[redacted]
8 December 1953
([redacted])

From: Chief, Merchant Vessel Inspection Division
To: Commandant
Via: Chief, Office of Merchant Marine Safety

Subj: Marine Board of Investigation; motor ferry JAMESTOWN, sue overboard with loss of life, Old Point Comfort, 13 September 1953

1. The motor ferry JAMESTOWN, a conventional double-ended ferry of 405 g.t. serving a ferry route between Willoughby Spit and Old Point Comfort, Virginia, entered its slip at Old Point Comfort after 2000 13 September 1953. Incidently the JAMESTOWN was not properly secured in its slip, due probably to intended quick turn-about. Although the weather was fair, prior wind direction and tide had produced water higher than normal. Eleven vehicles were discharged and four loaded when the JAMESTOWN was observed to be drifting with a car suspended between the ramp and the ferry. Shortly thereafter, before any effective action could be taken, the ferry drifted apart from the ramp and the car dropped into the water drowning both its occupants.

2. Pursuant to the provisions of Title 46 C.F.R. Part 136, the record of the Marine Board of Investigation convened to investigate subject casualty, together with its Findings of Fact, Opinions and Recommendations, has been reviewed and is forwarded herewith.

REMARKS

3. Since the Board found that the negligence of the Master and Mate contributed to the loss of life in subject casualty, and such negligence is made a crime by the provisions of 18 U.S.C. 1115, it is necessary under the provisions of 46 U.S.C. 239(h), 46 C.F.R. 136.23-1 and Section 7-3-9 F of the MVI Manual that two duplicate copies of the record of investigation of subject casualty be forwarded to HQ for transmittal to the U. S. Attorney General.

4. The Recommendations of the Board, paragraphs 1 to 4, represent good operating procedure. Their effectuation, however, is under the jurisdiction of the District Commander and the owners and representatives of the ferry vessels operated in the area. In this connection your attention is invited to Navigation and Vessel Inspection Circular No. 9-53, a copy of which is herewith attached.

5. Subject to the foregoing Remarks it is recommended that the Findings of Fact, Opinions and Recommendations of the Marine Board of Investigation convened to investigate subject casualty be approved.

[redacted]

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23 December 1953

FIRST ENDORSEMENT ON MVI memorandum of 8 December 1953

From: Chief, Office of Merchant Marine Safety
To: Commandant

Subj: Marine Board of Investigation; motor ferry JAMESTOWN, car overboard with loss of life, Old Point Comfort, 13 September 1953

Forwarded, recommending approval.

[redacted]

APPROVED:

29 DEC 1953

[redacted]

MERLIN O'NEILL
Vice Admiral, U. S. Coast Guard
Commandant

REPORT

OF A

MARINE BOARD OF INVESTIGATION

Convened at the
Navy Landing Building
433 West York St., Norfolk, Virginia

To inquire into and investigate the loss overboard of a car with loss of life from the motor ferry JAMESTOWN at Old Point Comfort, Virginia on 13 September 1953.

After full and mature deliberation, the board finds as follows:

FINDINGS OF FACT

On the night of 13 September 1953, at about 10:20 p.m., while the ferry JAMESTOWN was lying at Old Point Comfort, Va. ferry slip loading vehicles, she moved away from the ramp causing a vehicle with two passengers to fall into the water between the ramp and the vessel resulting in a loss of two lives.

1. The vessel involved was the motor ferry "JAMESTOWN" O.N. 226088, 405 gross tons, owner, Commonwealth of Virginia State Highway Commission, Richmond, Va. Last inspected by the Coast Guard on 31 October 1952, at Norfolk, Va., hull steel, built in 1926; required crew, 1 master and first class pilot, 1 pilot, 3 deckhands, 1 chief engineer motor, 1 oiler and in addition may carry two other persons in the steward's department. Certified for route; Rivers between Old Point Comfort, Va. and Willoughby Spit, Va., and between Pine Beach and Boat Harbor, Va. The vessel's engines are diesel electric with pilot house control.

2. The persons who lost their lives were passengers, Mr. Alexander Robinson and his wife Mrs. Ardella Jarvis Robinson, both of [redacted], Norfolk, Virginia.

3. The weather at the time of the casualty was clear with moderate to fresh north to northeasterly winds and the tide was two thirds flood. The combination of wind direction and tide produced a higher than usual height of water at the scene of the casualty.

4. The vessel berthed at the Old Point Comfort, Va. ferry slip without incident and was lying in the slip on a northeasterly heading. Eleven vehicles were discharged and four vehicles loaded when the ferry was seen to be moving away from the ramp at about 10:20 p.m.

5. A black 1950 Buick sedan driven by Mr. Robinson with Mrs. Robinson as a passenger was caught with the vehicles front wheels on the ferry and the rear wheels on the shoe of the ramp. As the ferry continued moving out the rear wheels of the vehicle fell from the shoe and the car balanced momentarily on the bow of the ferry before slipping into the water and sinking.

6. Several hours later the vehicle and bodies were raised and the deceased removed to funeral home where Mr. [redacted], Coroner, Hampton, Virginia pronounced Mr. and Mrs. Alexander Robinson dead by drowning on 14 September 1953.

7. The personnel serving aboard the ferry at the time of the casualty were as follows: Mr. [redacted], License No. [redacted], master; Mr. [redacted], License No. [redacted], Mate; [redacted] and [redacted], uncertificated, deck hands; [redacted], uncertificated, porter; [redacted], License No. [redacted], chief engineer; [redacted], [redacted], oiler.

8. The master, [redacted], on bringing the ferry into the slip and with the engines on slow ahead observed the lowering of the ramp by the mate, which, the master testified, signified the securing of the ferry to him. He then observed the dropping of the guard chains and commencement of discharge operations at which time he placed the vessel's engine control on stop and went to the offshore pilothouse.

9. While in the offshore pilothouse turning on the running lights for the return trip and making an entry in the logbook he heard someone shouting, "Hold it, hold it." On hearing this shouting the master immediately proceeded to the inshore pilothouse where, on looking to the bow of the vessel, he saw the ferry coming away from the ramp with a car partly on the ferry and partly on the shoe of the ramp. He placed the engines on ahead but before the ferry gained headway the car dropped from the shoe and remained balanced momentarily on the bow of the ferry. Fearing that the car would be crushed between the ferry and the ramp the master testified that he placed the engines in reverse as the car slipped off the bow into the water, with the rear end of the car hitting the water first.

10. The engines of the ferry "JAMESTOWN" can be controlled from either pilothouse depending upon the position of a selector switch located in the pilothouse at the Old Point Comfort end of the ferry. The testimony of the master is to the effect that at all times prior to, during and following the casualty the selector switch was in the Old Point Comfort control position.

11. The ferry is usually made fast with one mooring line on the left side of the ferry, by means of a hook at the end of a five inch manila mooring line (see exhibit 8). This hook is placed into a steel ring made fast to the pilings of the slip by means of a wire bridle. The manila line leads from the hook and ring about six feet aft then through a chock where it is made fast to a cleat. This cleat is so located that its view from the left side of the ferry at the bow and from the ramp control lever is obstructed by a passenger stairway.

12. Approximately ten days prior to the casualty, Mate [redacted] notified Captain [redacted] of his dissatisfaction with the mooring arrangement as existed and then in use. This dissatisfaction was based on the fact that the bridle and ring made fast to the pilings were too low during periods of high tide.

13. It was Mate [redacted] duty to see that the ferry was properly secured and that it remained properly secured during loading and unloading operations.

14. The mate, Mr. [redacted], took his normal station on the bow of the ferry as it came into the slip. As the ferry touched the pilings the gateman stationed at the Old Point Comfort Ferry Terminal lowered the ramp enough to allow Mr. [redacted] to step up to the ramp. The mate then went to the ramp control located on the left side of the ramp (facing into the slip) near the shoe. From this position at the ramp control Mr. [redacted] testified that he saw the hook in the mooring ring and the line tighten.

15. The mate then proceeded to discharge eleven vehicles. On completing discharge he stationed himself about 15 feet up the ramp on the right side facing into the slip. In this position he signalled for vehicles to load, took their tickets and directed them to particular lanes on the ferry. From this position he was unable to see the mooring line on the left side of the ferry.

16. Four vehicles were loaded when the mate became aware that the ferry was gradually moving away from the ramp. The fifth vehicle was lying partly on the shoe of the ramp and partly on the bow of the ferry. His only action was to stop traffic and order the vehicles on the ramp to back off.

17. [redacted] was the deck hand whose normal duty in mooring the vessel was to place the hook into the ring. He testified that on berthing the vessel prior to the casualty he placed the hook into the ring and saw the line tighten. He also testified that he saw Lee move from the cleat on the left side of the vessel to his position at the guard chains on the right side.

18. [redacted] was the deck hand whose normal duty in mooring the vessel was to secure the mooring line to the cleat. He testified that on berthing the vessel prior to the casualty he did not secure the mooring line to the cleat. He further testified that the other deck hand, [redacted] did not place the hook into the ring. He testified that the reason for this action was the instructions he received from the senior deck hand, [redacted], that the vessel is not tied up when the second ferry on the run secures and the "JAMESTOWN" is the only ferry in operation.

19. Deck hands [redacted] and [redacted] on discharging vehicles proceeded to the after end of the ferry which was their station on loading. On hearing shouting they ran forward but did not render any assistance.

20. The published ferry schedule shows a turnaround of 30 to 45 minutes depending on the time of day. When two ferries are operating the schedule calls for a turnaround of 35 to 45 minutes. At about 9:00 p.m. on weekdays and 10:00 p.m. on Sundays one ferry is secured and only one ferry is in operation. During that time the turnaround schedule of this ferry is reduced to 30 minutes. At the time of the casualty the ferry "JAMESTOWN" was the only ferry in operation and approximately 10 minutes behind schedule.

21. The wire bridle that held the steel ring to the pilings was of such length that at high tide the ring lay about one foot below the rubbing bead of the ferry. It was ordinarily the practice in such a situation to make the mooring hook fast to the cables that hold the pilings together and not to the steel ring. These cables lay about five feet above the lower steel ring.

22. On berthing immediately prior to the casualty it is the testimony of Mate [redacted] and Deck Hand [redacted] that the vessel was made fast, using the steel ring. When the mooring line is pulled tight in such a situation the hook and ring would lay from on the rubbing bead to one foot above the rubbing bead, more or less.

23. When the vessel came away from the ramp the hook was not in the ring.

24. The ramp and shoe made fast to the ramp overlaps the bow of the ferry by 14 feet.

25. The ferry officials replaced the arrangement as existed at the time of the casualty with three loops of wire placed at various heights. This change was effected before the board had an opportunity to examine the old arrangement.

26. An inspection of all mooring equipment available, photographs of prior mooring arrangements and testimony of witnesses reveal no failure of materiel (either physical or design) was involved or contributed to the casualty.

27. The lighting arrangement of the ramp, pilings and bow of the vessel was adequate.

28. The testimony of [redacted] and Deck Hand Johnson is in conflict with Deck Hand Lee wherein the former testified that the ferry was tied up prior to the casualty and the latter who testified that it was not tied up prior to the casualty.

29. No Coast Guard inspected equipment or Coast Guard Personnel or any representative or employee of any other government agency caused or contributed to the cause of the casualty.

30. Certain safety instructions were issued by the ferry management to ferry personnel subsequent to the casualty. Some of these instructions were prepared after the casualty and others were a compilation of previous safety instructions in booklet form and distributed to all licensed operating personnel (see exhibit 12). These safety instructions included among other points:

(a) That all ferries shall be secured with two mooring lines at all times.
(b) That the engines shall be worked ahead with a slight forward motion during all times of loading and unloading.
(c) While the engines are so working ahead the captain shall remain in the inshore pilothouse and the engineer in the engine room.
(d) That the two mooring lines now required will be secured in such a manner that the dock ends of the line are above the main deck.
(e) During loading and unloading procedure constant watch will be kept by both captain and mate to insure that mooring lines remain secure.

1. That the bridle and ring made fast to the pilings prior to the casualty were unsafe and unsuitable to use during conditions of high tide.

2. That an act of negligence on the part of Captain [redacted] contributed to the casualty. This opinion of negligence is based on the fact that Captain [redacted], having been apprised by Mate [redacted] approximately 10 days before the casualty that the mooring arrangement then being used was unsatisfactory and unsuitable in that it was too low during periods of high tide for safe operation, did wrongfully and negligently fail to take the following steps of a prudent seaman to anticipate and minimize or eliminate the danger of a casualty should the fears of Mate [redacted] prove justified:

(a) Fail to require that a second line be used on the starboard side should the reported unsuitable arrangement on the port side fail.
(b) Fail to keep the engines in slow ahead and thereby keeping the vessel into the berth as was customary should the reported unsatisfactory arrangements on the port side fail.
(c) Fail to station the mate in a more advantageous position on or nearer the ferry bow where a movement of the vessel could have been observed in time to avert the casualty.
(d) Fail to keep a watch on the ferry in her berth prior to and at the time of the casualty knowing that the tide was near high and the reported unsuitability and unsafeness of the existing mooring arrangement was at its maximum during periods of high tide.

In view of the foregoing, action will be instituted against the license of Captain [redacted] under authority of R.S. 4450, as amended (46 U.S.C.239).

3. That an act of negligence on the part of Mate [redacted] contributed to the casualty. This opinion of negligence is based on the fact that having become aware that the mooring arrangement was unsatisfactory and he had in fact testified that he was fearful that the hook might come out he did neglect and fail to take the necessary precautions to see that the ferry remained in a safe and proper moored position during the loading of passengers and vehicles, thereby contributing to the death of two passengers. In view of the foregoing, action under R.S. 4450, as amended (46 U.S.C.239) has been instituted against the license of Mate [redacted].

4. While the board was unable to ascertain with certainty whether or not the ferry was tied up prior to the casualty due to the conflicting testimony mentioned in number 28 of finding of facts, it is the opinion of the board that the ferry was not tied up on entering the slip prior to the casualty.

- RECOMMENDATIONS -

1. That those safety instructions outlined in paragraph 30 of the finding of facts be followed at all times.

2. That in docking the vessel a distinct signal be made between the master and the mate to signify that the mooring of the vessel is completed. This signal should be separate and distinct from any routine action of the mate in preparing the vessel for unloading.

3. That the masters be instructed that in endeavoring to maintain the published schedule they at no time disregard any safety instructions or fail to perform the acts or exercise the care of a prudent seaman in their effort to maintain the published schedule.

4. During loading and unloading operations the mates be stationed in such a position that they can observe at all times the condition of the mooring line, the ramp and the position of the bow of the ferry in the slip and that they be required to perform no other duties that will hinder or interfere with this responsibility.

5. In view of action to be taken as outlined in paragraphs 2 and 3 of the opinions, it is recommended that no further action be taken and that this case be closed.

[redacted]

R. M. HOYLE
Captain, U. S. Coast Guard, Chairman

[redacted]

W. J. CONLEY, JR.
Commander, U. S. Coast Guard, Member

[redacted]

E. E. DICKEY
Commander, U. S. Coast Guard, Member