KEEPING YOUR SEA SAFE FOR LIFE

Maritime Safety

MARITIME SAFETY AUTHORITY OF NEW ZEALAND
Kia Maanu Kia Ora

REPORT NO: 96 271
VESSEL NAME: SAN VENTURER

CASUALTY DETAILS

Date of Casualty:	14 May 2004
Time of Casualty:	1505 hours New Zealand Standard Time
Casualty Type:	Person Overboard
Casualty Location:	At Sea
Weather Forecast Area:	Rangitata
Date MSA Notified:	25 May 2004
Date Investigation Started:	25 May 2004
Date Investigation Completed:	1 October 2004
Investigator:	Zoe Brangwin

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REPORT NO: 96 271
VESSEL NAME: SAN VENTURER

VESSEL DETAILS:

Ship Name:	*San Venturer*
Date of Build:	1991
Ship Category:	Deep Sea Fishing Vessel
Certified Operating Limit:	Unlimited
Overall Length (m):	64
Maximum Breadth (m):	13
Gross Tonnage:	1 899
Net Tonnage (t):	592
Flag:	New Zealand
Registered Owner:	Sanford Limited
Ship Operator:	Sanford Limited
Classification Society:	SGS M&I

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SUMMARY

A deckhand from the fishing vessel ***San Venturer*** fell overboard while securing the rescue boat after its use. As he was bending over to thread the line through the eye on the deck, he lost his balance. He put his weight on the safety chain and felt it give way and then fell overboard. He landed in the water shoulders first. The crew recovered the Deckhand. He was later transferred to Timaru Hospital.

1. KEY EVENTS

1.1 At approximately 1400 hours, New Zealand Standard Time (NZST), on 14 May 2004, the First Officer on ***San Venturer***, which was at sea, called Timaru Harbour control to inform them of the vessel's movements. He advised the vessel would be launching the rescue boat to transfer a parcel to the San Won wharf at Timaru. The vessel was in clean up mode and due to arrive at Timaru the next day.

1.2 The First Officer briefed the boat's crew of the poor intermittent visibility, wind conditions, and to listen on VHF Channel 10. The boat was then launched.

1.3 At 1459 hours, Timaru Harbour control was notified that the rescue boat had returned from Timaru and was back onboard. The First Officer noted the weather conditions as a southerly force 3 sea, 1½ metres swell, and visibility of 1-2 nautical miles. The vessel's heading was 090°(T) with 20° of propeller pitch, giving a speed over the ground of about three knots.

1.4 Deckhand 1 and the General Hand were on the boat deck securing the rescue boat. The General Hand put up the safety chain/guardrail and then went to get the flush muffs freshwater attachment for the outboard motor. Deckhand 1 went to secure the forward tie down/guy line. As he was bending over to thread the line through the eye on the deck, he lost his balance. He put his weight on the safety chain and felt it give way and then fell overboard. He landed in the water shoulders first. He remembered shouting for help and saw that crewmembers on the after deck had seen him. He kicked his boots off and treaded water, but did not remember anything after that until he came to in the companionway onboard the vessel.

1.5 At 1503 hours, the First Officer heard a scream for help. The Second Mate and No. 1 Qualified Deckhand (QFDH) also heard it. They proceeded directly to investigate. The First Officer asked where was Deckhand 1. The General Hand replied that he thought he had seen him move towards the trawl deck. However, this was not the case.

1.6 At 1505 hours, the shift crew were mustered for a possible man overboard (MOB). At the same time, the First Officer fixed the vessel's position; the position where the rescue boat had been brought onboard and the position where he heard the cry. The vessel was stopped and the rescue boat launched.

1.7 The First Officer gave the No. 1 QFDH, instructions on the area to start the search. Lookouts were posted. The First Officer scanned the area using binoculars. He saw seaweed and what he thought was a log. A second scan of the area showed that the log was actually Deckhand 1. The rescue boat approached him seconds later and confirmed by VHF radio that they had found him and that "he was not looking good". The Marine Medic was called to the boat deck.

1.8 At 1516 hours, the rescue boat was recovered and Deckhand 1 was lifted onboard and given medical attention. The First Officer went to assist and told a crewmember to call the Master. Deckhand 1 was not breathing. The Medic performed mouth to mouth resuscitation, which was effective. He was then treated for hypothermia, shock and later back pain. The First Officer returned to the bridge and put on 20° of propeller pitch and steered a course of 077°(T).

1.9 At approximately 1520 hours, the Skipper arrived on the bridge. The First Officer briefed the Master.

1.10 At approximately 1540 hours, the Master called the Vessel Manager to inform him of the MOB and the suspected back injury.

1.11 At approximately 1630 hours, the ship received a phone call from the Deep Water Fleet Manager regarding medical advice, and the order was given to take Deckhand 1 into Port Timaru.

1.12 At approximately 1650 hours, the vessel was making its way to Timaru.

1.13 At approximately 1740 hours, the visibility reduced to ½ nautical mile. On inspection it was found that the throttle control of the rescue boat and trim control had been broken during the rescue. It was decided therefore not to use the rescue boat for the transfer into Timaru.

1.14 At approximately 1750 hours, there were further discussions with the Vessel Manager about Deckhand 1's back pain and the weather conditions.

1.15 At 1800 hours, the vessel was informed that the Timaru pilot vessel would carry out the transfer. The vessel was to meet the pilot boat at Red buoy to receive the Pilot, Vessel Manager and Medic.

1.16 At 1842 hours, Pilot, Vessel Manager and Medic boarded the vessel. Visibility was clearing at this time. The Medic administered painkillers to Deckhand 1 before transferring him to a stretcher.

1.17 At 1910 hours, when the vessel was inside the harbour, Deckhand 1 was transferred by stretcher to the pilot vessel with the Pilot, Medic, Vessel Manager and two QFDH's to assist.

1.18 At 1920 hours, the transfer was completed and Deckhand 1 was taken to the hospital in a St Johns Ambulance.

1.19 At 1940 hours, the pilot boat transferred the crew back to ***San Venturer***.

1.20 At 1946 hours, the pilot vessel departed and ***San Venturer*** headed back out to sea.

1.21 Deckhand 1 spent 24 hours in hospital at Timaru under observation, where he was diagnosed as having sustained a fractured vertebrae.

2. KEY CONDITIONS

2.1 Particulars of *San Venturer*

2.1.1 *San Venturer* is a deep sea fishing vessel of steel construction built in 1991. The vessel has an overall length of 64 metres, a breadth of 13 metres and a gross tonnage of 1 899.

2.1.2 The vessel was owned by Sanford Limited and operated out of Timaru. At the time of the accident, the vessel held a valid Safe Ship Management Certificate issued by SGS M&I. The vessel has since been sold to Russian owners and left New Zealand waters with a Russian crew.

2.2 Crew Details

2.2.1 Deckhand 1 was an employee of Sanford. He was employed as a QFDH and had been working for Sanford as a deckhand/factory hand on ***San Venturer*** for two weeks at the time of the accident. He was waiting for a Second Mate's position on one of Sanford vessels. He held a Mate Deep Sea Fishing Boat (MDSFB) Certificate, which he obtained in 1997. Prior to this trip, he had been Second Mate onboard Talleys vessel ***Ocean Ranger***, for four years. He had also spent two years onboard ***San Discovery*** as Second Mate. He had worked at sea since 1982 and worked his way up from Deckhand to Second Mate.

2.2.2 Deckhand 1 was not a strong swimmer.

2.2.3 Deckhand 1 worked a six on six off watch system and said he slept for about four of the six hours of every off watch. The accident happened one hour after the watch handover. He stated that at the time of the accident he was feeling good and that his general health was good. He had been taking non-sedating anti-histamines. The vessel was a "dry ship" and there was no alcohol onboard. He had not taken any illegal substances.

2.2.4 The General Hand, had only recently joined the vessel.

2.2.5 Deckhand 1 was wearing the following clothing:

- Leggings
- Tracksuit
- Hard Hat
- Steel cap boots

2.2.6 Deck vests (a buoyant working vest) were supplied for working on the upper deck. Deckhand 1 was not wearing one when he went over the side. Deck vests were normally used when working on the upper deck in rough weather and on the trawl deck.

2.2.7 Deckhand 1 operated the hydraulics for the boat transfer and was in charge of securing the rescue vessel after it was brought back on board ***San Venturer.***

2.3 Weather Conditions

2.3.1 At the time of the accident, the First Officer noted the weather conditions as follows:

Visibility	1-2 NM
Swell	1½ metres
Wind	Southerly force 3

2.3.2 Deckhand 1 described the weather conditions as, overcast, cold, with very little wind and a ½ metre swell.

2.4 The Safety Chain/Guardrail

2.4.1 The safety chain that gave way, acted as a handrail when the rescue vessel was in the stowed position. Before the rescue boat was lowered the safety chain/handrail had to be lowered, and then reinstated once the boat was in the stowed position.

2.4.2 After the Master had seen Deckhand 1 and told the crew to move him to the companionway, where it was more sheltered, he found the Second Mate and asked him what had happened. The Second Mate mentioned the safety chain. The Master went to the boat deck to look at the chain and after inspecting it, he went back to the accommodation to get the Second Mate and General Hand. The Master asked them what had happened. The General Hand replied that he had made the chain fast with the carbineer clip. He had screwed it tight and had then loosened it, by taking off two full turns, so that it did not seize. The Second Mate repeated the process of making the chain fast, to the Master. He then gave the chain a shake and the clip came undone. The normal and accepted practise for securing a carabineer type clip is to undo it a ¼ of a turn, to prevent it from seizing, and then to mouse it (secure it in position with a length of seizing wire).

2.5 Other Details

2.5.1 Deckhand 1 stated that he was not shown how to operate the hydraulics and secure the rescue boat as he had done it many times before. He did not know what training the General Hand had received but stated that he was a quick learner and competent. It is not known what training the General Hand had received but it can be deduced from this accident that he had not been shown the correct method of tightening a carabineer when replacing the safety chain.

2.5.2 The crew had carried out a man overboard drill during the first few days of the trip.

2.5.3 There was a considerable time delay between the recovery of Deckhand 1 from the water and the medical evacuation. The accident happened at about 1500 hours. Deckhand 1 did not reach Timaru until 1920 hours, four hours and twenty minutes after the accident occurred.

2.5.4 The vessel continued steaming out to sea after the accident and therefore had to turn around and recover the ground once it was decided to evacuate Deckhand 1.

2.5.5 The Master called the Vessel Manager to tell him of the accident and ask for advice. Because of this phone call there was a 50 minute delay in deciding what action to take. During this time the vessel continued heading out to sea.

2.5.6 The Maritime Operations Centre provides free medical advice service through VHF or Single Side Band radio. This was not utilised. The Radio handbook states:

> *"Medical advice may be obtained by sending a message to any of the coastal Very High Frequency (VHF) radio stations of the Maritime Radio Service or to Taupo Maritime Radio (ZLM) by Single Side Band (SSB). The stations forward the message to the appropriate medical authority, whose reply is passed on to the ship. There is no charge for this service."*

2.5.7 Deckhand 1 was admitted to the Intensive Care Unit (ICU) at Timaru Hospital on 14 May and did not leave there until he was moved by Rescue Helicopter at 1140 hours on 17 May to Christchurch Hospital and then to the Burwood Spinal Unit the following day. He underwent a spinal operation on 21 May and was discharged from Burwood on 24 May. The fracture sustained was a crush fracture of the vertebrae with loose fragments of bone in the area and in danger of causing damage to the spinal cord, if movement was allowed. He was kept under observation and monitored at Timaru Hospital because of his ingestion of dirty sea water and the serious risk of a lung infection.

3. CONTRIBUTING FACTORS

N.B. These are not listed in order of importance.

3.1 The General Hand had not done up the safety chain correctly.

3.2 Deckhand One relied on *(as he was entitled to)* the safety chain to take his weight.

3.3 Inadequate training with respect to the securing of the safety chain.

4. Cause

Human Factor

❑ Failure to comply with regulations	❑ Drugs & Alcohol	❑ Overloading
❑ Failure to obtain ships position or course	❑ Fatigue	❑ Physiological
❑ Improper watchkeeping or lookout	✗ Lack of knowledge	❑ Ship Handling
❑ Misconduct/Negligence	❑ Error of judgement	❑ Other . . .

Environmental Factor

❑ Adverse weather	❑ Debris	❑ Ice	❑ Navigation hazard
❑ Adverse current	❑ Submerged object	❑ Lightning	❑ Other . . .

Technical Factor

❑ Structural failure	❑ Wear & tear	❑ Steering failure
❑ Mechanical failure	❑ Improper welding	❑ Inadequate firefighting/lifesaving
❑ Electrical failure	❑ Inadequate maintenance	❑ Insufficient fuel
❑ Corrosion	❑ Inadequate stability	❑ Other . . .

4.1 Deckhand 1 fell overboard from ***San Venturer*** into the sea when the safety chain, supporting his weight, came undone.

4.2 It is not known what caused Deckhand 1's fractured vertebrae, namely whether it was as a result of the fall or during the rescue or a combination of the two. He did not remember being in pain after he landed in the water. However, he remembers nothing after that until he came to in the companionway in agony.

5. OPINIONS & RECOMMENDATIONS

5.1 ***San Venturer*** has subsequently been sold to a Russian Owner and is no longer working in New Zealand waters. However, the following recommendations and safety considerations should be applied to remaining Sanfords vessels.

5.2 The Master of ***San Venturer*** stated on the accident form the following corrective actions would be taken to prevent similar accidents:

- *"Make sure the safety chain carabineer is fully tightened and moused.*
- *Deck Officers to check all safeties (sic) are in place and secure after rescue boat is onboard."*

5.3 It is recommended that within two months of the publication of the final report, Sanfords implement formal, documented and robust induction and training procedures to ensure that all crew are trained properly for their respective tasks in compliance with Section 13 of the Health and Safety in Employment Act 1992. This is to be included in the SSM manual and signed off by all crewmembers.

5.4 It is recommended that Sanfords take immediate steps to ensure it becomes standard practice for deck vests to be worn when crew are working close to the side of the vessel and when working in the vicinity of lowered guardrails. This is to be documented in the vessels procedures and audited to ensure it is being complied with.

5.5 Masters of fishing vessels frequently contact their company representatives for medical advice, which can lead to a time delay in receiving professional medical advice and assistance. The MOC and Rescue Coordination Centre (RCC) which is manned 24 hours a day, are based in Wellington, New Zealand, and monitor all distress frequencies including VHF 16 and 2182 kilocycles. RCCNZ is tasked with the gathering and dispatch of medical advice to ships and should always be used as the first point of contact for medical matters. This information is to be included in the SSM manuals of all Sanford vessels and signed off by crewmembers.