# National Transportation Safety Board

Washington, DC 20594

## Safety Recommendation

**Date:** February 3, 2011

**In reply refer to:** M-10-7

Ms. Susan E. Linda
President
Interstate Navigation Company
14 Eugene O'Neill Drive
Post Office Box 482
New London, Connecticut 06320

The National Transportation Safety Board (NTSB) is an independent Federal agency charged by the U.S. 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 your company to take action on the safety recommendation in this letter. The NTSB is vitally interested in this recommendation because it is designed to prevent accidents and save lives.

The recommendation is derived from our investigation of the July 2, 2008, collision between your ferry vessel M/V *Block Island* and the U.S. Coast Guard cutter *Morro Bay*. The recommendation addresses the lack of a safety management system on Interstate Navigation Company's vessels, and is consistent with the evidence we found and the analysis we performed. Information supporting the recommendation is discussed below. The NTSB would appreciate a response from you within 90 days addressing the actions you have taken or intend to take to implement our recommendation.

On Wednesday, July 2, 2008, about 1215 eastern daylight time, the 187-foot-long passenger and car ferry M/V *Block Island* collided with the 140-foot-long Coast Guard cutter *Morro Bay* in reduced visibility on Block Island Sound, about 4 nautical miles south of Point Judith, Rhode Island. The ferry, carrying 294 passengers, eight crewmembers, two concession stand employees, and one off-duty employee, had departed Point Judith about 25 minutes earlier and was traveling south, headed for Old Harbor on the eastern side of Block Island, Rhode Island. The cutter, carrying 21 personnel, had departed Naval Station Newport, Rhode Island, about 1015 and was traveling west, headed for Coast Guard Station New London, Connecticut. As the vessels approached the accident site, the visibility decreased due to fog. At the time of the collision, the crew on the *Morro Bay* estimated the visibility at about 500 yards.

As a result of the accident, the *Block Island* ferry sustained about $45,000 in damage and the *Morro Bay* about $15,000. Two passengers were treated for minor injuries and released that same day.

The NTSB determined that the probable cause of the collision between the ferry *Block Island* and the Coast Guard cutter *Morro Bay* was the failure of the bridge watch officers on both vessels to monitor their radars, sufficiently assess traffic, and compensate for limited visibility. Contributing to the accident was the failure of the bridge watch officers on both vessels to maintain a proper lookout and to sound appropriate fog signals.

Safety issues identified in this investigation included failure to follow "rules of the road"[1] in reduced visibility, ineffective use of the radars on board both vessels, and lack of safety management systems and voyage data recorders on U.S. passenger ferries.

**Safety Management Systems**

As a result of its investigation of the October 15, 2003, allision of the Staten Island ferry *Andrew J. Barberi* with a maintenance pier at the Staten Island ferry terminal, New York,[2] the NTSB issued Safety Recommendation M-05-7 to all states that operate ferries:

> Encourage your public ferry operators to voluntarily request application of the Federal requirement at 33 [*Code of Federal Regulations*] CFR [Part] 96 for implementing a safety management system, if they have not already done so.

In response to the recommendation, the state of Rhode Island contacted Interstate Navigation Company and requested that your company implement a safety management system. In February 2008, about 5 months before the *Block Island*/*Morro Bay* collision, Interstate Navigation Company responded to Rhode Island and declined to take the recommended action.

During postaccident communication with several *Block Island* passengers, NTSB investigators found that a majority of the passengers thought that the accident response of the *Block Island* crew could have been better. In particular, passengers generally thought that a collision warning should have been announced over the public address system, and that a more prompt advisory announcement should have been made following the collision so that passengers could have had a better sense of what was happening. Only after being prompted did the master ensure that an announcement to the passengers was made following the collision.

In reviewing Interstate Navigation Company's policies and procedures, investigators found that your company's safety philosophy was informal and incorporated into on-the-job training. It was not evident whether Interstate Navigation Company had conducted any internal or management audits. As a result, your company may not have conveyed a consistent safety culture to your

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[1] Navigation Rules and Regulations: International Navigational Rules Act of 1977 (Public Law [P.L.] 95-75, 91 Stat. 308, or 33 *United States Code* [U.S.C.] 1601-1608), and the Inland Navigation Rules Act of 1980 (P.L. 96-591, 94 Stat. 3415, 33 U.S.C. 2001-2038). The accident site was under the authority of the International Navigational Rules Act of 1977.

[2] *Allision of Staten Island Ferry* Andrew J. Barberi, *St. George, Staten Island, New York, October 15, 2003,* Marine Accident Report NTSB/MAR-05/01 (Washington, DC: National Transportation Safety Board, 2005).

crewmembers. Better management oversight of crew operations could have prevented deficiencies such as the master's inadequate sounding of the *Block Island*'s fog signal, the ineffective posting of a lookout, and the crew's postaccident response to passengers. The NTSB therefore concludes that a safety management system at Interstate Navigation Company could have contributed to more thorough operational procedures on the *Block Island* and greater oversight by management. Your company has been responsive in correcting some of the problems that investigators identified during the accident investigation; however, Interstate Navigation Company still does not have a safety management system.

A safety management system identifies standardized and unambiguous procedures for each crewmember during both routine and emergency operations. Duties and responsibilities are specified and supervisory and subordinate chains of command delineated. Each crewmember, as a result, better understands precisely what is expected of him or her in critical phases of operations. In addition, safety management systems call for the creation of plans, with crewmember duties and responsibilities specified, to respond to the range of potential emergency situations that the ferry could encounter.

In operations such as passenger ferry services, where accidents can lead to catastrophic loss of life, a proactive safety management system can be a chief countermeasure to safety risks. Such a system entails risk assessment appropriate to the vessel and its operation, development of safety-centered practices and procedures for which documents and training are provided, and internal and external audits to ensure consistent performance. Interstate Navigation Company's Block Island ferries travel across a major east-west traffic route for large vessels transiting between New York Harbor and the Atlantic Ocean, often in limited visibility conditions. Had the July 2, 2008, collision been more serious, the consequences of this accident could have been far greater.

As a result of the findings in this accident investigation, the NTSB makes the following safety recommendation to Interstate Navigation Company:

> Comply with the provisions of 33 *Code of Federal Regulations* Part 96 for implementation of a safety management system for your fleet to improve safety practices and minimize risk. (M-10-7)

The NTSB also issued three new safety recommendations and reiterated one previously issued recommendation to the U.S. Coast Guard as a result of this investigation.

In response to the recommendation in this letter, please refer to Safety Recommendation M-10-7. If you would like to submit your response electronically rather than in hard copy, you may send it to the following e-mail address: correspondence@ntsb.gov. If your response includes attachments that exceed 5 megabytes, please e-mail us asking for instructions on how to use our secure mailbox. To avoid confusion, please use only one method of submission (that is, do not submit both an electronic copy and a hard copy of the same response letter).

Chairman HERSMAN, Vice Chairman HART, and Members SUMWALT, ROSEKIND, and WEENER concurred in these recommendations. Member Rosekind filed a concurring statement, which is attached to the report, regarding the *Block Island*'s lifesaving equipment.

*[Original Signed]*

By: Deborah A.P. Hersman
Chairman