MARINE OCCURRENCE REPORT

FALL OVERBOARD

FROM THE PASSENGER VESSEL "LOUIS JOLLIET" PORT OF QUEBEC, ST. LAWRENCE RIVER, QUEBEC 06 JUNE 1994

REPORT NUMBER M94L0015

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.

MARINE OCCURRENCE REPORT

FALL OVERBOARD

From the passenger vessel "LOUIS JOLLIET" Port of Québec, St. Lawrence River, Quebec 06 June 1994

REPORT NUMBER M94L0015

SUMMARY

The "LOUIS JOLLIET" was on a promotional round-trip excursion in the Port of Quebec to inaugurate her summer tour program. The on-board party was made up of a group of invited guests from the local media and hotel industry and passengers from a college student body. An invited guest jumped overboard into the harbour and tried to swim for the shore when the vessel was near Pointe à Puiseaux. The master initiated man overboard emergency procedures and the victim, suffering from mild hypothermia and exhaustion, was quickly rescued by a Search and Rescue (SAR) craft.

FACTUAL INFORMATION

Particulars of the Vessel

"LOUIS JOLLIET" Name Port of Registry Québec, Quebec Canadian Flag Official Number 170718 Type Passenger vessel Gross Tonnage 2,438 Crew 22 110 Passengers Invited guests 277 50.29 m Length Forward: 2.59 m Draught Aft: 3.81 m 1938, Lauzon, Quebec Built Four GM 671 diesel, 746 kW Propulsion Owners Croisière AML inc. Québec, Quebec

The "LOUIS JOLLIET" is certificated to accommodate 1,000 passengers during daily excursions in Class II minor waters. The vessel is boarded on the main deck "A", which includes an auditorium. Deck "B" has a closed-in bar and casino space midships with open lounges on the forecastle deck and the afterdeck. Deck "C" comprises a wheel-house forward with bridge wings running to the side of the vessel, and an open observation deck aft.

At approximately 1700¹, invited guests and passengers began boarding and, at 2000, the "LOUIS JOLLIET" departed. Four invited guests from the same hotel sat at a table near the port railing on the forecastle "B" deck. After consuming several drinks, one of the invited guests boasted that he could swim back to shore and, at approximately 2030, he sat momentarily on the railing. He was seen from the bridge and the ship's whistle was sounded to warn him of the danger. A deck-hand present on the port bridge wing was ordered to advise the guest to sit down and not lean on the railing. At approximately 2045, the passenger returned to the railing, leaned backwards and deliberately jumped overboard.

The helm was turned hard-to-port and the engine was stopped. The master threw a lifebuoy with light overboard from the port wing of the bridge. When he returned to the wheel-house, he sounded three blasts on the ship's whistle to mobilize a five-crew-member emergency team and he made an urgency call by radiotelephone.

The chief officer supervised the emergency team who prepared the

1

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

port lifeboat. At 2050, the "LOUIS JOLLIET" contacted the Québec Vessel Traffic Centre (VTC) which advised the Québec Marine Rescue Sub-Centre (MRSC). At 2053, the Canadian Coast Guard (CCG) cutter "STERNE" departed Section No. 98 for Pointe à Puiseaux.

The passenger vessel "ST. ANDRE", which was also carrying out an excursion in the harbour, radiotelephoned the "LOUIS JOLLIET" to confirm that she would lower a lifeboat and stand-by to assist.

The victim was observed to stop swimming for the shore and to float approximately 40 to 50 m from the lifebuoy. At 2100, the "STERNE" arrived on the scene and recovered, from the water, the victim who was suffering from mild hypothermia and exhaustion. Some confusion was caused by deadwood adrift in the vicinity which made the rescue party believe other persons had fallen overboard. At 2110, the CCG cutter arrived at her base. At 2115, the victim was taken to a local hospital by ambulance.

ANALYSIS

Before leaning on the railing, the invited guest had not drawn attention to himself. When he was asked to move away from the railing, he obeyed and sat down. The behaviour of the invited guest did not lead the crew to believe that he would repeat the dangerous action. The policy of the vessel is to handcuff and incarcerate belligerent passengers until the harbour police can take them into custody.

The lifebuoy was thrown near the victim and, as dusk set in, the lifebuoy light proved to be a good reference mark. The victim initially swam away from the lifebuoy. When he became exhausted, he concentrated on conserving his energy, trying to keep afloat and he did not attempt to swim toward the lifebuoy. Fortunately, the master saw the invited guest fall overboard. The master kept the victim in view throughout the SAR operation.

Both the "LOUIS JOLLIET" and the "ST. ANDRE" lowered a lifeboat manned by a crew ready to intervene. As neither lifeboat was power-driven, both vessels decided to stand-by and let the cutter "STERNE" carry out the rescue operation. The cutter took seven minutes to reach the scene. The victim was in the water for approximately 12 minutes and, as a result, suffered from mild hypothermia and exhaustion when rescued.

FINDINGS

- 1. The company has a policy which ensures that the behaviour of passengers will not affect their safety or the safety of other passengers, crew and vessel.
- 2. The consumption of alcohol affected the invited guest's behaviour.

- 3. The invited guest's action was deliberate and unpredictable.
- 4. The master and crew reacted appropriately to the man overboard situation.
- 5. A lifeboat is not a launch adapted to the recovery of persons in the water.
- 6. The victim was suffering from mild hypothermia and exhaustion when rescued by the Canadian Coast Guard cutter.

CAUSES AND CONTRIBUTING FACTORS

The invited guest impulsively jumped overboard from the "LOUIS JOLLIET" into the harbour while his judgement was impaired by his consumption of alcohol.

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 Hugh MacNeil, authorized the release of this report on 10 May 1995.