UNITED STATES COAST GUARD

LOSS OF LIFE DURING THE ALLISION OF THE DAVID AULD SCUDDER (CT3911BL) WITH THE MARINE PARKWAY BRIDGE, BROOKLYN, NY ON DECEMBER 4, 2023

MISLE ACTIVITY NUMBER: 7893517. MISLE CASE NUMBER: 1376578.

U.S. Department of Homeland Security
United States Coast Guard

Commandant
United States Coast Guard

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16732/IIA #7893517
22 October 2025

ALLISION OF THE WORK BOAT DAVID AULD SCUDDER (CT3911BL) WITH THE MARINE PARKWAY BRIDGE, RESULTING IN THE LOSS OF ONE LIFE WHIILE TRANSITING IN JAMAICA BAY NEAR BROOKLYN, NEW YORK ON DECEMBER 4, 2023

ACTION BY THE COMMANDANT

The record and the report of investigation completed for this marine casualty have been reviewed by the Office of Investigations & Casualty Analysis. The record and the report, including the findings of fact, analyses, and conclusions are approved. This marine casualty investigation is closed.

E. B. SAMMS
Captain, U. S. Coast Guard
Office of Investigations and Casualty Analysis (CG-INV)

U.S. Department of Homeland Security
United States Coast Guard

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16732
02 October 2025

LOSS OF LIFE AS A RESULT OF THE ALLISION OF THE DAVID AULD SCUDDER (CT3911BL) WITH THE MARINE PARKWAY BRIDGE, BROOKLYN, NY, ON DECEMBER 4, 2023

ENDORSEMENT BY THE COMMANDER, COAST GUARD NORTHEAST DISTRICT

The record and the Report of the Investigation (ROI) convened for the subject casualty have been reviewed. The record and the report, including the findings of fact, analysis, conclusions, and recommendations are approved subject to the following comment: It is recommended that this marine casualty investigation be closed.

[redacted]

D. E. O'CONNELL
Captain, U.S. Coast Guard
Chief of Prevention, Coast Guard Northeast District
By direction

U.S. Department of Homeland Security
United States Coast Guard

Commander
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16732
12 Feb 2025

MEMORANDUM [redacted]

From: Jonathan A. Andrechik, CAPT
CG SECTOR New York (s)

To: COMDT (CG-INV)
Thru: CGD One (dp)

Subj: LOSS OF LIFE DURING THE ALLISION OF THE DAVID AULD SCUDDER (CT3911BL) WITH THE MARINE PARKWAY BRIDGE, BROOKLYN, NY ON DECEMBER 4, 2023

Ref: (a) Title 46 United States Code, Chapter 63
(b) Title 46 Code of Federal Regulations, Part 4
(c) Marine Safety Manual, Volume V, COMDTINST M16000.10 (series)
(d) Marine Investigations Management and Documentation Requirements, CG-INV Policy Letter 3-18 (CH-1)

1. In accordance with the above references, the Sector New York Investigations Division conducted a Marine Casualty Investigation into the allision and subsequent loss of life involving the DAVID AULD SCUDDER and the Marine Parkway Bridge, that occurred on December 4, 2023.

2. I have reviewed and concur with the Report of Investigation's findings of fact, analysis, conclusions, and recommendations. Please find the enclosed Report of Investigation, formatted in accordance with reference (d), for your review and approval.

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Enclosure: (1) Report of Investigation into the Loss of Life during the allision of the DAVID AULD SCUDDER (CT3911BL) with the Marine Parkway Bridge, Brooklyn, NY on December 4, 2023.

U.S. Department of Homeland Security
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16732
February 11, 2025

LOSS OF LIFE DURING THE ALLISION OF THE DAVID AULD SCUDDER (CT3911BL) WITH THE MARINE PARKWAY BRIDGE, BROOKLYN, NY, ON DECEMBER 4, 2023

EXECUTIVE SUMMARY

At approximately 0600 hours on December 4, 2023, the DAVID AULD SCUDDER (CT3911BL) departed Tamaqua Marina in Brooklyn, NY, e n route to the El Sol job site at the Cross Bay Bridge, Jamaica Bay, NY. The vessel was assigned as a safety vessel at the El Sol construction project and was scheduled to be on site by 0700. At 0730, an employee of Northeast Work & Safety Boats LLC (Employee 1) received a call from the El Sol job site stating that the DAVID AULD SCUDDER had not arrived. At approximately 0745, Employee 1 drove to the Master's home of residence to check if he was there; he was not. At approximately 0746, Employee 1 then drove to Tamaqua Marina to check if the DAVID AULD SCUDDER was still at the dock. The Master's vehicle was in the parking lot, but the DAVID AULD SCUDDER was not at the dock. At approximately 0800, Employee 1 got the Northeast Work & Safety Boats LLC vessel, the MAIRE CASEY, underway from Tamaqua Marina to search for the DAVID AULD SCUDDER. At this point, a second company employee (Employee 2) was contacted, and he was picked up at the beach on the Rockaway Beach side of Brooklyn, NY. Employee 2 was picked up at approximately 0830 and the two began searching for the DAVID AULD SCUDDER.

Soon after, the DAVID AULD SCUDDER was seen beached near the seaplane ramp of Floyd Bennett Field, Brooklyn, NY. At approximately 0836, the MAIRE CASEY came alongside the DAVID AULD SCUDDER and the Master was laying on the deck. It was assumed by Employees 1 and 2 that the DAVID AULD SCUDDER had allided with the Marine Parkway Bridge. Employees 1 and 2 boarded the DAVID AULD SCUDDER and called Emergency Medical Services. Shortly after, the Master lost consciousness, and Employee 1 began administering Cardiopulmonary Resuscitation (CPR). The Master of the DAVID AULD SCUDDER was transported by Emergency Medical Services to Brookdale Hospital in Brooklyn, NY, where he was pronounced dead at approximately 1000.

Through its investigation, the Coast Guard determined the initiating event to be the allision of the DAVID AULD SCUDDER with the Marine Parkway Bridge, Brooklyn, NY. Injuries sustained from the impact of the allision resulted in the death of the Master. Causal factors contributing to the casualty were: 1) Master's Loss of Consciousness During Vessel Operation, 2) Master's Contact with the Steering Console, and 3) Lack of Second Mariner Onboard the Vessel.

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February 11, 2025

LOSS OF LIFE DURING THE ALLISION OF THE DAVID AULD SCUDDER (CT3911BL) WITH THE MARINE PARKWAY BRIDGE, BROOKLYN, NY, ON DECEMBER 4, 2023

INVESTIGATING OFFICER'S REPORT

1. Preliminary Statement

1.1. This marine casualty investigation was conducted and this report was submitted in accordance with Title 46, Code of Federal Regulations (CFR), Subpart 4.07, and under the authority of Title 46, United States Code (USC) Chapter 63.

1.2. The Investigating Officer has designated Nicoletti Hornig & Sweeney, representative for Northeast Work & Safety Boats LLC, a party-in-interest (PII) in accordance with 46 CFR § 4.03-10.

1.3. The Coast Guard was the lead agency for all evidence collection activities involving this investigation. Due to this incident involving a loss of life, the Coast Guard Investigative Service (CGIS) was notified and agreed to provide technical assistance as required. New York Police Department (NYPD) assisted in the Coast Guard's investigation by providing documentary evidence from their investigation.

1.4. All times listed in this report are in Eastern Standard Time using a 24-hour format, and are approximate.

2. Vessel Involved in the Incident

Official Name:	DAVID AULD SCUDDER
Identification Number:	CT3911BL
Flag:	United States
Vessel Class/Type/Sub-Type	Miscellaneous Vessel/Rescue/Standby Vessel/General
Build Year:	2012
Length:	26 feet
Main/Primary Propulsion: (Configuration/System Type, Ahead Horsepower)	Gasoline Engine/Gasoline Outboard, 300 HP
Owner:	Northeast Work & Safety Boats LLC New Hartford, CT USA
Operator:	Northeast Work & Safety Boats LLC New Hartford, CT USA

Figure 1: Company Photo of DAVID AULD SCUDDER received April 8, 2024.

3. Deceased, Missing, and/or Injured Persons

Name	Relationship to Vessel	Sex	Age	Status
Michael A. Romeo	Master	Male	58	Deceased

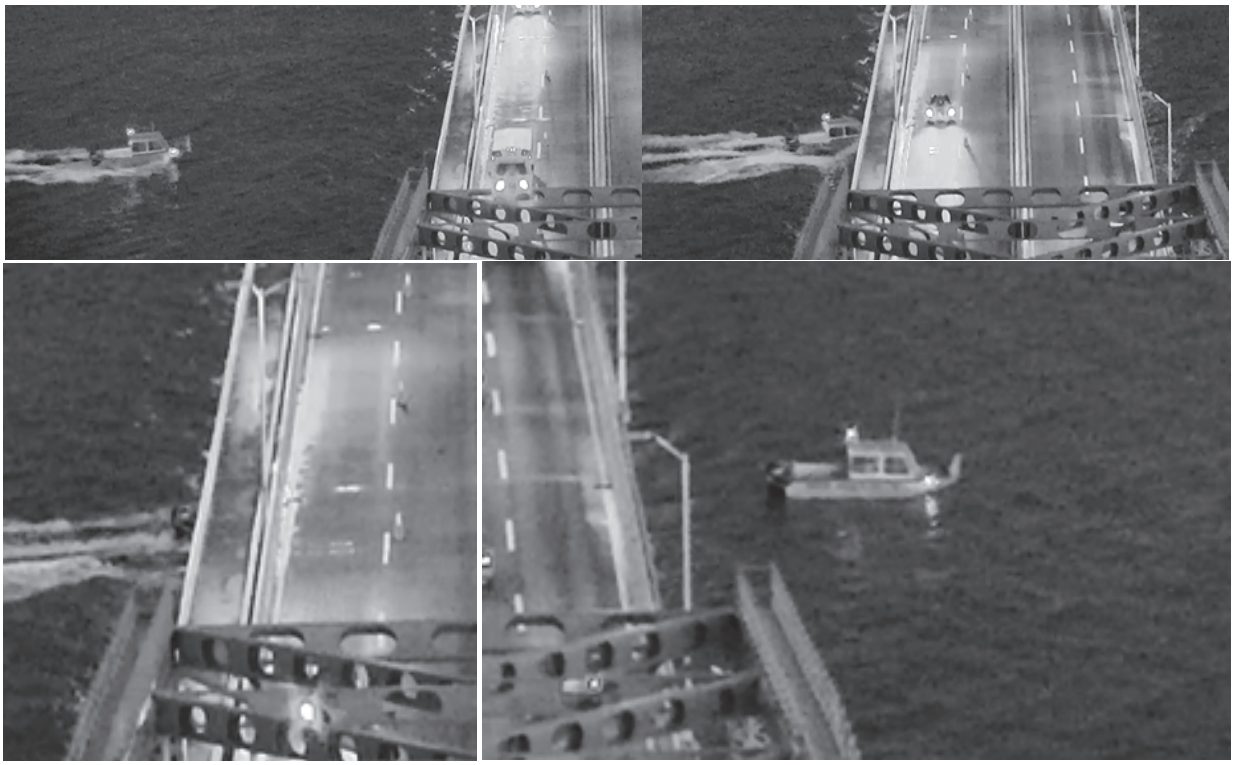
4. Findings of Fact

4.1. The Incident:

4.1.1. On December 4, 2023, the Master was scheduled to work as a safety boat captain on the DAVID AULD SCUDDER, on scene at the El Sol construction project, Cross Bay Bridge, Jamaica Bay, NY. The Master was scheduled to be at the Cross Bay Bridge site at 0700. The transit from Tamaqua Marina to the Cross Bay Bridge was approximately six nautical miles and likely would have taken approximately 25 to 30 minutes.

4.1.2. At approximately 0600 hours, the DAVID AULD SCUDDER departed the Tamaqua Marina en route to the El Sol job site at the Cross Bay Bridge. Sunrise on December 4, 2023 was at 0703.

4.1.3. At approximately 0630, the DAVID AULD SCUDDER allided with the west side of the Marine Parkway Bridge.



Figures 2, 3, 4, and 5: Marine Parkway Bridge Surveillance Video Screenshots moments before the DAVID AULD SCUDDER allided with the west side of the bridge, as it allided with the west side of the bridge, and drifting on the east side of the bridge post-allision.

4.1.4. At approximately 0730, Northeast Work & Safety Boats, LLC received a call from a Cross Bay Bridge construction site worker stating that no company safety boat was on site yet.

4.1.5. At approximately 0745, Employee 1 drove to the Master's home of residence to see if he was still home. Employee 1 did not find the Master at home. Employee 1 then drove to Tamaqua Marina to see if the DAVID AULD SCUDDER was still in port. Employee 1 saw the Master's vehicle parked at the marina, but the DAVID AULD SCUDDER was gone.

4.1.6. At approximately 0800, Employee 1 boarded another Northeast Work & Safety Boats LLC vessel, the MAIRE CASEY, that was moored at Tamaqua Marina. Employee 1 got the MAIRE CASEY underway and began heading towards the Cross Bay Bridge.

4.1.7. At approximately 0810, Employee 1 called Employee 2 and coordinated being picked up on the Rockaway Beach side of Brooklyn, NY.

4.1.8. At approximately 0835, Employees 1 and 2 spotted the DAVID AULD SCUDDER beached near the seaplane ramp at Floyd Bennett Field, Brooklyn, New York. As Employees 1 and 2 approached the DAVID AULD SCUDDER, the Master could not be seen. As Employee 1 brought the MAIRE CASEY alongside the DAVID AULD SCUDDER, the Master was seen on the deck of the DAVID AULD SCUDDER. The Master showed visible signs of serious injuries, including blood coming from his left leg and a laceration on the side of his torso.

Figure 6: Map showing approximate trackline of the DAVID AULD SCUDDER from the Tamaqua Marina, location of allision, and location of vessel when found.

4.1.9. Employees 1 and 2 jumped onto the DAVID AULD SCUDDER and witnessed the Master alive but struggling to remain conscious. The Master stated that he passed out while operating the DAVID AULD SCUDDER and did not think he was going to live.

4.1.10. Employees 1 and 2 saw physical damage to the DAVID AULD SCUDDER and the throttle lever in the full-throttle position. The engine was not running.

Figures 7 and 8: NYPD photos of DAVID AULD SCUDDER throttle in full position, helm, and bow damage.

4.1.11. Shortly after Employees 1 and 2 got on board the DAVID AULD SCUDDER, Employee 2 attempted first aid, while simultaneously calling Emergency Medical Services. The Master then lost consciousness and Employee 1 began rendering Cardiopulmonary Resuscitation (CPR).

4.1.12. At approximately 0847, a Fire Department of the City of New York (FDNY) vessel arrived on scene and began situation assessment and lifesaving procedures.

4.1.13. At approximately 0850, the Master was transported to Brookdale Hospital, Brooklyn, NY by ambulance that had arrived on shore.

4.1.14. At approximately 1000, the Master was pronounced dead at Brookdale Hospital, Brooklyn, NY.

4.1.15. The Report of Autopsy conducted by the Office of Chief Medical Examiner, City of New York, declared the cause of death as blunt force trauma of the torso. The Report of Autopsy did not identify the cause of unconsciousness that led to the trauma. The Master's toxicology report was negative for drugs and alcohol.

4.2. Additional/Supporting Information:

4.2.1. Northeast Work & Safety Boats, LLC had operated for approximately 13 years and provided services including manned safety, inspection, crew, and work boats as well as work platforms, barges, and bridge access equipment. The company worked on federally funded bridge inspection, construction and rehabilitation projects throughout the Northeast from Maine to Virginia.

4.2.2. The DAVID AULD SCUDDER was a 2012 26-foot aluminum vessel manufactured by Lobel, powered by a 300 horsepower outboard motor. The vessel was homeported at Tamaqua Marina, Brooklyn, NY.

4.2.3. The Master held a valid "Master of self-propelled vessels, not including sail or auxiliary sail of less than 100 gross register tons upon near coastal waters" merchant mariner's credential (MMC), although not required by law or regulation. He also held a valid medical waiver for obstructive sleep apnea. He had worked for Northeast Work & Safety Boats LLC for approximately six years.

4.2.4. According to the Cleveland Clinic, awake-centered symptoms of obstructive sleep apnea may include insomnia, which is when an individual experiences disruptions in how they feel or function because of improper sleep. Daytime effects of insomnia may include: feeling tired, unwell, or sleepy; delayed responses, such as reacting too slowly when you are driving; slowed thought processes, confusion or trouble concentrating.

4.2.5. Employee 1 held a valid "Master of self-propelled vessels not including sail or auxiliary sail of less than 100 gross register tons upon inland waters" MMC, although not required by law or regulation. He had worked for Northeast Work & Safety Boats LLC for approximately four months.

4.2.6. Employee 2 had worked for Northeast Work & Safety Boats LLC for approximately three years and had been in the maritime industry on and off for approximately 10 years.

4.2.7. Employees 1 and 2 were not scheduled to work on December 4, 2023.

4.2.8. Northeast Work & Safety Boats LLC did not have any formal training plans in place for current employees or new hires. Training was conducted through on-the-job training with other employees who had already been with the company. Northeast Work & Safety Boats LLC relied on their vessel operators to identify any mechanical or safety issues with the company vessels, and either fix locally or send the vessel to be professionally repaired.

4.2.9. Employees 1 and 2 stated that all vessels owned and operated by Northeast Work & Safety Boats LLC were fully operational, in good condition, and did not have any issues or defects that would affect safe operation.

4.2.10. Engine cutoff switches were installed on each company vessel and Northeast Work & Safety Boats LLC had a company policy requiring employees to wear the engine cutoff switch lanyard while operating the vessels.

5. Analysis

5.1. **Master's Loss of Consciousness During Vessel Operation.** Following the allision with the Marine Parkway Bridge, Employees 1 and 2 located the DAVID AULD SCUDDER beached near the seaplane ramp at Floyd Bennett Field. Upon arrival, the Master was able to state that he passed out while operating the vessel and did not think he was going to live. The Master was described as a very knowledgeable boat operator with experience operating vessels on the waters near the Marine Parkway Bridge. With the Master's experience and the company policy to wear the engine cutoff switch lanyard, it is reasonable to assume that the Master was wearing the lanyard when the allision occurred. Although conscious when Employees 1 and 2 arrived, it is likely to assume that the Master was unconscious when the allision with the Marine Parkway Bridge occurred. If the Master was sitting and passed out, it is unlikely that the engine cutoff switch would have shut down the outboard motor. Had the Master been conscious, the allision with the Marine Parkway Bridge may not have occurred.

5.2. **Master's Contact with the Steering Console.** When the allision occurred between the DAVID AULD SCUDDER and the Marine Parkway Bridge, Newton's First Law of Motion applied, which caused the Master to continue moving in the direction and speed of the vessel until acted upon by an external force. The steering wheel on the DAVID AULD SCUDDER was bent on the left side, indicative that the Master made forceful contact with it. Had the Master not impacted the steering wheel, it is likely he would have impacted another portion of the console and sustained similar blunt force trauma.

5.3. **Lack of Second Mariner Onboard the Vessel.** Northeast Work & Safety Boats LLC typically employed one mariner per company vessel, due to the bidding price for construction projects and the need to stay competitive in the safety boat industry. Although uncommon for the company, in certain circumstances, Northeast Work & Safety Boats LLC may have employed two mariners. Had there been more than one mariner on the DAVID AULD SCUDDER on the morning of December 4, 2024, it is likely that control of the vessel would have been maintained and the allision may have been avoided. Two hours and five minutes passed between the bridge strike and the crew's arrival on the scene. It is reasonable to believe that having an additional crewmember could have expedited calling for help or obtaining medical assistance.

6. Conclusions

6.1. Determination of Cause:

6.1.1. The initiating event for this casualty occurred when the DAVID AULD SCUDDER allided with the Marine Parkway Bridge. Causal factors leading to this event were:

6.1.1.1. The Master passed out while operating the DAVID AULD SCUDDER and could no longer maintain control of the vessel. The cause of unconsciousness was not determined in the Report of Autopsy and could not be determined through this investigation.

6.1.1.2. There was one mariner on the DAVID AULD SCUDDER. In case of an emergency, there was no one else on board to assist, render aid, or take over operation of the vessel.

6.1.2. The allision of the DAVID AULD SCUDDER and the Marine Parkway Bridge resulted in the next event, which was the death of the Master. Causal factors leading to this event were:

6.1.2.1. The impact of the allision caused the Master to make forceful contact with the steering console of the DAVID AULD SCUDDER. The Office of Chief Medical Examiner, City of New York, Report of Autopsy stated the cause of death as blunt force trauma of the torso.

6.2. Evidence of Act(s) or Violation(s) of Law by Any Coast Guard Credentialed Mariner Subject to Action Under 46 USC Chapter 77: There were no acts of misconduct, incompetence, negligence, unskillfulness, or violations of law by a credentialed mariner identified as part of this investigation.

6.3. Evidence of Act(s) or Violation(s) of Law by U.S. Coast Guard Personnel, or any other person: This investigation did not identify any potential acts or violations of law by U.S. Coast Guard Personnel.

6.4. Evidence of Act(s) Subject to Civil Penalty: This investigation did not identify potential acts that would warrant civil penalty.

6.5. Evidence of Criminal Act(s): This investigation did not identify potential violations of criminal law.

6.6. Need for New or Amended U.S. Law or Regulation: This investigation identified no potential matters needing new or amended U.S. law or regulation.

6.7. Unsafe Actions or Conditions that Were Not Causal Factors. This investigation identified no unsafe actions or conditions that were not causal factors.

7. Actions Taken Since the Incident

7.1. As a result of this investigation, Northeast Work & Safety Boats LLC amended and increased the company's safety procedures. Every morning, the company's Vice President of Operations contacts all employees working that day for a formal check-in. The check-in consists of a cell phone call first, then a radio check with whatever vessel that mariner is assigned to. A detailed recording system had been created, displaying every active project the company is involved in, employees assigned at each, and the status of each mariner and vessel to better maintain positive communication between shoreside personnel and mariners on the water.

8. Recommendations

8.1. Safety Recommendation: As part of this investigation, there were no proposed actions for the Commandant of the Coast Guard to amend existing or establish any new U.S. laws or regulations.

8.2. Administrative Recommendations:

8.2.1. Recommend this investigation be closed.

Lieutenant, U.S. Coast Guard
Investigating Officer