



National Transportation Safety Board

Marine Accident Brief

Grounding of Fish-Processing Vessel *Gordon Jensen*

Accident no.	DCA16FM013
Accident type	Grounding
Vessel	<i>Gordon Jensen</i>
Location	Bella Bella, British Columbia, Canada, about 250 nautical miles (nm) northwest of Vancouver Approximately 52°10'12.91"N, 128°07'12.67"W
Date	December 19, 2015
Time	About 1810 Pacific standard time (coordinated universal time – 8 hours)
Damage	\$583,376
Injuries	None
Environmental damage	None reported
Weather and sea conditions	Darkness, light rain, visibility about 8 nm, winds 9–24 mph, air temperature 35°F
Waterway information	Channel in the Inside Passage (a coastal route for oceangoing vessels along a network of passages that weave through the islands on the Pacific coast of North America), Canada's southwest coast, east side of Campbell Island.

On December 19, 2015, about 1810 local time, the US-flag fish-processing vessel *Gordon Jensen*, en route from Seattle, Washington, to Dutch Harbor, Alaska, grounded in Canadian waters near the town of Bella Bella, British Columbia, about 250 nm northwest of Vancouver, Canada. As a result of the grounding, the forward-most portside ballast tank was breached, costing \$583,376 in repairs. There were 165 persons aboard the vessel. No injuries or pollution were reported.



Gordon Jensen undergoing postaccident repairs in Ketchikan, Alaska.

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Satellite image of the northwest North American continent, with key locations overlaid. A red triangle marks the site of the grounding, near Bella Bella, British Columbia, Canada.

The *Gordon Jensen*, originally named the USS *Zeus*, was built in 1943 by the Chicago Bridge and Iron Company as a tank transport ship. It was sent to the World War II Pacific Theater to enable Navy personnel to repair damaged ships. After the end of the war, it remained a part of the Navy's reserve fleet until 1973. The following year, the Navy sold it to a commercial operator, who converted it to a salmon-processing vessel. Icicle Corporation, the owner and operator of the *Gordon Jensen* at the time of the accident, purchased and renamed the vessel in 2012.

The vessel departed Seattle for Dutch Harbor, Alaska, about 0100 on December 18, 2015, the day before the accident. The grounding occurred about 1810 the following evening, December 19. Vessel personnel were preparing for an abandon-ship drill that the master had scheduled to begin at 1815. Because of the darkness, the master illuminated deck lights in advance of the drill to enable vessel personnel to readily locate and proceed to their assigned muster stations. The master and an able seaman serving as lookout were in the wheelhouse navigating the vessel at the time. A third person, the fish-processing operations manager, was also in the wheelhouse to take notes about the drill. The master had set the vessel's steering to autopilot for the passage. The autopilot had built-in alarm features that, if properly set, would have alerted the navigation crew if the vessel proceeded off course; however, the master did not set these alarms. He told investigators after the accident that he had scheduled the abandon-ship drill for that time of the evening (1) so that it could be conducted while the vessel was in protected waters, and (2) to minimize disruptions to the sleep and rest times of personnel standing watches, so that as few people as possible were adversely affected by the timing of the drill.

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However, the master also told investigators that, in hindsight, scheduling the drill for the time when the vessel would be traversing the passage was a mistake. He said that he was distracted from navigating by his supervision of the crew drill, while the vessel was traversing the narrow passage. He told investigators, had he waited 15 minutes, “I would have been in pretty clear, open water and would not have had to focus as much on the navigation part there, as opposed to where I was.”



Satellite image of the waterway and islets near Bella Bella, where the *Gordon Jensen* grounded. Overlaid in yellow is the approximate trackline leading up to the grounding. The inset map shows the Canadian coast between the cities of Vancouver and Bella Bella.

The master told investigators that in the wintertime he typically took the accident route to avoid open water so as not to expose the people aboard to more adverse weather conditions. In the summertime, when weather conditions were typically calmer, the master would transit with the vessel in open seas to the west.

The master also believed that, because of the drill, the illumination of the deck lights outside the wheelhouse limited his ability to scan the external environment and restricted his navigation to radar. Had the master set the navigation alarms, they would have alerted him when the vessel veered off track into shallow water, thereby enabling him to correct the course.

The evidence supports not only the master’s explanation of his errors, including his effort to conduct two intensive activities—the emergency drill and the vessel navigation in a narrow passage—simultaneously, but also the effects of those errors on the safety of the vessel. Conducting the drill while attempting to navigate through a narrow passageway increased opportunities for error, because the master could not do either task effectively while trying to do them simultaneously. The master’s decision to navigate through a narrow passage while overseeing an abandon-ship drill at the same time limited his ability to navigate, which led directly to the grounding.

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After the accident, about 1900, the ship's crew notified the Canadian Coast Guard, who allowed the vessel to divert to Ketchikan, Alaska, to undergo repairs. The US Coast Guard, who was notified by the company after the grounding, inspected the vessel after its arrival in Ketchikan.



Breached hull on the *Gordon Jensen*'s port side.

Investigators attempted to determine why this master—who, according to his estimate, had made 50 transits through that waterway and had years of experience as a fishing vessel master—decided to conduct a drill while transiting the narrow waterway. Company policy, in accordance with Coast Guard rules, called for postaccident drug- and alcohol-testing of the officers on watch.¹ The vessel's safety officer and the fish-processing operations manager tested the master for alcohol about 1940 that evening using a saliva swab. The result was positive for alcohol consumption, and a second swab revealed the same result. Consequently, at 2037, company officials took a breathalyzer sample of the master, which showed a blood alcohol concentration of 0.029 gm/dL. At 2100, company officials searched the master's onboard living quarters, which he shared with his wife who worked in the fish-processing part of the vessel: two mostly empty bottles of alcohol were found. The company prohibited possession and consumption of alcohol on its vessels. The master's breath alcohol level of 0.029 gm/dL, tested about 2.5 hours after the accident, indicates that at the time of the accident his alcohol level exceeded the Coast Guard's maximum-allowable alcohol level of 0.040 gm/dL. Assuming no consumption of alcohol after the accident (the master was in the presence of company officials during that time) and based on the accepted rate of elimination of

¹ Drug-testing checks for marijuana, cocaine, opiates, amphetamines, and phencyclidine.

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ethanol from blood (ranging from 0.015 to 0.020 gm/dL per hour), the master's calculated breath alcohol level at the time of the accident likely ranged from about 0.066 to 0.076 gm/dL. Company officials also collected urine samples from the master and watch officers, which were tested for the five classes of illegal drugs. The results of the urine tests were negative.

In addition, the master told investigators—as the Coast Guard's medical records of the master confirmed—that at the time of the accident he was taking gabapentin, an anti-seizure prescription medication that may be sedating, to treat back pain. The Coast Guard approved the master's use of the drug after reviewing supplemental information about his acceptable history of its use, which the prescribing physician provided. The master also told investigators that he had taken NyQuil the afternoon of the accident because he was having flu-like symptoms, such as coughing. NyQuil is the brand name of an over-the-counter medication that contains doxylamine, a sedating antihistamine that is also the active ingredient in over-the-counter sleep aids. NyQuil also contains 10-percent alcohol, which investigators ruled out as having caused the master's breath alcohol level but may nevertheless have been sedating. In addition, because of digestive issues, the master reported that he had made frequent visits to the bathroom the night before the accident.

Therefore, at the time of the accident, the master was under the influence of alcohol and two sedating medications that interacted with each other (the prescription drug gabapentin, known to be sedating when interacting with other medications, and the over-the-counter antihistamine doxylamine found in NyQuil). Moreover, he was sleep-deprived as a result of being awakened numerous times throughout the night by his coughing and the need to use the bathroom. Consequently, the master's cognitive performance at the time of the accident—that is, his ability to make good decisions, to shift attention as needed, and to quickly react to events, among other cognitive skills—was compromised. The cumulative effects of sleep deprivation, two sedating substances, and alcohol consumption on the master's performance explains his poor decision-making at the time of the accident and his inability to recognize the hazards of conducting a drill while transiting a narrow waterway. Further, the Coast Guard's approval of the master's using gabapentin was predicated on his avoiding the use of other medications, including over-the-counter ones, simultaneously. In its Navigation and Vessel Information Circular (NVIC) 04-08, the Coast Guard warned mariners of the need to avoid combining medications with other potentially impairing medications.

Along with not conforming to the Coast Guard's warning to mariners regarding the use of over-the-counter medications with prescribed medications, the master knowingly violated the company's zero-tolerance policy regarding the possession and use of alcohol while on board its vessels. He also violated Coast Guard regulations that prohibit operating a vessel while under the influence of alcohol. In sum, the master's actions endangered himself and the other 164 persons aboard the *Gordon Jensen*.

Probable Cause

The National Transportation Safety Board determines that the probable cause of the grounding of fish-processing vessel *Gordon Jensen* was the combined effects of prescription pain medication, over-the-counter cold medication, alcohol, and sleep deprivation, which led to the master's impaired cognitive performance, preventing him from recognizing that he could not effectively perform the duties and responsibilities of master.

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Vessel Particulars

Vessel	<i>Gordon Jensen</i>
Owner/operator	Icicle Corporation
Flag	United States
Type	Commercial fish-processing vessel
Builder, date	Chicago Bridge and Iron Company, 1943
VIN	594619
Construction	Steel
Length	311 ft (95 m)
Beam	50 ft (15 m)
Draft	25 ft (7.6 m)
Gross tonnage	4,807
Propulsion/main engines	Twin 900 hp (670 kW) EMD-567 diesel engines
Persons on board	165

NTSB investigators worked closely with our counterparts from Marine Safety Detachment Ketchikan throughout this investigation.

For more details about this accident, visit www.nts.gov and search for NTSB accident ID DCA16FM013.

Issued: September 29, 2016

The NTSB has authority to investigate and establish the probable cause of any major marine casualty or any marine casualty involving both public and nonpublic vessels under Title 49 *United States Code*, 1131. This report is based on factual information either gathered by NTSB investigators or provided by the Coast Guard from its informal investigation of the accident.

The NTSB does not assign fault or blame for a marine casualty; rather, as specified by NTSB regulation, “[NTSB] investigations are fact-finding proceedings with no formal issues and no adverse parties . . . and are not conducted for the purpose of determining the rights or liabilities of any person.” Title 49 *Code of Federal Regulations*, 831.4.

Assignment of fault or legal liability is not relevant to the NTSB’s statutory mission to improve transportation safety by conducting investigations and issuing safety recommendations. In addition, statutory language prohibits the admission into evidence or use of any part of an NTSB report related to an accident in a civil action for damages resulting from a matter mentioned in the report. Title 49 *United States Code*, 1154(b).