLIPS: Good morning, Commander. Please stand and raise your right hand.

(Whereupon,

CDR BAXTER SMOAK

was called as a witness and, after being first duly sworn, was examined and testified as follows:)

LT McPHILLIPS: Thank you. Please be seated. Please state your full name and spell the last name.

THE WITNESS: My name is Baxter Smoak. Last name spelled S-m-o-a-k.

LT McPHILLIPS: Please identify counsel or representative, if present.

THE WITNESS: Lieutenant Commander Matthew Pekoske is my legal counsel.

LT McPHILLIPS: Counsel, please state and spell your last name, as well as your firm or company relationship.

LCDR PEKOSKE: Lieutenant Commander Matthew Pekoske. P-e-k-o-s-k-e. U.S. Coast Guard Judge Advocate and witness counsel to Commander Baxter Smoak.

LT McPHILLIPS: Thank you, sir.

Commander Smoak, please tell us, what is your current employment and position?

THE WITNESS: I currently work at Coast Guard headquarters, in the Office of Investigation and Analysis, where I'm the chief of the Compliance Analysis Division.

LT McPHILLIPS: What are your general responsibilities in that job?

THE WITNESS: My staff and I are the primary providers of Coast Guard marine safety data to internal and external customers. We answer over 200 requests for data each year. Some are relatively simple, like extractions from MISLE, while others are more complex, require manual review of records, analysis, and generation of reports and presentations. Our mission is to deliver the information and analysis necessary to ameliorate the value of, drive change to, and improve the utility of the marine safety mission of the Coast Guard.

LT McPHILLIPS: Can you briefly tell us your relevant work history?

THE WITNESS: Yes. I've been involved in the Coast Guard's marine safety program for most of my 17 years. I served as a prevention officer afloat and ashore. I have field experience as a marine inspector, port safety control officer, marine investigator, and marine enforcement officer. In my current position, I routinely present marine safety data to industry partners and other government agencies.

LT McPHILLIPS: What is your education relating to your position?

THE WITNESS: I hold a Master's of Science degree and an MBA, Master's of Business Administration.

LT McPHILLIPS: Thank you. Do you hold any professional licenses or certificates related to your job?

THE WITNESS: No licenses, but I hold six Coast Guard marine inspection qualifications, five port safety control examiner qualifications, three investigating officer qualifications, and I'm also certified ISO9001 quality management system unit auditor.

LT McPHILLIPS: Thank you, Commander. Captain Callaghan will now have follow-up questions for you.

EXAMINATION OF CDR BAXTER SMOAK

BY CAPT CALLAGHAN:

Q. Okay. Thank you, Commander, for joining us this morning. I understand you've prepared a presentation to walk us through. Before we bring that presentation up, I just want to ask that you try and reduce or try and eliminate the use of acronyms to the best extent possible, just for the best understanding of the general public.

In utilizing this virtual platform, you'll see, once we pull that up, it will -- it should show in front of you, and Lieutenant McPhillips can advance slides. When we're ready, I would just ask that as you get through each slide, give us a minute to digest the slides, see if we have any questions, and then we'll give you an

indication to move on to the next slide.

A. Understood.

Q. Lieutenant McPhillips, can you bring up Commander Smoak's presentation, please? All right. We'll turn it over to you.

A. Thank you, and good morning, everyone. Before I begin my presentation, I'd like to offer my most sincere condolences to the survivors and the families that lost loved ones on the *Scandies Rose*. In the data that I'll present and discuss, I'll be referring to losses of life and injuries, and I want to impress upon the group that we take our role of looking at and providing this data very seriously, and understand that there are people and families behind these numbers.

Please advance to slide number 2.

As I mentioned in my introduction, my staff and I support a variety of internal and external stakeholders. I apologize for the eye chart and all the acronyms here on this slide, but our customers can most easily be broken down into four broad categories: our marine based or marine related federal advisory committees, quality partnerships -- which are typically chartered between the Coast Guard and industry trade groups like the Passenger Vessel Association or American Waterway Operators -- other government agencies, and then also internal Coast Guard headquarters offices, as well as field units and investigating entities like this marine board or, if the investigation is at the field level, IOs individually.

Any questions? If not, please advance to slide 3.

Before diving into the data, I think it might be valuable to quickly discuss the Coast Guard's marine investigation process and the data collected and stored within Coast Guard databases. Annually, the Coast Guard conducts approximately 19,000 preliminary investigations. This involves receiving a report of an incident, collecting basic information about the incident, and involved subjects, people, vessels, companies, facilities and waterways, and making a determination on authority and jurisdiction.

When a preliminary investigation reveals that a reportable marine casualty per 46 C.F.R. Part 4 has, in fact, occurred, the level of investigation shall be raised by the investigating officer. For incidents that are reportable marine casualties, there are differing levels of investigative effort based on the severity of the incident.

Formal investigations like this are reserved for the most serious incidents, from which most value can be gained. Marine Boards convened by the Commandant, formal investigations convened by the district commander or OCMI, Office in Charge of Marine Inspection, or captain of the port fit into this category.

Informal investigations are less exhaustive than formal investigations but include the determination and reporting of causal factors of the casualty, and documenting of this information within our MISLE system. Data collection activities

do not require much significant investigative effort, and usually only consist of collecting basic factual information and entering it into MISLE for future reference and analysis. Only minimum follow-up is required to verify accuracy and completeness.

Separate from the levels of investigative effort are designations of marine casualties. We have major marine casualties, significant marine casualties, serious marine incidents -- or often referred to as SMIs; these include incidents that meet the threshold that require post-casualty drug testing and alcohol testing -- and then the lowest level being a routine incident. Just for a little perspective, the *Scandies Rose* sinking and loss of life was a reportable marine casualty, which also met the serious marine incident threshold, meaning the operator would be required to conduct post-casualty chemical testing for individuals deemed directly involved in the accident.

This incident was also determined to be a major marine casualty, because the *Scandies Rose* was a mechanically propelled vessel greater than 100 gross tons, and was lost at sea. This requires the Coast Guard to inform the NTSB, in accordance with Title 46 C.F.R. Part 4.40. On the *Scandies Rose*, it was determined that the Coast Guard would lead and that the NTSB would join the investigation and be a part of the Marine Board, as they are today.

By policy, the level of investigative effort to this incident was a formal investigation, because tragically it involved the

loss of multiple lives. Additionally, the Coast Guard Commandant felt that this investigation -- or this incident warranted a Marine Board of Investigation and convened this Board on January 16th of last year. For those that aren't aware, a Marine Board of Investigation is the highest level of investigation within the Coast Guard.

If there aren't any other questions, move to the next slide, please.

Q. Okay. Commander, just for the perspective of the general public who is receiving this, could you give us a sense of how many Marine Board of Investigations are opened on average per year?

A. Yes, there are relatively few, and it depends on the year. There's some more than others. But typically there is a couple a year. And then, there are other investigations that are opened at the district commander level, and there are several of those. And then, even fewer at the OCMI or local level. The bulk of our marine casualty investigations falls into the informal investigation and data collection activities.

Q. Great. Thank you.

A. So the marine casualty investigation process. At its most basic level, you have an incident or marine casualty which requires an on-scene investigation and evidence collection, followed by analysis, documentation, and continued investigation as necessary. Decisions on if safety recommendations are needed,

or enforcement actions are warranted, those are considered. And then finally, the routing and closure of cases. I think it's important for folks to understand that all incident investigation activity -- so all investigations that are a reportable marine casualty are routed to and closed at the headquarters level.

In complex systems such as the marine transportation system, there are many interactions between operational parts of system, including mariners, shore side workers, vessel traffic services, the vessel itself, equipment, facilities, charts, publications, and even environment. Because of the complexity of the marine transportation system, there is a constant danger that critical information may be overlooked or lost during a marine investigation.

To avoid this, the Coast Guard's marine investigation process, which is based on and mirrors the approach prescribed by the International Maritime Organization, was developed. The detailed steps of this process are listed in the figure to the right, which is directly out of the Coast Guard's Marine Safety Manual. I know it's a little hard to read. The major parts are generate a timeline, conduct causal and human analysis, draw conclusions, and issue safety recommendations, if warranted.

The Coast Guard's investigation management documentation requirements are defined in CG-INV Policy Letter 003-2018, specifically sections 3(c)(1) and (2), discuss endorsements and final action, which are the last two steps in this process.

For investigation reports, the endorsement is the documentation from the Office in Charge of Marine Inspection and/or, depending on the level of the investigation, it might have both the district commander stating, one, that they approve or otherwise of the investigating officer's report; two, the action taken with respect to the recommendations; and three, whether or not any enforcement actions have been or are recommended. All endorsements are documented within the report of investigation.

Final action, also referred to as Commandant action, is documentation from the Commandant stating that final approval or otherwise of the investigating officer or, in this case, the Marine Board's report; number two, any action that has been or will be taken or recommendations; and three, that the investigation is completed and closed. Just like endorsements, the final action is documented within the report of investigation.

If no questions, next slide.

So, as the investigations are documented within the Coast Guard's Marine Information for Safety and Law Enforcement. We refer to it as the MISLE database. As previously discussed, initial investigations are documented in MISLE through a preliminary investigation activity. This was the 19,000 number that I mentioned earlier. And if the threshold for a reportable marine casualty is met, an investigating officer will create an incident investigation activity within MISLE. There are also enforcement activities and boarding activities and other

activities within MISLE, but from an investigative perspective, there are PIAs -- preliminary investigation activities -- incident investigation activities, and enforcement activities.

The amount of information collected and entered into MISLE depends on the level of investigative effort that I mentioned earlier, data collection, informal, or formal. Within the IIA, investigator documents vessels; facilities; waterways; parties, the people and organizations that are involved; their roles -- whether they're a witness, subject of investigation, their location, or if they were just cited in the area; their status -- whether they're damaged or undamaged, at risk, not at risk, injured, missing, or deceased.

Within the database, these associations tie to existing or new records for these people, vessels, organizations, and places. From a data perspective, you have one IIA, one incident investigation activity, for each incident. But it will be associated with multiple parties -- multiple people, multiple vessels, multiple waterways and facilities, depending on the scale and scope of the investigation.

For instance, a collision or drowning with a tug pushing 15 barges most people think is a -- it is a single incident, but there are 16 vessels that are tied to that activity. So some of those vessels may be listed as grounded while some others are not.

Along with other critical information on the incident, including evidence, correspondence, causal analysis, conclusions,

and safety recommendations, the investigator develops an incident timeline. This was the first step in the process that I had mentioned earlier. This incident timeline is comprised of actions, conditions, and events that are important to the process of the investigation, but are also important for follow-on analysis.

Actions are things that people do. For example, the crew placed X number of crab pots on the vessel or the master placed the throttles full ahead. A condition is some existing circumstance, like weather, a worn part, or an individual's level of training. Events are things that happen to things, for example, a material failure of a part, an injury of a person, or the flooding of a vessel. Within the timeline in the MISLE casework and in the database, the investigating officer documents the initiating event, which is the first unwanted or negative outcome in the timeline.

From an analysis perspective, this is important, and I'll give you an example why. A vessel grounding that was preceded by a material failure event and then a loss of vessel maneuverability event is quite different than a grounding without any preceding events. Understanding this when looking at especially broad data sets of 10 to 40 years of reportable marine casualties involving commercial fishing vessels -- this understanding is important.

Any questions on this slide? Next slide please.

So the MISLE system documents and stores Coast Guard data.

And it was introduced back in 2001. It contains information on all Coast Guard activities, from Search and Rescue planning and sorties to pollution response and marine law enforcement boardings, vessel inspections and facility inspections, to marine casualty investigations and enforcement actions.

While MISLE goes back to 2001, my staff and I have access to records on our legacy marine safety data systems all the way back to 1981. The Coast Guard as a whole accesses MISLE through the database itself, or the use of Coast Guard Business Intelligence program, which we refer to as CGBI. CGBI is an IT integration tool which turns Coast Guard data from disparate but authoritative into a searchable analytic data warehouse for decision-making. While helpful, CGBI does not get to all the data elements stored within MISLE, especially within the casualty data set. My staff and I have direct access to all MISLE data elements via open database connectivity to the MISLE data warehouse or the MISLE extract, and are able to query all data within MISLE.

Public access is available through the Coast Guard Maritime Information eXchange -- we call it CGMIX -- and the Port State Information eXchange -- PSIX -- which are web-accessible and contain vessel specific information, including the results of boardings, examinations, and inspections, all derived from MISLE itself. Also publicly available, there are two large data files available for download: the Marine Casualty and Pollution Data file provides details about marine casualties and pollution

incidents investigated by the Coast Guard, and the Merchant Vessels of the United States Data file, which contains information on all documented U.S. merchant and recreational vessels.

Commercial fishing vessels are involved in approximately 850 reportable marine casualties per year. This is on average over the last decade or so. For perspective, remember the Coast Guard investigates about 3,500 reportable marine casualties annually.

If there are no questions on this slide, go to slide 7, please.

So what you see here on this slide is a breakdown of vessels involved in reportable marine casualties on the left. On the right shows vessels involved in serious marine incidents. Please note that these are vessels involved, so the numbers are reflective of vessel counts, not individual incident investigations.

If you go to the next slide -- we can go back if there are questions, but if you go to the next slide, it shows the number of major marine casualties by involved vessel or service. I caution the Board and public from making any broad assumptions based on these charts, as vessel services are not apples to apples comparisons. Their operating conditions, inspection reviews, fleet sizes, et cetera, are all different. Additionally, as I mentioned, this shows vessels involved. And the towing industry looks to be involved in more casualties, which is true from a vessel count perspective, but this is because most towing

casualties involve multiple vessels, like the example I gave earlier of a tug pushing 12 barges would be counted twice in this.

I'm sure the question is -- I mentioned earlier from a reportable marine casualty perspective, there's about 850 on average a year that involves at least one commercial fishing vessel. And we have about 3,500 a year. So that's about 25 percent, if you look at just an incident investigation raw count. I tend not to put those numbers up, because they don't add up to 100 percent, because of the duplicate vessels involved. But, for your perspective, about 25 percent of all reportable marine casualties involve a fishing vessel.

We'll talk a little bit more about -- go into some more details about commercial fishing vessel casualties, but, if you bring up the next slide, I'd like to talk about the fleet in general.

The Coast Guard estimates that there are nearly 58,000 commercial fishing vessels in documented service. I'm unsure of how exactly the Coast Guard's Commercial Fishing Vessel Safety Division arrives at this number, because there are only about 17,000 in MISLE. These are captured in MISLE because of some Coast Guard interaction -- a boarding, an investigation, or a safety exam. At the bottom, there's a table that shows the 2019 domestic annual report numbers for the commercial fishing vessel decal program. As you can see, there are about 3,800 safety decals issued and about 10,000 deficiencies identified and

documented.

Next slide.

So this slide, then, shows the most prevalent deficiencies for commercial fishing vessels in 2019. And if you go to the next slide, we'll -- I'll show you the 2020 statistics. So, while the 2020 annual report has not been published, here is the data from calendar year 2020. As you can see, there's a slight decrease in the number of decals and deficiencies issued, as compared with 2019. This is likely a result of the COVID pandemic. The top deficiency areas that are listed on the bottom half of the screen are fairly consistent with the 2019 data.

Any questions?

Q. I think we --

A. So go to the next slide -- oh, excuse me. Go ahead.

Q. Just saying we're good, clear to proceed.

A. All right. Next slide.

Okay, so this slide shows some additional commercial fishing vessel data. Starting in the upper left, you can see that the most prevalent commercial fishing vessels subtype is a fish catching vessel, making up nearly 99 percent of the active documented fleet in MISLE.

One thing I'll note here, you probably noted in the NIOSH presentation that they had data on the fishery involved. So, while MISLE doesn't have a lot of detail on the vessel type, in 2005, our office made a change to MISLE to allow -- to require IOs

to capture the fishery that the vessel was involved in when they -- the vessel was working when they were involved in the casualty. So that's where that data comes from; it's not from the actual vessel type.

From a tonnage perspective, which is the next -- the upper right, about 86, 87 percent are under 100 gross tons. On the very left, you can see that -- the age data, almost 99 percent of the 1,700 vessels in MISLE do not have a keel laid date, which leaves much to be desired. Lastly, only about 62 of the 1,700 commercial fishing vessels have an international or coastwise load line certificate documented in MISLE.

Any questions?

Q. I've just got one, and this -- maybe it referred back to the previous slide with -- regarding deficiency statistics. Now, the statistics on deficiencies, does that include offshore law enforcement boardings or offshore fishing vessel boardings?

A. No, it does not.

Q. Or is that just dockside?

A. These are just from the decal program. These are not law enforcement boarding activity deficiencies. If that's something that's needed by the Board, we could query it and provide it.

Q. No, I appreciate that. I just wanted to make that clarification. Thank you.

A. Next slide.

Over the next several slides, I'll show you some marine

casualty data for incidents involving commercial fishing vessels. All right. This first graph shows you reportable marine casualties in blue and serious marine incidents in red that involved at least one commercial fishing vessel for a little over the past decade. The counts here are individual incident investigation activities, so singular incidents.

Over the last decade, there's been a slight downward trend in reportable marine causalities, while serious marine incidents have been relatively steady. In calendar year 2020, we saw a reduction in both SMIs -- serious marine incidents -- and reportable marine casualties across all fleets, most likely due to decreased activity as a result of the COVID pandemic.

All right. Next slide, please.

So this pie chart shows a breakdown of initiating events. So this is the first unwanted event in the timeline for reportable marine casualties. As you'll see, the most prevalent are material failures at a little over 32 percent, and pollution incidents and personnel casualties, which are injuries, deaths, or missing individuals.

The next slide.

This is similar data, except for it's only serious marine incidents. So, as you can tell, almost 50 percent of serious marine incidents are because of a personnel casualty, then material failures, then followed by collisions and allisions. It's important to note when looking at serious marine incident

data that any injury that's reportable is automatically an SMI.

Incidents at slide 16.

So this shows commercial fishing vessel personnel casualties, which include injuries beyond first aid, a death, or a missing person. Numbers on this chart are counts of individuals, so not singular incidents, meaning one incident that resulted in multiple injuries or death is counted as the number of people hurt, dead, or missing.

Slide 17 shows the same data, but here the missing and dead are combined into one data field.

Please advance to slide 18.

These tables show commercial fishing vessel injuries and fatalities by the documented accident type. So injuries are on the left, and as you can see, the most prevalent type are contact injuries, with over 80 percent as some type or form of contact injury. For fatalities, the most prevalent accident type is preexisting medical conditions, at nearly 20 percent, followed by falls into the water and asphyxiation, which is typically due to smoke inhalation or drowning.

As you may remember, the threshold for post-accident chemical testing is a serious marine incident. And as previously shown, the leading initiating event for a serious marine incident are personnel casualties. This chart shows the post-casualty alcohol testing conducted for commercial fishing vessel casualties, and the resultant positive tests. I draw your attention to the fact

that in 2020, 25 percent of the casualty drug testing included a positive test result.

Please advance to slide 20.

Q. If I may, sir --

A. Yes.

Q. -- just in looking at that slide, has there been any analysis on relative states to where those casualties have occurred, and whether or not those are in states that have legalized some sort of drug use?

A. No, we have not broken that down by state. No, sir.

Q. Roger. Thank you.

A. So here we have commercial fishing vessel loss data for the past decade, and as you can see, approximately 30 percent of the commercial fishing vessel losses occur in the Pacific Northwest, Coast Guard Districts 13 and 17. I'll just give you a moment to look and see if you have any questions.

If you go to the next slide, we've broken commercial fishing vessel losses down by age, and as you can see, the majority of the fishing vessels that are lost are between 25 and 50 years old. Earlier, I mentioned that the vessel age data, particularly the keel laid date, left much to be desired. What I'd point out here is that it appears that our casualty investigators are collecting and documenting vessel age when they are lost, as only 11 percent of the vessels lost lack age data, as opposed to the nearly 99 percent of the rest of the fleet.

Q. And is there initiative -- I know it's, you know, new policies and everything, but are there any initiatives to try and narrow that down a little bit, in the field, as far as recording that data?

A. The program office for that subject area -- like, so, CBC-3, a commercial vessel -- excuse me, Commercial Fishing Vessel Safety Division, is the one that would set the policy for what things are required to be entered into MISLE. So I'm not exactly sure what their data entry requirements are for commercial fishing vessels, but I do know that on the investigation side, IOs are documenting the age when known, as shown by this data.

Q. Okay. But outside of the internal INV policy letter, they're not -- you're not aware of any policy from the Office of Commercial Fishing Vessel Safety that would require capturing of the keel laid date.

A. No, sir.

Q. Thank you.

A. So, if we go to the next slide, marine casualty investigations, particularly formal investigations, often result in safety recommendations. The purpose of safety recommendations are to identify corrective actions the Coast Guard or other substantially involved federal agencies should take to address discovered unsafe conditions, actions, or other unwanted outcomes, to prevent future casualties and improve safety of life at sea.

Coast Guard-INV Policy Letter 002-2018 sets the policy for

safety recommendations, safety alerts, and findings of concern, formerly known as lessons learned. In this policy letter, specifically section 4, it discusses safety recommendations and outlines their purpose, basis, content, the submission process, the process for review and endorsement, final action, tracking of actions, and documentation. Investigation officers or Marine Boards of Investigation shall consider making safety recommendations when their investigation concluded that laws, regulations, or the policies, tactics, techniques and procedures that implement those laws are inadequate or missing.

Safety recommendations are not expected for every investigation. If the findings of an investigation do not warrant changes to laws or regulations or policy, then a safety recommendation should not be issued. Each safety recommendation shall be submitted and subjected to a process of review and endorsement through the relevant Coast Guard chain of command, in order to evaluate its merit for implementation. Each endorsement shall indicate whether the reviewing unit or command concurs or does not concur with the recommendation, and provide an explanation for the determination.

So, over the past 30 years, there have been nearly 7,000 safety recommendations made by Coast Guard IOs. 80 percent have been adjudicated with some final agency action determination. Approximately 1,000 have been forwarded to headquarters or district and are awaiting final agency action. Of the 70,000

safety recommendations, over 18 percent came from a case that involved a commercial fishing vessel. Regardless of a safety recommendation status, we consider them all living, meaning that they are always available for analysis and can influence policy or regulatory decision. Over time, recommendations that may not have been concurred with may be reconsidered, based on new or numerous similar recommendations that followed.

I'll pause for questions on this slide, and then go into a little bit more detail on the fishing vessel recommendations.

Okay. Advance to slide 24, please.

In order to assist this MBI with reviewing and understanding the nearly 1,300 previous safety recommendations that involve a commercial fishing vessel, we search for recommendations within this subset with particular keywords that may be of interest. The raw data and results can be provided for further analysis by this Marine Board if desired. This table here just shows the keywords that we looked for and the results within the safety recommendations and the status of those safety recommendations.

Please advance to slide 26 -- or 25, excuse me.

As I'm sure you're aware, the NTSB also issues safety recommendations based on their investigations. While these are not tracked within MISLE, I asked my colleagues in CG-INV to provide me access to their internal tracking of NTSB safety recommendations. These recommendations are not categorized by vessel type, recommended action, or even the safety theme.

However, I queried the 1,400 recommendations from 1967 for fish, to catch fish, fishing, fishery vessel, and identified 64 recommendations that may be -- that are related to -- potentially related to commercial fishing vessels.

If you advance to slide 26, you'll see the same keywords that were queried for the Coast Guard safety recommendations, and these are the results here, which can also -- the raw data, so the text of the safety recommendations and the keywords associated, can be provided to this MBI if desired.

Q. This is really helpful, and I think what I'd also probably look at -- maybe we'll reach out and contact you -- is an analysis of -- in this regard, since 2010, and follow it -- you know, for recommendations that have been made to the Coast Guard following the 2010 auth act, and more recent.

A. Sure. I'm just taking a note, Captain. Yes, sir, we can do that. And if the Board will let us know if there are any additional keywords. I was able to tune in a little bit earlier, so we can search icing or any other words that the Board would be interested in. Just let me and my staff know.

Q. Absolutely. And I think that would be definitely one. I think as we've -- as the hearing has progressed, I think that has become a pretty common theme that we'd be interested in trying to get a deeper analysis of.

A. Yes, sir.

If you'll proceed to the next slide, if there are no further

questions.

So I'd like to close my presentation by highlighting a chart created by my office and often used by the Commercial Fishing Vessel Safety Division here at headquarters. I'm sure you've already seen this over the course of the past two weeks. This chart shows operational commercial fishing vessel losses and related crew deaths. Think of these as vessel losses and fatalities at sea, underway fishing or transiting to or from a commercial fishing vessel area. This data does not include vessel losses in port or at anchor, like a fire or sinking at the pier. So this is a subset of all commercial fishing vessel losses and deaths.

I'd like to point out the numbers that I presented previously did not delineate between operational and nonoperational, so this is a subset of the data that was previously presented. So, for perspective, about 70 percent of commercial fishing vessel losses that occur are deemed operational in nature, and approximately 55 percent of the fatalities are deemed operational. The loss of the *Scandies Rose*, and tragic loss of her crew, was deemed operational in nature. While this 38-year perspective shows a marked improvement in commercial fishing vessel safety, I think it can be misleading.

Please advance to slide 28.

If you look at the past two decades, you'll see what I mean. The number of vessel losses and fatalities seem fairly stagnant,

even more so if you focus on the last decade.

Please advance to slide 29.

Since 2010, we have lost over 430 commercial fishing vessels and 217 lives. Remember, these are just operational statistics. If you count nonoperational accidents, we've lost twice that number of fishermen and over 100 additional vessels. There is room for improvement. This should not be considered a cost of doing business in this industry, and we can all do better.

Please advance to slide 30.

This concludes my formal presentation. And I'd be happy to go back and answer any additional questions you may have about data or any of the processes we discussed.

Q. Commander, thank you very much. I mean, this has been extremely informative. I greatly appreciate that breakdown and explanation, in the later graphs, and the delineation on how that's broken out in only a subset to better understand the operational nature of that -- of those casualties.

In looking at that and realizing that you -- when you look at the graph all the way back from start to now, it looks like there's some major changes and drop-offs. But as you pointed out, in the last decade or so, it does remain pretty stagnant, and it's -- there aren't major fluctuations in any direction. Is there anything that's being attributed to the initial drop-off that forced -- that kind of created some of that initial change before things kind of leveled off again?

A. So you're talking about back in 1982, when the drop there? I am not familiar with all of the commercial fishing vessel regulations and policies over the last 40 years and what markers hit around, you know, the 1990s and 2000. I think that would be a question better for the Commercial Fishing Vessel Safety Program, but -- so you're right, there is marked improvement. It just seems to stagnate over the past decade or two.

Q. And so I think the other important feature -- the other important thing to emphasize here is I think, somewhere in there, what we maybe need to do a little more analysis of, in comparison to total number of vessels at those timeframes, as well, to maybe paint a better picture. We've heard things like rationalization have had a major impact at times of just the number of vessels that operate in the fishery, so it would be interesting to see how that -- how these numbers of casualties and losses relate to the total number of vessels over the same timeframe.

CAPT CALLAGHAN: So I'm going to try and pass it around -- go around for questions. I want to start with our colleagues at the National Transportation Safety Board.

Mr. Barnum?

MR. BARNUM: Thank you, Captain.

Thank you, Commander Smoak, for that very good presentation. I just had one follow-up on slide 12.

Lieutenant McPhillips, if you can bring up the presentation again, please.

BY MR. BARNUM:

Q. Commander Smoak, just for my knowledge here, I'm looking at the upper right table, the commercial fishing vessel tonnages by vessel subtype. So the 100 ton to 199.9, is there an ability or do you have a sense of these 2,072 vessels, what the average age of those would be?

A. I don't know off the top of my head. But the data that created these tables, I have the raw data for, so we could very easily look at that raw data and see what the age of those 2,000 or so fish catching vessels that are between 100 and 200 gross tons, so --

Q. Great. Thank you. And --

A. In the recess, I can look.

Q. Okay. I can just follow up with you after, sir, if it's -- or you can follow up with the Board. That's fine. And that's taking into account only -- on average, only one percent of the total 58,000 vessels have a keel laid date. So we might not be able to get -- every one of those 2,000 vessels might not have a recorded keel laid date.

A. Right.

Q. Okay. And it was premature on taking the slide down. Sorry, Lieutenant. I have one more question on that slide for Commander Smoak. And then the bottom left-hand table -- I'm sorry, bottom right-hand table. And so, the vessels that are 79 -- this is the commercial fishing vessel fleet with international or coastwise

load lines certificates. So my understanding the load line offers -- it's a more stringent inspection of the vessel and some more stringent requirements. So the vessels that are 79 to 199.9 feet, there's 35, and I was just curious if there -- if we could calculate, you know, the percentage of total vessels of that size. And I'm sorry, that's improper questioning, but --

A. I understand what you're asking.

Q. Yeah. Okay.

A. It's -- of the vessels that are 79 to 200 feet in length, 35 of them have a load line certificate. What's the percentage compared to the other subset of the 17 that are that same length?

Q. Thank you. That don't have the load line. Yes, that's correct.

A. Right.

Q. Yes, sir. And that might be something I could follow up with you on as well.

A. Absolutely.

Q. Thank you, Commander Smoak. I really appreciate it.

MR. BARNUM: That's all the questions I have, Captain.

CAPT CALLAGHAN: Thank you, Mr. Barnum.

And Commander Smoak, I'm going to now go to our parties in interest, starting with counsel representing the two survivors, Mr. Stacey.

MR. STACEY: Thank you, Captain Callaghan.

And thank you, Commander Smoak, for your testimony. Can you

hear me okay, sir?

THE WITNESS: I can. Thank you.

MR. STACEY: Wonderful. Just very, very briefly, Lieutenant McPhillips, if you could please bring up page 23 of the commander's presentation, Exhibit 108. Thank you, Lieutenant. That's actually perfect.

BY MR. STACEY:

Q. So I see on there that you have about 79 percent of the safety recommendations that are issued have been adjudicated. Is there anything similar about the 21 percent that are not adjudicated, or any trends as to why some are issued but not adjudicated?

A. So the un-adjudicated safety recommendations are likely -- they're the newer ones. They're more recent. So they're still going through the process, which is extremely slow.

Q. So, over time, would you expect that percentage to continue increasing?

A. The number of un-adjudicated -- so, we -- we'll always have safety recommendations coming in, but we're also always clearing them. That backlog, if you will, is decreasing for the first time in recent history. The Office of Investigations and Analysis, the division that oversees the safety recommendations, is being proactive with that backlog and starting to chip away at it. So we expect it to go down over time, but it's -- as you said, there's a large backlog, and we're working through it. Some of

those haven't reached our office, headquarters level. They're at the district level and being adjudicated down there before they're endorsed and routed to us.

Q. All right. Thank you, Commander.

MR. STACEY: Thank you, Captain Callaghan. Those are all the questions I have.

CAPT CALLAGHAN: Thank you, Mr. Stacey.

And now, to counsel representing the vessel owners, Mr. Barcott.

MR. BARCOTT: Thank you, Captain. I don't have any questions for Commander Smoak, but thank him for the presentation.

CAPT CALLAGHAN: Thank you very much, Mr. Barcott.

And I will double-check, any members of the Board?

(Pause.)

CAPT CALLAGHAN: No follow-up questions.

Commander, thank you very much for your presentation. I think, as you kind of got through there, there's some pretty eye-opening stats, particularly with regards to -- you know, if we draw a graph starting from 40, 50 years ago, sure, it looks like there's been some marked improvement. But when you really narrow down into a smaller time frame, in comparison with the fleet size itself, we start to realize that there's still plenty of room for improvement and that those numbers are seemingly level over the past decade or so, and not necessarily continuing to drop off. You know, I think that should be eye-opening, and it does fit in

with some of the discussions that we've had over the past two weeks in this hearing. I think we've got some follow-on that we'll reach out to you on, to see if we can narrow some of those stats down, as we look to move this investigation on further.

So, again, thank you very much for your time. This has been a fantastic presentation. And at that point, you are now released as a witness from this formal hearing. Thank you for your testimony and cooperation. If I later determine that this Board needs additional information from you, we'll contact you through counsel. If you have any questions about the investigation, you may contact any member of the Board or the investigation recorder, Lieutenant Ian McPhillips.

Commander Smoak, thank you very much for your time.

THE WITNESS: You're very welcome. Have a great day.

(Witness excused.)

CAPT CALLAGHAN: Okay. This now concludes witness testimony for this formal hearing. At this time, all witnesses are now released from these formal proceedings. Coast Guard exhibits presented today will be posted to the Coast Guard media site, and remaining Coast Guard exhibits that were not presented during the hearing will be posted to the media site at a later date, to maximize transparency of the investigation.

We will now take a short recess, and we will -- are currently scheduled to begin closing remarks at 1000. We will post updated time, if we intend to start sooner, on livestream. And we will

resume with closing remarks from parties in interest, the National Transportation Safety Board, and this Coast Guard Marine Board.

We'll now go into recess.

(Off the record at 9:12 a.m.)

(On the record at 9:30 a.m.)

CAPT CALLAGHAN: It is now 0930. This hearing is now in session.

Before beginning formal closing remarks from parties in interest and the National Transportation Safety Board, I would like to express the Board's gratitude for all the support and cooperation to make this hearing what it was in this -- over these last ten days. To Sara Mixson and the crew here at the Edmonds Center for the Arts, you have all been outstanding hosts and have gone above and beyond to support this hearing.

Coordination in the virtual environment also took a lot of Coast Guard support here locally and at Coast Guard units who hosted witnesses. I'd like to thank District 13 staff, the District 17 staff, Sector Puget Sound, Sector Anchorage, Marine Safety Detachment Kodiak, and Marine Safety Detachment Dutch Harbor. I'd also like to thank Customs and Border Protection for hosting a witness to facilitate additional virtual testimony. Additionally, I'd like to thank everyone involved for their strict and consistent adherence to the Board's COVID mitigation plan.

I will now ask NTSB to make their closing remarks, and I will have formal remarks later to close out the hearing session.

Mr. Barnum?

MR. BARNUM: On behalf of the entire NTSB, especially the team conducting this investigation, as I've said daily in my opening statement, I want to extend my deepest condolences to the families who've lost loved ones in this tragic accident.

I would like to thank Captain Callaghan and the Coast Guard Marine Board for including our agency in these hearings and for their exceptional cooperation throughout this investigation.

I would also like to thank the parties of this investigation for their continued support throughout the last 14 months by providing their firsthand accounts of the accident, their expertise, sharing hundreds of documents, conducting several technical interviews, and assisting in interviews and supporting our investigation while continuing their daily lives.

At a future date, a separate report of the NTSB's findings will be issued which will include our official determination of the probable cause of this accident. We will continue to collect evidence, develop findings, conduct analysis, and issue recommendations based on all facts developed throughout this investigation.

In closing, I would like all the family members, especially those who have been watching the hearing day after day over the course of the two weeks, to know how much this accident has personally affected every one of us, as so many of us have spent years at sea. Assisting the investigation and following the

hearing so attentively demonstrates your dedication to your loved ones and to each other and further empowers us to ensure we are doing everything to prevent similar tragedies from happening in the future.

Thank you very much.

CAPT CALLAGHAN: Thank you, Mr. Barnum.

Now we'll start closing remarks from our parties in interest, and I'll start with counsel representing the two survivors, Mr. Stacey.

MR. STACEY: Thank you, Captain.

Good morning to the Board and to everyone listening on livestream. I want to thank Captain Callaghan and the entire Board on behalf of Dean Gribble and John Lawler for the important work that's been done over the past two weeks. I want to thank all the witnesses who participated. As Mr. Barnum said, their expertise and their analysis will prove invaluable as will their experience to this Board in making their determinations and more importantly in making the seas a safer place to work.

John and Dean also want me to explicitly thank Coast Guard Search and Rescue again for their heroic actions that allowed them to be brought back to their families safely. Their testimony spoke for themselves regarding their appreciation. But I want to echo their families' thanks as well.

We also want to thank the Board for allowing Dean and John to participate as parties in interest. They hope that their

testimony has helped the Board complete its mission. Dean and John wanted to voluntarily appear before this Board. They did so with the hopes of assisting the Board in discovering the cause of this terrible tragedy and bringing some peace to the families of their lost shipmates, to those who were lost in other casualties, and to prevent future mariners and their families from having to suffer through the pain of a similar disaster in the future.

As you could see in their testimonies, John and Dean continue to struggle every day to understand why they were spared. Like other casualty survivors, not a day goes by they don't battle with survivor's guilt. Those who witnessed John and Dean's testimony saw how discussing or even thinking about the casualty brings back the raw pain 15 months later and probably will for the rest of their lives. Their pain illustrates the importance of this Board's mission to prevent similar casualties happening in the future.

This often crippling pain is made much worse when, after their testimonies, they read public comments such as they're heroes only in their own mind and those who proclaim from behind the computer screen that they should have gone down with their shipmates. Especially in light of these comments, I want to thank the Board, Captain Callaghan, Mr. Barnum, for their public and private condolences to all the victims of this tragedy. As Captain Callaghan stated throughout these hearings, these are people and families being discussed, so we cannot overstate the

importance and appreciation for the support that John and Dean have received from the fishing community in front of this Board.

John and Dean know they're lucky to be with us here today. They're looking for ways to make their second chances at life as best as it can be. Both are searching for a new purpose in this new life. They avow that part of this purpose will be looking to help ways for mariners and their families to cope with tragedies and to work to prevent another. Their shipmates will always be remembered and honored by John and Dean.

Thank you very much, Captain. That's all we have.

CAPT CALLAGHAN: Thank you very much, Mr. Stacey.

And now I will go to counsel representing vessel owners, Mr. Barcott.

MR. BARCOTT: Thank you very much, Captain.

I'd like to begin my remarks by thanking all the members of this Board. It has been evident to us from the day we first met 14 months ago that your mission was to find the truth and hopefully to help this industry in the future not have to convene another one of these boards. We have appreciated the way you have gone about the gathering of information. We hope we have been helpful in that process. We have appreciated that it was not a blame game, that it was only to find out what happened. It has been our pleasure to work with you, and Lieutenant Pels as your attorney liaison has been -- it has been a delight to call her a colleague.

In our first meeting, if you recall it, Dan Mattsen told you that he hoped you'd find out what happened to the *Scandies Rose*. And I think we have, and I'll talk about that.

Let's go through what we know. Here is what we know based on the evidence -- and many people have got many things to say about this tragedy and the *Scandies Rose*, but we rely on evidence, and the evidence that we have tells us this was a good and well-kept boat. Fishermen referred to it as a Cadillac, and in fisherman speak, that's as high a compliment as you can get about the quality of the machinery.

This was a good and experienced crew who knew that boat. No one has said anything to the contrary, and so often in these proceedings, people come forward with hurtful things to say. And maybe that's happened behind the scenes, but no one here has testified that this vessel and her crew were anything other than top notch.

This was a good, well-respected captain who knew this area better than almost anyone else, and Bryce Buholm told you that. This was an owner who spent the money that needed to be spent to keep this boat in tip-top condition, and we know that from Mr. Jacobsen and his surveys, and he specifically called that out in a footnote to one of his surveys; this is the best vendor boat he'd ever seen in the Northwest.

Drills were regularly performed, thank goodness. The mayday drill saved Mr. Lawler and Mr. Gribble. The safety equipment was

well maintained. The two life rafts did just what they were supposed to do. They popped to the surface when the hydrostatic releases let go, and they saved Mr. Gribble and Mr. Lawler.

After the *Destination*, Mr. Mattsen spent the money to have his vessel have a new stability report done. He followed the Coast Guard's recommendation. He weighed his pots -- or rather the Coast Guard weighed his pots, and he had a new stability report done. And that stability report said that he could carry -- or the *Scandies Rose* could carry 208 pots in icing conditions. And Gary Cobban built a little margin of safety in that and was carrying probably 195 pots. He was acting even safer than his stability letter required.

So this is not a picture of a vessel or her owner or her captain who would take unreasonable risk. Captain Cobban had his vessel at stake. He had his crew's lives at stake. He had his own life at stake, and he had his son on board. You wouldn't expect him to be taking unreasonable risks.

There was no time pressure to get to the fishing grounds. Cod fishing was open for another 15 days. They only needed to make one delivery, so time pressure is not a factor in this case.

There have been a lot of issues raised, including the Coast Guard's self-introspective look, and all of those are good. I'm going to only address a couple of those issues in my closing remarks, and I'm going to look really carefully at one.

But I want to start with a discussion about the discharge

chute. I can understand why there would be an interest in this discharge chute. At one time, it was a faulty piece of equipment on this vessel, but not when it left on December 30th. The same welding company that works on your vessels in Kodiak, Mr. Young, did the welding on the new chute, and there is not a word of evidence -- we rely on evidence -- not a word of evidence that that discharge chute was anything other than perfect.

I trust you are all familiar with Occam's razor where there is a simple, straightforward explanation for something. It is not appropriate to look at a complex one. Mr. Lawler and Mr. Gribble believe that there was water inside this vessel, and I think there was, too, but it didn't come from the discharge chute, and I'll get to that in a bit.

I also want to talk about tarps, just a brief sidetrack here. There was a discussion that tarps might provide a way to mitigate the dangers of icing. And you heard Bud Bronson tell you he is a sailor, and he knows what it's like to grab a hold of a big, flapping tarp. But I bet Mr. Bronson's never done it in 30-foot seas, and I'll bet he's never done it when the wind is blowing 50 miles an hour, and I'll bet he's never done it from the top of an iced-up stack of crab pots. Using tarps, Mr. Lone uses that as a way to mitigate the danger, and in some circumstances, might work just fine, but as a general fix is -- I don't need to tell you how dangerous that situation is.

So the *Scandies Rose* shoved off on December 30th with icing

in the forecast, severe icing. Why? Why did they leave? And we are never going to know that answer for sure. But I think the investigation done here, and with the evidence that has come out in these hearings, there is an answer. Gary's stability book done seven months previously told him he could go to sea in icing conditions with 208 pots, and he had 195. Of course he felt safe. He had a margin of safety built into his own numbers.

Here's what he didn't know. At no place did his stability book tell him that if ice was over six-tenths of an inch on a vertical surface and 1.3 inches on a horizontal surface that he was in trouble, because that is what the stability book was based on. At no place in that book did it tell him that if ice forms unevenly on a vessel, he's in trouble, because the calculations in his stability book assumed an even ice level.

At no place did he -- was he told that this icing was based upon a 1977 convention in Torremolinos, Spain, which did not consider the porous surface of a crab pot. At no place did it tell him that no one had ever actually done a study on icing on crab vessels in the real world. At no place did it tell him that that book, the one you asked us for on the first day we met and every one of these proceedings that I've ever been in, it is the first thing that's requested. Can we have the stability book, and can we have the surveys? At no place did anybody ever tell him that this book was a work of fiction.

If his stability booklet had truthfully conveyed to him what

he needed to know in icing conditions, what the naval architecture world knew, this is what it would have said.

May I have my first slide, please?

Take a moment and read this slide. This is what his stability book would have said if it were truthfully representing the science. And for those who might be attending by telephone, let me read this.

Icing conditions. There are no studies on how ice accumulates on crab pots. There are no studies on how much weight ice can add to even one crab pot, let alone a stack. One unscientific demonstration has shown over a ton of ice added to one pot. There are icing standards contained in the federal regulations, but those standards have no relationship to icing on crab vessels. Ice is bad for vessel stability, and icing on one side of your vessel is even worse, but it cannot be quantified in any meaningful way to tell you how many pots to carry in icing conditions.

Good luck. That's what it shows here. That's the truth. That's what naval architects know about icing on crab boats. They know it's bad, but they have nothing to add by way of quantitative numbers. As ridiculous as this slide seems, it would have been better than what he was told in his stability book.

Could I have the second slide, please?

This is the portion of Mr. Cobban's *Scandies Rose* stability book related to icing. And it tells him that he can carry 208

pots in icing conditions and non-icing conditions. These words in his booklet, and for those of you who have seen the stability book, it's a page or two instructions to the mariner. That's where this comes from. And then it is pages and pages and pages of charts and numbers and math, and it all looks so scientific. Who could possibly doubt this book? It gives the impression it can be relied on. It lures people into a false sense of security. The number fishermen turn to when they most need it, when they're headed into icing conditions and they want to know what they can do, so they look at their book, and this is what they see. And it is based on no useful data whatsoever.

The warning in this book was more dangerous than the one I suggested because the one I suggested, at least the fishermen would know. They would know there is no scientific information that supports the numbers that are in their books. At least they wouldn't be lured into believing that they could carry 208 pots or 195.

I want to thank so much Jonathan Parrott and Bud Bronson and Paul Zankich who just came forward. They've been in this business for a combined more than century, and they knew and they finally had to speak up. And if you look back at the *St. George*, the *Northwest Mariner*, the *Lynn Jamie* [sic], the *Destination*, you will see this same story in every one of those events. Finally, somebody came forward and explained this to people with no agenda. If you'll excuse the colloquialism, they had no dog in this fight,

but they wanted people to know about this problem. So this problem's been identified, and you have done a remarkable job of bringing people to this hearing to express the breadth of ignorance about this critical condition on crab boats.

So it transcends this event. Every crabber operating in the Bering Sea has a stability letter, and every one of those letters, every one of them -- I haven't seen them, but I know what's in them -- tells these operators how many pots they can carry. During the course of this hearing, I have been in touch with various skippers about this, and at least they're beginning to understand the problem. My hope is that the report coming out of these hearings will clearly point out this deficiency. My hope is that in -- and in a perfect world, data will be collected, and a regulation might be promulgated -- or maybe not, but a regulation might be promulgated with accurate information or at least requiring -- the very least requiring naval architects to express very clearly the limitations of these stability books.

You will find tremendous support from the fishing industry and organizations like the North Pacific Fishing Vessel Owners' Association if you reach out and form a task force of people without an agenda but with knowledge. It will take a long time, but you'll find tremendous support for this.

I understand, and I hope the public understands, that all this Board can do is make a recommendation. This Board doesn't have the power to enact any regulations, and that needs to go up

the chain. I hope the Board makes a strong recommendation. Hope it is recommendation number one. But I realize that the Coast Guard has a number of missions, and especially since 9/11 your resources are spread very, very thinly. But these -- excuse me. These 60 boats matter. This little corner of the United States matters. And if there is no change, we'll be back here again.

This hearing has done a lot to raise awareness of this issue. And you have learned that it is common, it is almost universally common that these crabbers don't start breaking ice until they've got two or three inches on their crab pots. And those pot are coated in the inside. Goodness, Mr. Lone talked about having six inches before he would break it.

Question has been raised by some people I've talked to, if this is such a big deal, why aren't there more losses? Why aren't boats going down all the time? And I have a few suggested answers to that. One is actually, if you look back, there have been quite a few. Some operators carry fewer pots than their stability letters allow, and some quite a few fewer. They instinctually know something's wrong. Gary Cobban carried fewer. Even this horrible data has big margins of safety, and that makes some difference.

The other thing we don't know is how many near misses have there been? If the *Scandies Rose* had gotten to Sutwik Island and broken the ice, we'd have never known about this event. How many of those have there been as close as this boat was to going over?

And if you look at the statistics -- and you've already made note of this -- this problem only arises typically at the beginning of opening season, typically when the boats are loaded with pots and they're loaded with fuel. And if there's not a big storm -- icing storm right then, well, we don't have any events. But when those factors come together, when those factors coalesce, this is the result.

What happened to the *Scandies Rose*? I actually think it is fairly clear what happened to the *Scandies Rose*. I've listened to all of the evidence, and I've seen evidence that wasn't even presented here but you all know. When Gary Cobban took the helm, there was some icing, and it progressed. And he was listing -- the number 20 degrees has been used, and I'm not sure that's right, but he was listing pretty seriously. And we know from his conversation with Oystein Lone that he did not want to send his crew out on the deck in those seas, in those conditions. He was looking out for the safety of his crew, so he didn't send them out to break ice.

In retrospect, maybe it would have been better if he did, but his decision was a good one. He was thinking about his crew. And he wasn't particularly worried, and we know that because he had this long conversation with Oystein Lone, just kind of matter of fact, or at least if he was worried, he wasn't letting other people know about that. He was headed towards Sutwik Island. We know that from the conversation with Mr. Lone. He was going to

take shelter, and he was going to break ice, maybe drop the pick. Everything would have been just fine if he'd made it. He was looking for a place to hide, and he knew these waters. But something went terribly wrong in the few minutes before his vessel capsized.

If you talk to your naval architects in your offices, the description that Mr. Lawler and Mr. Gribble give of what happened -- and we're so fortunate to have their testimony about this one piece -- it is almost a textbook description of what happens in a freeze-surface event, when water is sloshing around in a vessel. Now people have looked for the chutes as where that water might be. It's not. There's so much -- such a simple explanation, because in an ice storm like they were in, it's not just the crab pots that ice up, and it's not just the rails that ice up. The freeing ports ice up. The things that get water off the deck on the starboard side of this vessel will be iced over almost surely. One wave breaks over the side of that vessel and puts water on the deck, and it's got nowhere to go, and it knocks the vessel down. This is a textbook situation.

And then what happens? Then what happens is that downflooding point that evidently, from the study you did, would come into play at a 45-degree list is underwater. And at that point, water pours into the engine room. And Mr. Lawler was right. There was water in this vessel, and that's where it was. And there's such an easy explanation. You don't have to have a

chute collapse. There's a huge hole in the side of the vessel under those stairs, and once the downflooding began, the boat wasn't coming back up. That was the end. It's no more complicated than that.

But we haven't heard a lot about freeing ports. And the freeing port regulations, how big do they have to be for certain vessels, presume they're open. So among the things that should be looked at in icing is we need to take another look at how big freeing ports should be for vessels that ice up. Take a good, hard look at that.

Public awareness is a really good thing. Mr. Crawford and Mr. Walsh started a class to teach skippers about stability, and we can educate the skippers about the shortcomings of their stability reports. But a better fix is to fix the problem, not just teach people about the problem. Hal Bernton of the *Seattle Times* and Jessica Hathaway and her colleagues at *National Fisherman* and others can publish articles about this, and bless them for doing so. And the public is so much more aware of this problem now than they were two weeks ago. But, again, that just points out the problem. It doesn't fix it.

So my last point, and here I'm speaking hopefully to people who may be watching, and that is political awareness. Things happen in Washington D.C. when powerful politicians are interested. Senators Murkowski and Sullivan and Congressman Young, the entire Alaska congressional delegation has been briefed

on this issue. Their staff knows about this issue. I assume Senators Cantwell and Murray would be very interested, and that encompasses the whole body of politicians on a national level that really have an interest in this.

I'm going to suggest to the members of the public who may be watching, if you've never written a letter to a senator or a member of Congress, now's the time to do it. And you don't need to be articulate. You don't even need to say very much. Just reference the *Scandies Rose*. Enclose Hal Bernton's article from the *Seattle Times* of last week. They will be well received. They already have that article.

Now, in closing, I am no fan of excessive government regulation, and I will tell you my clients are even less enamored. You almost need a law degree to operate a fishing vessel in these fisheries with the various regulations. But my fervent hope is that ten years from now, at some Thanksgiving dinner, a crab fisherman is complaining to his brother-in-law about how tough it is to make a living with all these government regulations: you know, we used to be able to carry 200 crab pots in icing conditions, and now, because of the Coast Guard and the government, we can only carry 100, and it's tough to make a living. The important fact in that story is that he's home for Thanksgiving.

Five men died on the *Scandies Rose*. Let's make something positive come of that. Thank you.

CAPT CALLAGHAN: Thank you, Mr. Barcott.

For the record, Mr. Culver, the last party in interest, has chosen not to make any closing remarks.

Today, this formal hearing now comes to a close, and the Marine Board and National Transportation Safety Board investigations transition to the analysis phase. Although there's always a chance that a short hearing session could be convened if new witnesses are identified as the report is being written, I believe we have gathered the factual evidence necessary to proceed with our analysis. However, the Marine Board of Investigation will continue to collect and review any evidence collected or submitted in the future, including submissions to the uscg.scandiesrosembi@gmail.com email address.

This investigation and formal hearing faced additional challenges over the past year due to the global COVID-19 pandemic, and although the Board was not able to travel or conduct this hearing as originally scheduled, the Board was able to utilize the time to collect nearly 1,000 pieces of evidence. The amount of information shared with this Board is a testament to the strength and unity of the fishing industry within Alaska and our commitment to be as thorough as possible to best inform potential recommendations to prevent future such incidents.

The Coast Guard weighs all evidence and conducts analysis independently from any other party. I'd like to take the opportunity to sincerely thank the National Transportation Safety

Board, our parties in interest, government agencies, maritime organizations, company representatives, commercial fishermen, and the individual witnesses who dedicated their time and resources to this monumental endeavor. The collective expertise of those involved in this process has helped to clarify numerous technical and regulatory matters that the commercial fishing industry grapples with on a regular basis.

I have also been personally inspired by the solidarity and the selfless spirit which has been clearly displayed throughout the investigation process by those impacted by this incident. Your feedback and suggestions have aided the overall investigation and your commitment to preventing a similar tragedy in the future is noble and appreciated.

In closing, I want to emphasize that the members of this Marine Board of Investigation are conducting this investigation with a profound sense of duty to identify the incident's causes to the best of our ability and push for any needed changes to enhance maritime safety. Even though the public side of this investigation is coming to an end, please rest assured that we will work to continue in earnest as the report is drafted and the recommendations are generated.

In the interim, I'm confident that conducting the proceedings in this virtual public forum and making them available on the Internet has helped to raise important safety issues that are actively being identified and addressed around the world as we

speak today. The industry and those watching these proceedings are talking. From a basic experiment aboard the Coast Guard Cutter *Polar Star* to the call for more detailed analysis of stability and the effects of icing on crab pots, the seed has been planted, and collectively, there's a call to act.

For anyone that was not able to see portions of the hearing, all sessions are on Coast Guard livestream site to view at your convenience, and I would recommend that you do so.

I encourage industry participation in seeking and promoting positive change to help prevent the loss of life and property at sea. It is your voice that matters the most. You carry with you the long traditions of life working the sea that includes the loss of loved ones and shipmates. We heard numerous times for the past two weeks the call for better regulations during this hearing. On behalf of the Board, I ask you to be involved. Utilize the many resources that were highlighted during these proceedings to implement voluntary interim safety measures. As has been stated multiple times, the regulatory process takes significant effort and time, and while that takes place, there is nothing that prevents proactive implementation, especially if the call for change is coming from within your own community.

Additionally, on behalf of the entire Board, I'd like to express our deepest condolences to the families, friends, and shipmates of the fishermen who were lost at sea during this accident, and to the survivors, Dean Gribble and John Lawler, that

continue to live through the accident daily. It has been difficult to watch and listen as the struggle to come to terms with this tragedy continues on a daily basis for those affected. It is also important for us as investigators to observe the emotional toll, as that strengthens our resolve.

The goal of this Board is to carry out our investigation in a manner that honors loved ones lost in this incident and those that commit their lives to work on the sea. And it is my sincere hope that this formal investigation -- this formal hearing represented that goal.

Looking for the right words, I came across this short poem by Christy Ann Martine that I'd like to read for Gary, David, Seth, Brock, and Art:

Dance with the waves,
move with the seas.
Let the rhythm of the water
set your soul free.

Lieutenant McPhillips, please bring up the prepared slide.

Finally, before we adjourn, I'd like to call for another moment of silence to honor those we lost. If everyone could please stand at this time.

(Pause.)

CAPT CALLAGHAN: Thank you. You may all now be seated. The time is 1015 a.m., March 5th. This hearing is now adjourned.

(Whereupon, at 10:15 a.m., the hearing was adjourned.)

CERTIFICATE

This is to certify that the attached proceeding before the

NATIONAL TRANSPORTATION SAFETY BOARD

IN THE MATTER OF:	Marine Board of Investigation Into the Sinking of the *Scandies Rose* On December 31, 2019
PLACE:	Seattle, Washington
DATE:	March 5, 2021

was held according to the record, and that this is the original, complete, true and accurate transcript which has been compared to the recording accomplished at the hearing.

[redacted]

Jane Gilliam
Transcriber

[redacted]

Karen Ehatt
Transcriber