George G. Sharp, Inc.

Staten Island Ferry Field Office

c/o Marinette Marine Corp, 1600 Ely St, Marinette, WI 54143

FACSIMILE TRANSMISSION

Date: 10/19/04

To: ROB JONES **Company:** NTSB.

Attention: _____ **Fax. No.:** 202-314-6454

From: SEAN McDERMOTT **Company:** George G. Sharp, Inc / STATEN ISLAND FERRY

Fax No.: 715-735-4745
Phone: 715-735-4744

Number of Pages (including this page): 7

If you do not receive this transmission in its entirety, please call 715-735-4744.

NOTES: ROB,

PLEASE FIND ATTACHED NYCDOT'S COMMENTS REGARDING THE NTSB FACTUAL REPORTS. WOULD YOU PLEASE CALL ME ON MY CELL TO CONFIRM YOU HAVE RECEIVED THEM.

PLEASE NOTE THAT BECAUSE I'M IN WISCONSIN INVOLVED WITH THE NEW VESSEL CONSTRUCTION, I'VE FAXED OUR RESPONSE. WHEN I RETURN TO N.Y. NEXT WEEK I WILL MAIL A HARD COPY. -

THANKS SEAN

Home Office: George G. Sharp, Inc., 100 Church Street, New York, NY 10007
Phone: 212-732-2800 Fax: 212-732-2809

CELL # 646-210-1795

New York City
Department of Transportation
Iris Weinshall, Commissioner

40 Worth Street
New York, New York 10013
Tel: 212/676-0868
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October 15, 2004

VIA Facsimile 202 314-6454

National Transportation Safety Board
Office of Marine Safety
490 L'Enfant Plaza East, SW
Washington, DC 20594-2000

Attention: Morgan Turrell
Brian Curtis
Captain Rob Jones

Re: ANDREW J. BARBERI
Staten Island Ferry Disaster
October 15, 2003

Gentlemen:

I reviewed the draft factual reports from the Operations Group, Engineering Group and Survival Factors Group. As a threshold matter, the Operations Group report lists Pat Ryan as the party representative. During the process, I was substituted, and I would appreciate it if you would amend the report to reflect that I am the party representative. As you can appreciate, I was not involved in many of the interviews which the various groups conducted, but I have reviewed the draft reports and now provide you with my comments.

OPERATIONS GROUP

1. At Page 3, the report reflects a design speed of 18.5 knots. The design speed is actually 18.5 m.p.h., rather than knots.

2. At Page 5, the report reflects that the two mates were primarily responsible for helping the vessel dock and transferring passengers safely. While the mates are responsible for assisting with the docking operation and transferring passengers, they have additional responsibilities as outlined in the Standard Operating Procedure document which has been provided as well as in additional documents which we will provide under separate cover.

3. In the "Operational Information" section, at Page 10 and 11, the report discusses the implications of the Memorandum of Understanding which was entered into between the U.S. Coast Guard and the Department of Transportation. At Page 10 the report suggests that the U.S. Coast Guard determined that a Memorandum of Understanding was the best way to keep the vessels "under the Coast Guard's inspection authority." The Department of Transportation requested that the Coast Guard continue with its inspections, and voluntarily agreed to comply with the regulations, but technically the vessels were not under the Coast Guard's inspection authority.

4. At Pages 13-14, the report states that the vessel was operating in the highest revolution setting while underway during the transit. This should be clarified. The vessel operates at between 725 and 750 r.p.m. while underway, but the engines are rated at 800 r.p.m.

5. At Page 14, the report reflects that the vessel can be stopped in 1 and 1/2 ship lengths. This information was taken from the sea trial data, which was compiled in 1981. We do not have recent data, and cannot confirm the accuracy of that information. Further, the stopping distances in the sea trial data are based on defined conditions (draft, sea conditions, etc.) We believe the report should point out that the sea trial data is more than twenty years old and is not necessarily reflective of the vessel's capability at the time of the casualty or given the conditions which existed at the time of the casualty.

6. At Page 14, the report states that the ferry does not notify the U.S. Coast Guard Vessel Traffic System at the end of a transit, as most other vessels are required to do. It is important to point out that given the short duration and number of Staten Island Ferry transits during a given day, the Coast Guard does not believe it necessary for the boats to notify the Coast Guard at the end of each transit.

7. At Page 14, the report mentions that the ferry is not equipped with an Automated Identification System unit and does not have a course recorder or any type of data recorders onboard. Again, for completeness, we believe that it should be noted that none of this equipment is required by the Coast Guard.

Along these same lines, we believe it is important to point out that the ferry had all navigation and safety equipment which was required under the regulations relating to passenger vessels.

8. At Page 15, you stated that there is no requirement for training in crowd control, bridge resource management or firefighting. We believe it should be clear that the Coast Guard has no requirements for training in crowd control or bridge resource management, and the fire fighting requirements are covered as part of the Coast Guard's licensing procedures.

9. At Page 16, you point out that the two mates did not receive formal training in ship handling. Robert Rush is a 1968 graduate of SUNY Maritime. He sailed for several years on oceangoing vessels, and currently holds a Chief Mate's License, unlimited tonnage. David Hyde is also a graduate of the Great Lakes Maritime Academy and had a pilot's license for portions of the Great Lakes. Therefore, both men did receive training in ship handling.

10. At Page 16, the report sets out the reporting structure within the ferry operation. The following more accurately reflects the reporting structure which was in existence at the time. We have underlined and/or lined through the original text so that you can follow the changes.

> The deckhands reported to the mates of the ferry, and the mates reported to the Captain or Assistant Captain during vessel operations. The Assistant Captain, reports to the Captain and the Captain reported to two Port Captains of the ferry, who oversaw the day-to-day operations of the ferries and were the immediate supervisors of the ferry officers, writing the officers performance appraisals. The Port Captains reported to the Director of Ferry Operations, who oversaw the ferry systems operations and maintenance. The Director of Operations reported to the Assistant Commissioner, ~~NYC DOT Staten Island Commissioner~~ who oversaw all aspects of ferry operations, i.e., operations, maintenance, terminals, and ferry personnel and budgeting. Two other individuals also reported to the Assistant Commissioner, ~~DOT Borough Commissioner~~ the Director of Terminal Operations and the Director of Administration. The ~~Staten Island Commissioner~~ Assistant Commissioner reported to the NYC DOT Deputy Commissioner. The Deputy Commissioner reported to the NYC DOT First Deputy Commissioner. She in turn reported to the NYC DOT Commissioner.

11. At Page 17, the report states that there was no formal Safety Management System in place. We believe that you are referring to a Safety Management System within the meaning of the ISM Code, but believe that should be clarified.

You refer to the Standard Operating Procedure document and state that few formal procedures were in place. We do not have an index of all of the documents which you obtained during the course of your investigation, but there are a series of Standard Operating Procedures documents, and we will provide you with copies.

12. At Page 17, you suggest that the Standard Operating Procedure document was not widely distributed or known among the employees investigators interviewed. We understand that certain employees advised that they had not seen the document, but other employees clearly advised that they had seen the document. To be accurate, we believe the report should say that certain of the employees interviewed advised that they had not seen the document.

ENGINEERING GROUP

1. At Page 4, the report mentions that during the transit, the engines were running at full speed and the propulsion drives were at 100% pitch. As mentioned earlier, full speed for the transit is between 725 and 750 r.p.m., but the engines are rated at 800 r.p.m.

2. At Page 14, the report reflects that the main engines are naturally aspirated. This is incorrect. The engines are roots blown.

3. At Pages 15 and 16 you point out that post-accident testing showed that while the ringer worked on the sound-powered phone system in the Staten Island wheelhouse, the audio function was not operating. The sound-powered phone system is used routinely, and there were no pre-accident reports of any deficiencies. Under these circumstances, it seems clear that the system was damaged as a result of the accident.

4. At Pages 16 and 17, you note that in post-casualty testing of the telegraph system, the system properly rang, but there was no engine order telegraph needle movement to reflect the speed change which had been ordered. The telegraph system was checked on October 7, 2003, as part of the preparation for the Coast Guard inspection scheduled for October 16. A copy of the pre-Coast Guard inspection form will be provided. Therefore, the report should reflect that any defects with the telegraph system were the result of the casualty. Moreover, it is important to point out that the telegraph system was not in operation at the time. The vessel was being operated on bridge control. The throttle responded properly throughout and there were no problems in controlling the main engine from the time of the casualty through the time that the ferry was brought alongside the dock.

5. At Page 18, you mentioned the sea trial data which reflects the vessel's ability to stop and full ahead in approximately 420 feet in 43 seconds. As mentioned earlier, the sea trial data is more than twenty years old and is based on defined conditions. Therefore, we cannot verify that this stopping criteria is accurate.

6. At Page 22, you estimated the total repair cost to be $6,500,000. We will provide you with the actual repair cost.

SURVIVAL FACTORS GROUP

This report appears to be based primarily on interviews with survivors and independent investigations by the NTSB which we were not involved in. We have not spoken with any of the accident victims and have not done any investigation into the nature and extent of the injuries. Therefore, we are simply not in a position to comment on or confirm the information contained in this report. We do note, however, that at Page 5, the report estimates that there were 1,500 passengers onboard at the time of the casualty. The Operations Group report (at Page 3) estimates that there were 800 people onboard. We believe that there were approximately 800 passengers onboard at the time of the casualty.

Finally, page 15 refers to the senior mate onboard as the "2d Mate," whereas at page 16, the report refers to the senior mate as the "Senior Mate (Mate No.1)." We believe that using the term "2d Mate" is confusing in this context, and believe it would be clearer if the mates are referred to as "Mate No.1" and "Mate No. 2."

OVERALL COMMENTS

We understand that once the factual reports are finalized, the NTSB will draft sections of the report outlining its conclusions regarding the cause of the casualty and providing recommendations. We appreciate the Board giving us the opportunity to comment on these factual reports, and would also appreciate an opportunity to review and comment on the conclusions and recommendations before the overall report is finalized. Along these lines, we note that the three factual reports do not mention the medications which Captain Smith was taking at the time of the casualty. We assume that this will be covered in the factual report from another group, or will be

covered in the causation section of the Board's report. In any event, we look forward to hearing from you further, and again thank you for the opportunity to comment on the factual reports.

Very truly yours,

Sean McDermott

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*** RX REPORT ***
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