National Transportation Safety Board

Washington, D.C. 20594

Safety Recommendation

Date: December 30, 2002

In reply refer to: M-02-29 and -30

Mr. Charles Sofge
President
Boatrides International, Inc.
555 NE 15th Street, No. 102
Miami, Florida 33132

The National Transportation Safety Board (Safety Board) is an independent Federal agency charged by Congress with investigating transportation accidents, determining their probable cause, and making recommendations to prevent similar accidents from occurring. We are providing the following information to urge you to take action on the safety recommendations in this letter. The Safety Board is vitally interested in these recommendations because they are designed to prevent accidents and save lives.

The recommendations address the adequacy of management oversight by your company and the stowage of lifejackets on your company's vessel. The recommendations derive from the Safety Board's investigation of the collision between the U.S. Coast Guard patrol boat *CG242513* and the small passenger vessel *Bayside Blaster* in Biscayne Bay, Florida, on January 12, 2002, and is consistent with the evidence we found and the analysis we performed.[1] As a result of the investigation, the Safety Board has issued safety recommendations to the Coast Guard, the Passenger Vessel Association, and Boatrides International, Inc. The Safety Board would appreciate a response from you within 90 days addressing actions you have taken or intend to take to implement our recommendations.

Based on its investigation, the Safety Board determined that the probable cause of the collision between the *CG242513* and the *Bayside Blaster* was the failure of the coxswain of the Coast Guard patrol boat to operate his vessel at a safe speed in a restricted-speed area frequented by small passenger vessels and in conditions of limited visibility due to darkness and background lighting. Contributing to the cause of the accident was the lack of adequate Coast Guard oversight of nonstandard boat operations.

[1] For further information, read National Transportation Safety Board, *Collision Between the U.S. Coast Guard Patrol Boat* CG242513 *and the U.S. Small Passenger Vessel* Bayside Blaster*, Biscayne Bay, Florida, January 12, 2002*, Marine Accident Report NTSB/MAR-02/05 (Washington, DC: NTSB, 2002).

From interviews with an official of Boatrides International, Inc., and with the master and deckhand of the *Bayside Blaster*, Safety Board investigators determined that the sightseeing vessel departed on the accident voyage without one of the two deckhands required by its certificate of inspection (issued by the Coast Guard in August 2001). Despite the specific requirement of the company's procedures and policy manual to report deficiencies, the master did not notify management that he did not have the required crew before departing on the accident voyage. The master stated that he made the decision it was safe to sail with only one deckhand and that he had done so in the past, although infrequently. The company's operations manager stated that he was not informed the *Bayside Blaster* was short one deckhand before the vessel departed on the accident voyage. He also indicated that he was aware it was not the first time the *Bayside Blaster* had sailed shorthanded, but that it did not typically do so.

Company procedures required the master to report the number of passengers on board before leaving the dock. It would have been a simple matter to require him at the same time to report whether he had a full crew on board. Moreover, because the *Bayside Blaster* had departed without a full crew in the past, management should have been aware that it was possible for the vessel to be shorthanded and should have established procedures to arrange for backup crewmen so that such incidents did not occur in the future.

In assessing the impact on safety of the lack of the second deckhand on the *Bayside Blaster*, the Safety Board considered the opinions of the vessel master. The master stated that if the second deckhand had been present, he would have been selling drinks and film to the passengers and would not have been serving as a dedicated lookout. The lack of the required second deckhand did not affect the ability of the *Bayside Blaster* to maintain a proper lookout, but it meant that one less person was available to assist the passengers in the emergency. The second deckhand could have been helpful in handing out lifejackets to passengers, in helping passengers don and secure their lifejackets, and in helping the passengers disembark after the accident.

Had the accident been more serious, however, the need for the second deckhand could have been critical. If, for example, passengers had been seriously injured or thrown into the water and in danger of drowning, the second deckhand would have been needed for such duties as providing medical assistance or handling the boat while the master rendered medical assistance. If the boat had been in danger of sinking, the second deckhand would have been needed to help with damage control, to help distribute lifejackets, or to help the passengers safely abandon the vessel. The Safety Board concluded that operating the *Bayside Blaster* without the required number of crewmembers could have had a negative impact on the safety of the passengers, although it did not in this accident.

The Safety Board also concluded that the master of the *Bayside Blaster* was operating his vessel at a safe and prudent speed and that he and the deckhand were maintaining a proper lookout. The Safety Board further concluded that the master was precluded from taking action to avoid the collision by the high speed and sudden

appearance of the Coast Guard patrol boat, and that in beaching the *Bayside Blaster* after the collision, the master acted appropriately, because he did not know the extent of the damage to his vessel.

In examining the *Bayside Blaster* after the accident, Safety Board investigators found that the adult-size lifejackets stowed in lockers at the vessel's bow were difficult to retrieve, and that no lifejackets were stowed in the aft accommodation area. The vessel's child-size lifejackets were stored in a compartment at the operator's station, but the opening mechanism was broken and had to be pried open. Both the single stowage location of adult lifejackets and the broken opening mechanism on the child lifejacket stowage compartment delayed the distribution of lifejackets to all passengers. Fortunately, the delay did not affect the outcome of the accident. However, under different circumstances, the delay in distributing lifejackets could have had serious consequences. The Safety Board concluded that if lifejackets had been stowed throughout the accommodation space on the *Bayside Blaster,* they would have been more readily accessible to the passengers.

Small passenger vessels such as the *Bayside Blaster* that carry 150 or fewer passengers or have overnight accommodations for 49 or fewer passengers are required by Title 46 *Code of Federal Regulations* (CFR) part 180.78 to have lifejackets "stored in convenient places distributed throughout accommodation spaces." (The same regulation is found at 46 CFR 117.78 for small passenger vessels that carry more than 150 passengers or more than 49 overnight passengers.) The CFR further requires that "each lifejacket kept in a storage container must be readily available."

Stowage of lifejackets on small passenger vessels was an issue in the Safety Board's recent investigation of the November 2000 fire on board the *Port Imperial Manhattan*.[2] After that accident, the owner of the *Port Imperial Manhattan*, New York Waterway, voluntarily elected to modify lifejacket stowage on its vessels. Lifejackets on New York Waterway vessels are now stowed under the passenger seats. The Safety Board is aware that the original stowage arrangements for lifejackets on the *Bayside Blaster* were approved by the Coast Guard. The same was true of New York Waterway vessels before the *Port Imperial Manhattan* fire. The Safety Board is convinced that, despite Coast Guard approval of the lifejacket arrangements on the *Bayside Blaster*, Boatrides International should consider voluntarily reconfiguring the way lifejackets are stowed on the vessel to make them readily available to passengers.

In light of the above issues, the National Transportation Safety Board makes the following safety recommendations to Boatrides International, Inc.:

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[2] For further information, see National Transportation Safety Board, *Fire On Board the Small Passenger Vessel* Port Imperial Manhattan, *Hudson River, New York City, New York, November 17, 2000*, Marine Accident Report NTSB/MAR-02/02 (Washington, DC: NTSB, 2002).

Establish procedures to prohibit your small passenger vessel from leaving the pier with passengers on board unless the vessel has the crew required by the vessel's certificate of inspection. (M-02-29)

Revise the stowage of lifejackets on board your vessel so they are located throughout the passenger areas for immediate use in case of emergency. (M-02-30)

In your response to the recommendations in this letter, please refer to M-02-29 and -30. If you need additional information, you may call (202) 314-6177.

Acting Chairman CARMODY and Members HAMMERSCHMIDT, GOGLIA, and BLACK concurred in these recommendations.

Original Signed

By: Carol J. Carmody
Acting Chairman