MARINE OCCURRENCE REPORT

FOUR PASSENGERS FELL OVERBOARD
DURING A CRUISE ON THE TOUR BOAT
"CANARD MALARD" IN THE PORT OF MONTREAL, QUEBEC
05 JULY 1995

REPORT NUMBER M95L0027

The Transportation Safety Board of Canada (TSB) investigated this occurrence for the purpose of advancing transportation safety. It is not the function of the Board to assign fault or determine civil or criminal liability.

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Summary

On the evening of 05 July 1995, the tour boat "CANARD MALARD" was engaged on a cruise in the Port of Montreal with 23 passengers and two crew members on board.

The vessel took up position north of Île Sainte-Hélène for the passengers to watch the fireworks. At one point, four passengers stood up on the stern seat and leaned on the stern railing. The deck under the seat suddenly tipped back. The stern railing gave way under the weight of the four passengers, and they were thrown into the water. No one was injured as a result of the accident, and the four persons were retrieved from the water by the "CANARD MALARD".

Ce rapport est également disponible en français.

Other Factual Information

Particulars of the Vessel

	"CANARD MALARD"
Official Number	817126
Port of Registry	Montreal, Quebec
Flag	Canadian
Type	Passenger vessel
Gross Tonnage	8.31
Length	9.48 m
Draught	Forward: 0.76 m Aft: 1.22 m
Crew	2
Passengers	23
Built	1994, St-Sulpice, Quebec
Propulsion	Two Volvo 200 hp engines, driving two contra-rotating propellers
Owners	Les Croisières-Excursions au fil de l'eau inc. St-Jérôme, Quebec

The "CANARD MALARD" is a rigid-hull inflatable boat with a control station on the starboard side of the afterdeck. The foredeck and stern platform serve as observation decks for passengers.

At about 2115 on 05 July 1995, the tour boat "CANARD MALARD" departed a Longueuil marina on a cruise to the area north of Île Sainte-Hélène where the passengers were going to watch fireworks.

At about 2200, the tour boat took up position at the north end of Île Sainte-Hélène among a flotilla of boats also there for the fireworks. The "CANARD MALARD" did not drop anchor, but stemmed the current (estimated at three knots) off berth No 39. As the vessel was not making headway, the passengers were allowed to stand and move about on the lower foredeck and the upper deck aft of the control station. The master and the mate kept watch at the control station.

¹ All times are EDT (Coordinated Universal Time (UTC) minus four hours) unless otherwise stated.

During that time, two couples stood up on the stern seat and leaned on the railing, and the crew did not ask them to sit back down on the seat. At about 2228, a passenger who was standing on the front of the engine compartment hatch cover stepped down to join the other passengers on the lower foredeck. The engine hatch cover tipped back, the stern railing gave way, and the passengers fell into the water.

The master stopped the engines and informed the Montreal Vessel Traffic Centre (VTC) of the accident on channel 16 of the VHF. He then asked the passengers to throw lifejackets into the water while he manoeuvred the boat to approach the victims who had drifted about 25 m downstream of the boat in relatively calm water. Meanwhile, the mate threw two lifebuoys into the water.

A pleasure craft near the tour boat overheard the radio message and turned on its searchlight in the direction of the persons in the water. They managed to grab hold of the life-saving appliances. Within a few minutes, they were hauled back on board by one of the passengers and one of the crew members because the "CANARD MALARD" had no boarding ladder. At 2232, the Canadian Coast Guard patrol boat "GC 1204" arrived on the scene and assessed the situation.

The crew members reportedly informed the passengers of the location of the lifejackets before the start of the cruise. However, the passengers said that they had not received a safety briefing. According to the passengers, some of them had started looking for life-saving appliances even before the crew instructed them to do so. No alcoholic beverages were served during the cruise, and none of the passengers appeared to be under the influence of alcohol.

Responses to potential emergency situations are covered in the practical examination for the Master of a Small Passenger Craft Certificate held by the two crew members. As no Marine Emergency Duties (MED) course is required for this certificate, neither crew member had taken such a course. The company had no emergency procedures in place.

The engine compartment hatch cover is a platform covering most of the upper afterdeck. The platform swings on two hinges located on the deck line above the transom.

A bench seat welded to the platform occupies the aft section, and there is a step near the control station for easy access to the lower foredeck.

The afterdeck side railings are bolted to the deck. The stern transverse railing is secured to the back of the seat which in turn is welded to the hatch cover. The original stern railing was modified in 1994 pursuant to a Transport Canada inspection. The tour boat held a Passenger Ship Inspection Certificate for voyages within Minor Waters, Class II, limitations, issued at Montreal on 13 May 1995.

The fact that the passengers did not hear or pay attention to the safety briefing given on the wharf suggests that it was not delivered under appropriate conditions. The MED course required for higher certificates initiates mariners to safety measures to be taken in an emergency. Assembling the passengers to brief them on emergency measures in not required by existing regulations except on passenger vessels making voyages of more than 24 hours. The crew did not warn the four passengers of the risk involved in standing on the seat.

As the stern railing was bolted to the slanted back of the seat, the railing was aft of the hinges on the hatch cover. The passengers standing on the seat and leaning on the seat back and railing produced a lever effect, because their weight exerted a force behind the hinges. As the engine compartment hatch cover was not fitted with a safety catch to secure it shut, the hatch cover tipped back when a passenger standing near the step went down onto the lower deck.

The railing was fastened to the seat back by bolts passing through the stays and the back. The weight of the four passengers caused the railing stays in way of the top bolts to give way. The boat held a valid inspection certificate, but the railing was being used for purposes other than those for which it was designed. The anchoring points at the top of the hydraulic cylinders gave way when the platform tipped back.

Findings

- 1. The passengers were not formally assembled at the start of the cruise.
- 2. The crew did not provide an effective safety briefing to inform the passengers of measures to be taken in case of emergency.
- 3. Four passengers stood up on the stern seat.
- 4. The crew did not ask the four passengers to sit back down on the seat.
- 5. The engine compartment hatch cover which served as the observation deck at the stern was not fitted with safety catches to prevent it from tipping back.
- 6. The weight of the passengers leaning on the seat back and railing produced a lever effect that caused the hatch cover to tip back.
- 7. The stern railing gave way under the weight of the four passengers.
- 8. The passengers were not wearing lifejackets nor were they required to do so by regulations.
- 9. The tour boat retrieved the passengers from the water safe and sound.

Causes and Contributing Factors

Four passengers fell overboard off the "CANARD MALARD" because they stood up on the stern seat and the crew did not require them to get back down on the deck. The engine compartment hatch cover, which served as the stern observation deck, tipped back because it was not fitted with a fastening device. The stern railing gave way under the weight of the four passengers.

Safety Action Taken

Since the occurrence, two safety catches have been installed on the front of the platform, and a new stern railing has been secured to the side railings and the deck. In addition, the anchoring plate has been bolted down with locknuts. These alterations were carried out under the supervision of a Transport Canada Marine Safety inspector.

This report concludes the Transportation Safety Board's investigation into this occurrence. Consequently, the Board, consisting of Chairperson John W. Stants and members Zita Brunet and Maurice Harquail, authorized the release of this report on 21 May 1996.