

LESSONS LEARNT
BY ACCIDENT

LOOKOUT!

SEPTEMBER 2007 ISSUE SIX

LOST in darkness

A NIGHT ON THE ROCKS!



COMMERCIAL *accidents and incidents*

2004-2006 STATISTICAL SUMMARY

5



Sleeping on the job

- ▶ Alarm turned off – vessel grounds

6



Look before you leap

- ▶ Deckhand injured in fish hold

8



Wedged under rapids

- ▶ Rafter nearly drowns

13



Lost in darkness

- ▶ A night on the rocks!

LOOKOUT! **Contents**

SEPTEMBER 2007 **ISSUE SIX**

7



Explosion and drowning

- ▶ Man never found

9 **High speed collision**

10 **Size does count**

10 **Dragging anchor danger**

11 **Grounding in narrow channel**

12 **Drugs contribute to drowning**

14 **Quick jump to safety**

15 **High speed strike**

16 **Commercial accidents and incidents**

18 **Safety bulletins – latest issues**

17



Kiwis join *Pasha* Bulker rescue effort

- ▶ Successful refloating – no harm to environment

Regulars

3 **Introduction**

4 Guest editorial:
Ensuring maritime safety in harbour waters



LOOKOUT!

▶ Welcome once again to *Lookout!* our quarterly safety newsletter featuring the lessons to be learnt from maritime accidents.

Good safety practice is at the core of Maritime New Zealand's vision of a maritime environment with minimal deaths, accidents, incidents and pollution. The stories in this issue again highlight the risks and issues that relate to the sea and remind us of how all too easily mistakes can be made.

Lookout! is part of our range of communication tools that we have developed to support the maritime industry to continuously improve safety in both recreational boating and commercial shipping.

Central to our strategic priorities for 2007/2008 is enhancing the Safe Ship Management system, and providing the communication tools and supports to ensure the robustness of that system.

The dangers of fatigue and the necessity of keeping a good lookout feature in a number of the stories in this *Lookout!* Currently we are in the process of publishing some excellent new resources to reinforce these messages – do check out the box on page 5 regarding *Understanding fatigue*.

We were recently delighted to acknowledge the achievement of Port Taranaki and the Taranaki Regional Council in gaining approval under the New Zealand Port and Harbour Marine Safety Code, and our guest writer, Mike Pryce, reminds us of the importance of harbour safety.

Do pass on this issue to your colleagues and crew or contact any one of our offices if you would like more copies.

The full accident reports are available on our website: www.maritimenz.govt.nz or by calling our toll free line 0508 22 55 22.

Catherine Taylor
Director of Maritime New Zealand



Ensuring maritime safety in harbour waters



Regional Harbourmaster Mike Pryce has been Wellington Harbourmaster since 1989 for the Greater Wellington Regional Council. Before that he was a career mariner with Shell – he had 23 years on oil and gas tankers working up from cadet to master mariner until coming ashore in 1987.

Lookout! – lessons learnt by accident is a commendable way of learning from (preferably) other people's mistakes. Many mariners will read some incident reports and think the unspoken "there but for the grace of God go I".

The idea is not a new one, and in the past large shipping companies often produced similar in-house reports, for example Shell published *Casualty reports* from 1947.

An early report dating from August 1947 was quite famous throughout the fleet.

This 6,100 tonnes deadweight vessel was proceeding northward along the East Coast of New Guinea and a course was set to pass 5 miles off Kitava, a high unlighted island with a steep-to coastline. It was expected to be abeam of the island about 00.15 and at 23.45 the third officer went into the chartroom to write up the log.

At the material time the visibility due to rain had decreased to a distance of from one to two miles, and the master had not been informed of this special

circumstance. At 23.52, due to an unexpected set of the current, the vessel grounded at full speed, the third officer still being in the chartroom at the time.

From competent observers on the bridge immediately after the accident, it was ascertained that the island was clearly visible and taking into consideration the nature of the coastline there is no doubt that this accident would have been averted had a good lookout been kept.

Despite vast advances in navigational equipment and technology, some lessons still hold true, and one of them is "always keep a good lookout".

Much study and science has been devoted to analysing why seafarers make silly mistakes or become careless but marine accidents still happen. I recall one old mariner who defined "experience" as "something that you had JUST got away with"!

Many casualty reports detail the events (or omissions) that took place on board ship, and are written from the point of view of the mariner.

The introduction of ISM (International Safety Management Code) and Safe Ship Management documentation systems are intended to reduce such risk.

Sometimes those involved include the harbour authority of the port where an incident occurred, and they might have slightly different priorities than investigating the immediate cause of an incident.

Collision or groundings inside harbour limits produce a risk of sinking or oil pollution, and actions may need to be taken immediately to mitigate the risk of injury, loss of life or environmental damage.

Legislation regarding the responsibilities of harbour authorities has become somewhat "patchwork" in recent times after nearly two decades of "reforms". However, the adoption of the New Zealand Port and Harbour Marine Safety Code by New Zealand harbour authorities is intended to improve this situation and introduce formal risk assessments and safety management systems.

I believe that implementation of the New Zealand Port and Harbour Marine Safety Code will give harbour authorities better guidelines and understanding of their responsibilities and duties in fulfilling their role of ensuring maritime safety in harbour waters.

Mike Pryce
Regional Harbourmaster

“ DESPITE VAST ADVANCES IN NAVIGATIONAL EQUIPMENT AND TECHNOLOGY, SOME LESSONS STILL HOLD TRUE, AND ONE OF THEM IS ‘ALWAYS KEEP A GOOD LOOKOUT’.”

Taranaki wins national recognition for port safety

The operators of Port Taranaki have won national recognition for their commitment to maritime safety, becoming the first port in the country to receive official approval for their port and harbour safety management systems.

This milestone was celebrated on 16 August, with the presentation of certificates by Maritime New Zealand to the Taranaki Regional Council and Port of Taranaki.

Sleeping on the job

A designated watchkeeper had been asleep for at least 2 hours when a commercial fishing vessel grounded.

A course was set for the next fishing ground. Once clear of the land, the autopilot was engaged. The pre-arranged plan was to stop the vessel after steaming for about 1 hour and let the vessel drift for the night, allowing the crew to sleep before resuming passage the following morning.

After sharing a large roast dinner that night, and each drinking two cans of beer before the meal, the skipper and one of the two crewmembers went to bed. The skipper left instructions with the other crewmember to continue steaming for about 1 hour, then stop the main engine and leave the vessel to drift.

The watchkeeper did the dishes and then just before midnight, settled into his watch in the comfortable high-backed truck driver's chair in the wheelhouse.

By stretching out in the chair with his feet up on the console, the watchkeeper could cancel the watchkeeping low level alarm with his toes. The alarm was set to go off at 20 minute intervals. If the low level alarm was not deactivated each time, an alarm loud enough to wake the whole crew would sound.

The wheelhouse door and windows were probably closed and the watchkeeper soon fell asleep.

About 2 hours later all three crew woke to the shuddering of the vessel as it grounded on rocks.

The skipper sent the crew to check for damage and fortunately no water ingress was found. An attempt to refloat the vessel by pumping out the live crayfish water tanks failed and the tanks were flooded again to keep the vessel on the ground.

About an hour later, another vessel arrived in the darkness to try to help. A line was attached to the stricken vessel and kept taut through the night. At first light another vessel arrived on the scene and managed to pull the fishing vessel free.

It was returned to port for repairs to a damaged propeller, bent rudder shaft, bent tail shaft, and minor damage to the hull.

 View the full report online at: www.maritimenz.govt.nz



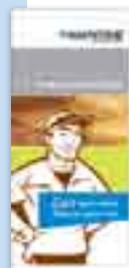
▲ BY STRETCHING OUT IN THE CHAIR, THE WATCHKEEPER COULD CANCEL THE WATCHKEEPING ALARM WITH HIS TOES.
▲▲ THE FISHING VESSEL REQUIRED REPAIRS TO THE PROPELLER, RUDDER SHAFT, TAIL SHAFT AND HULL.

Hot off the press – Understanding fatigue

Maritime New Zealand's new fatigue resources including a brochure called *Understanding fatigue* are now available.

Developed after extensive consultation with the industry and key stakeholders, *Understanding fatigue* covers ways to manage fatigue as well as employee rights.

For more information, contact your Safe Ship Management company, FishSAFE mentor or Maritime New Zealand on **0508 22 55 22** and ask to be put on the distribution list.



LOOKOUT!POINTS

1. It was very unusual for this vessel to spend the night drifting, and this was the first time the crew had done so since the watchkeeping alarm had been moved to accommodate a new seabed mapping system. The skipper had not been aware that the alarm could now be deactivated from the watchkeeping chair. Such alarms should be positioned so that this is not possible.

2. As the high level alarm never activated, the watchkeeper must have cancelled the low level alarm several times with his toes during the time he remained asleep.

3. The watchkeeper took no actions to ensure he did not fall asleep. He had had two beers and a large meal and was operating well past the time he usually went to bed. The environment was warm and non-stimulating. He did nothing to ensure he kept a proper lookout as required by Maritime Rules Part 22.5 – Lookout.



Look before you leap

A deckhand continued working with a fractured back and broken tail bone for 10 days after landing heavily on to fish bins in a hold.

THE DECKHAND WAS WORKING with other crew to unload a fishing vessel's catch in port. The workers were loading the catch into fish bins, which were then hoisted out of the fish hold by a crane.

During the loading, the deckhand climbed part way out of the hold to pick up some gloves and then dropped back down into the hold without first checking below. He landed heavily on top of four fish bins that were stacked up beneath him.

After the accident, the deckhand climbed out of the fish hold and lay down for about half an hour to rest his sore tail bone before resuming work. Over the following 10 days the injury did not improve, and was eventually diagnosed by x-ray as a fracture to the sacrum and a broken tip of the coccyx.



▲ THE FISHING VESSEL. ▲▲ THE FISH HOLD DID NOT HAVE A SUITABLE ACCESS LADDER.



View the full report online at:
www.maritimenz.govt.nz

LOOKOUT!POINTS

1. The fish hold did not have a suitable access ladder, so crew had to climb in and out of the hold using bins, boards or pure strength. An inexpensive aluminium ladder would make entry and exit much safer.

2. The vessel always berths on its port side for unloading, and the freezer truck crane always operates into the port side of the fish hold. The skipper should instruct crew to enter and exit only via the starboard side of the fish hold to minimise the likelihood of obstructions below and unloading hazards above.

3. When several people are working together in a confined space, the position of objects frequently changes without warning. It is well worth taking the time to look before you leap.

Explosion and drowning

Two ship's engineers threw themselves into the sea to extinguish flames after oxygen/acetylene cutting equipment exploded. The first managed to catch hold of a trailing securing line that was attached to the vessel, but the second man was never found.

The two engineers had been working on board the fishing vessel together with a third engineer. The trio were removing bolts at a flanged connection of the hydraulic piping on deck using oxygen/acetylene cutting equipment.

An explosive fire broke out, while using the oxygen/acetylene equipment, trapping the two injured men on the port quarter of the vessel. The first engineer suffered burns to his right arm and face, and the second engineer's clothes were set on fire. Both jumped into the sea to extinguish the flames.

One of the engineers was able to catch hold of a trailing securing line that was attached to the vessel, but the other was unable to do so. The third engineer at the stern informed the bridge of what had happened and the fire fighting and "man overboard" alarms were activated. The position of the vessel was marked on the sea plot chart and the vessel turned to attempt a rescue.

Despite a protracted search involving several vessels, the man was never found.



▲ THE CHIEF, 1ST AND 2ND ENGINEERS WERE UNDERTAKING REPAIRS TO SOME HYDRAULIC PIPING ON DECK, AT THE PORT QUARTER OF THE VESSEL, ADJACENT TO THE TRAWL RAMP AND GATE.
▶ THE FISHING VESSEL.

“ AN EXPLOSIVE FIRE BROKE OUT, TRAPPING THE TWO INJURED MEN ON THE PORT QUARTER OF THE VESSEL. ”



LOOKOUT!POINTS

1. High usage of the oxygen/acetylene equipment could have caused physical damage to the hoses resulting in leakages. Gas could also have escaped from leaking couplings connecting the tail ends of the main hoses. It is possible that unburnt gases could have formed an explosive pocket underneath the plating above the deck and been ignited by a spark or the cutting torch flame. Also, leaking oxygen may have reacted with grease or oil in this vicinity.

2. This kind of cutting equipment can be extremely dangerous and must be used with caution. In particular, it should be

remembered that to safely control the ignition of these gases, the cutting equipment must be properly maintained, and hoses should be checked for any wear and tear that could lead to leaks.

3. Leaking oxygen can be highly explosive if mixed with any grease or oil. Acetylene, being heavier than air, can form explosive "pockets" which would be ignited by a spark or contact with a hot surface. Also remember that acetylene is absorbed by cotton.

Wedged under rapids

An Australian high school student came close to drowning during a rafting accident.



THIS IS HOW THE CHANNEL LOOKED AT THE TIME OF THE INCIDENT, HOWEVER, THE ROCK ON THIS RIVER IS PRONE TO FREQUENT EROSION AND CHANGE AND THE SIEVE IS NOW GONE.

THE GROUP OF 30 STUDENTS and five adults was visiting New Zealand for a week-long skiing trip, and had also scheduled other adventure activities including guided rafting.

Before the rafting trip the students were given detailed safety briefings and skills practice before setting off in five rafts (each led by a qualified rafting guide).

The river flow was relatively low and the group successfully negotiated several Grade two and three rapids without incident. After about an hour, the group stopped and were given a safety briefing about the Grade four/five rapid (difficult/very difficult) just ahead.

The rapid was characterised by a large rock at the entrance. The guides explained that the rafts would need to go to the left of the rock and that there was a chance that they may ride up on it. The crews would need to paddle hard to get past.

The first raft went through without incident, but the second raft didn't make it to the left-hand channel and was swept up onto the upstream face of the rock, despite the crew's best efforts to get past.

Just as the raft guide ordered the crew to lean over to the right side of the raft in an attempt to free it from the rock, the raft started to flip.

The raft guide saw a crewmember begin to fall into the rapid. He tried to grab her but could not and the pair tumbled into the rapid. The raft continued to flip, spilling the rest of the crew into the water.

Most of the eight crewmembers were flung into the right-hand channel, which forced them through a natural sieve in the river, formed by a rock and outlying twigs and branches. They soon popped out the other side and were able to scramble to shore.

However, the raft guide quickly realised one team member was missing and signalled to the trip leader at the bottom of the rapid. Scrambling back along the rocks up to the sieve, the trip leader found the missing rafter wedged face down about 15 cm under the water.

Finding they were unable to free the rafter, the trip leader and another guide tied a line around the shoulder strap of his life jacket and tried pulling him clear. However, they had only a restricted angle of pull, and their force ripped the shoulder strap of the life jacket.

By now time was running out. The trip leader edged out over the water across the rock that was trapping the rafter and used his foot to push down forcefully on the rafter's back. The movement was enough and the rafter was washed quickly through the sieve, popping up on the other side.

A guide swam out to the unconscious rafter and managed to pull him up onto a rock ledge on shore about 50 m further down river.

The rafter was blue in the face, but responded to rescue breathing from the guide, regaining consciousness and starting to cough.

A rescue helicopter was called, and at this time another of the rafters, who had been momentarily caught under the sieve, began to show signs of hypothermia.

The helicopter was unable to land at the site. Both passengers were loaded while the helicopter hovered, and were taken to hospital.

Both were discharged within 24 hours.



View the full report online at:
www.maritimenz.govt.nz

LOOKOUT!POINTS

1. The river guides tore the rafter's lifejacket in their efforts to extract him. This was a difficult circumstance, but rescuers should use the option to tie a rescue line around a subject's torso wherever possible.

2. The guides were restricted in their access to the accident site. They were tugging the line at an angle that potentially forced the rafter harder against the side of the rock channel. Always anticipate angles of least resistance in moving water and whenever possible

use the natural force of the river to assist physical efforts.

3. The rafting base personnel called the rescue helicopter, but did not know whether or not it would be able to land. The helicopter arrived without winch gear and crew, expecting to be able to land. In this situation it was able to hover load, and also had space to take the second patient. When calling a rescue helicopter, predetermine whether or not it will be able to land. The rafting company has reviewed potential helicopter landing

sites at several points along the river and documented these in its Safe Operating Plan.

4. The rescue efforts of the trip leader and raft guides saved the rafter's life. River rescue is a dynamic skill that requires speed, anticipation, team work, familiarity with river environments, and the forces of moving water. Rescue skills must be practised and the ability to quickly assess options is vital.



THE SPEED BOAT HIT THE WAKA JUST AFT OF AMIDSHIPS.

High speed collision

A speed boat ploughed into an outrigger canoe (waka) that had six people on board.

One crewmember on the waka suffered severe injuries including a collapsed lung, fractured ribs, spinal fractures and lacerations to the knee. Other crewmembers suffered severe bruising.

The speed boat hit the waka at high speed despite being restricted to 5 knots by local bylaws. The collision took place within 200 m of the shore.

The helmsman had just increased power to get up to planing speed. He claimed he did not see the waka because of sunstrike.

The skipper of the waka said she saw the speed boat heading toward her vessel when it was 50 m away. She raised her oar and tried to attract the attention of the speed boat's skipper. She said the skipper did not see the waka because he was in conversation with another crewmember and not keeping a proper lookout ahead.

The speed boat hit the waka just aft of amidships. The seriously injured

crewmember was unable to jump clear before impact. Another crewmember was able to jump clear before impact thus avoiding serious injury and possibly being killed.

The speed boat rode over the waka and came to rest on the other side. It is believed that some of the serious injuries inflicted were caused by the speed boat's propeller.

After the impact, the skipper of the speed boat manoeuvred to offer assistance and towed the waka back to the ramp.

LOOKOUT! POINTS

1. The skipper of the speed boat failed to keep a proper lookout.
2. The skipper of the speed boat was operating at speeds well in excess of the 5 knot maximum.
3. Speed boats must keep clear of vessels under sails, oars or paddles.

4. The waka was not carrying the correct number of life jackets.

5. This was a serious accident that could have resulted in multiple fatalities. The helmsman of the speed boat pleaded guilty to charges brought by MNZ under the Maritime Transport Act.

6. MNZ is concerned at the increasing number of high speed collisions where failure to keep a proper lookout is a major factor. MNZ urges all mariners to ensure they comply with this basic obligation.

Size does count

A large passenger vessel was forced to take evasive action to avoid a close quarters situation with a yacht.

The yacht's skipper was experienced and the vessel was returning home through the sounds in darkness after a couple of days' cruising.

The yacht was making about 8 knots and the skipper had turned off the VHF

radio to conserve its batteries.

The skipper heard a ship's horn sound. Shortly after, the horn sounded again. Looking up, the skipper saw, for the first time, a row of deck lights belonging to a large vessel. He could not make out the navigation lights and so was not sure whether the vessel was heading toward the yacht or tracking away.

After a short time, the skipper decided that they were in a crossing situation, with

the yacht crossing from port to starboard, so as to pass ahead of the larger vessel.

Although he thought there was no risk of collision, the skipper decided to turn hard to port, away from the track of the approaching vessel.

As the two vessels got closer, the larger vessel shone a spotlight onto the yacht for about a minute. They passed at a distance of about 100 m.

LOOKOUT!POINTS

1. The crew of the larger vessel had seen the yacht and had slowed down to avoid a close quarters situation. Mariners of smaller craft are reminded that they must keep clear of vessels more than 500 gross registered tonnes when operating in harbour limits (a distance of 500 m ahead of ships and 100 m to the side should be treated as a minimum). Larger vessels can have difficulty keeping clear where there is a lack of sufficient sea room. As the crossing vessel, the yacht was also required to keep clear.

2. A water-borne inspection of the larger vessel's navigation lights at

night showed they were not positioned dead ahead, however, the vessel's two masthead lights were clearly visible. As a forward masthead light is lower than the after masthead light, the approximate direction of the vessel should have been discernable when viewed from ahead.

3. Two prolonged blasts were sounded by the large vessel – this was in breach of Maritime Rules Part 22.34 (4). The correct warning for such a situation is at least five short and rapid blasts.

4. The larger vessel had just left port and was required to give a departure report

via VHF radio. If the skipper of the vessel had left his VHF radio running, he would have been aware the larger vessel was heading toward him.

5. A continuous radio watch must also be maintained by commercial vessels (and pleasure craft should adopt the same practice) on VHF radio channel 16 – Maritime Rules Part 43.4 (2) (a) (i). This aids in better response to emergency situations. It must not be presumed that because there are other vessels in the area, you do not have to monitor these frequencies.

Dragging anchor danger

Poor anchor watch caused a fishing vessel to run aground at night.

The skipper and two deckhands had anchored the vessel for the night about one mile from the nearest land and about 0.8 miles from the nearest shallow water. It was an anchorage the skipper had used many times before and the weather was calm.

The skipper established a plot and set up a guard zone of 200 m around the anchoring position. An audible alarm would sound if the vessel shifted beyond that zone. The two deckhands then

retired to bed and the skipper settled in to keep the watch. After about 3 hours he decided to carry out some routine work in the engine room and busied himself cleaning air filters and stopping leaks.

He returned to the wheelhouse once for about 10 minutes and then returned to his maintenance work for a further 2 hours. At about 3am, the skipper was heading back to the wheelhouse when he heard the audible alarm coming from the plotter. Reaching the bridge he saw the weather had deteriorated and that the vessel had moved close to shore and was dragging her anchor.

At the same time, the skipper heard

local maritime radio broadcasting that a member of the public had reported seeing a vessel drifting inshore, and was calling for all vessels to check they were secure. Realising it was his vessel, the skipper made a radio call identifying the vessel. Minutes later it ran aground.

Fortunately there was no ingress of water and no obvious damage. The vessel was successfully refloated on the next high tide with the help of a tug and a helicopter.



View the full report online at:
www.maritimenz.govt.nz

LOOKOUT!POINTS

1. The skipper did not keep a proper anchor watch in deteriorating weather and did not realise the vessel had been dragging its anchor. If the skipper had needed to be away from the wheelhouse for extended periods, a deckhand should have been stationed on anchor watch.

2. The skipper had checked the weather forecast at the time of anchoring and it had given him no cause for concern. His poor anchor watch meant he had not noticed the weather deteriorate.



Grounding in narrow channel

A passenger vessel grounded when its skipper and helmsman lost situational awareness. The vessel had set out on a 3-day chartered voyage with four passengers on board and was heading out of a harbour.

The helmsman was navigating by GPS/chart plotter, but was also relying heavily on visual navigation and local knowledge. The skipper was busy giving the passengers a safety briefing, but was also keeping an eye on the vessel's passage.

The helmsman decided to head toward a narrow channel between the mainland to starboard and a nearby island to port. He did not set waypoints and was cruising at about 16 knots.

As evening approached, the skipper joined him at the helm and the two had a chat about the functions of the GPS equipment and how the radar display could be overlaid on the chart plotter.

Both men could make out the outline of the nearby island, and as it neared they saw a port marker lying a few metres to starboard of the vessel. The helmsman immediately realised the danger and moved the throttles to neutral. As he did so the vessel impacted the reef, running over the top and into clear water where the port engine stalled.

The helmsman attended to the passengers while the skipper inspected the bilges. Water was being taken into the aft lazarette (the storage space) but there was no flooding found in the engine room.

Returning to the bridge, the crew found the vessel had no port propulsion, limited starboard propulsion and no

▲ THE VESSEL SUFFERED SEVERE DAMAGE TO ALL RUNNING GEAR.
▲▲ THE KEEL.

steering. The vessel was anchored and the crew radioed for help. A further check found the engine-driven bilge system was only just managing to cope with the water inflow and the skipper launched the tender as a precaution.

The vessel was towed clear and back to berth by private launch and coastguard. The passengers were taken to safety by water taxi.

It was later determined that the rudder had protruded through the hull. The vessel suffered severe damage to all running gear. Propellers, rudders, shafts and struts were replaced and both gearboxes were removed for servicing.

LOOKOUT! POINTS

1. The vessel did not have a section in its Safe Ship Management documentation dedicated to safe navigation. There was no passage plan for the voyage being undertaken and the helmsman had simply opted to journey through the narrow channel.

2. There may have been some confusion as to who was conning the vessel as both the skipper and the helmsman were at the helm at the time of incident and this had not been formally discussed.

3. Both men were familiar with the area, and so were not expecting to lose situational awareness.

4. By not setting up waypoints, and cross checking with paper charts, the crew did not use all of the navigational aids available to them.

Drugs contribute to drowning



THE FISHERMAN AND HIS COMPANION BORROWED THE KAYAK.

A fisherman drowned after using a kayak to string a long fishing line out from shore for about 1 km. The body was recovered and the blood toxicology report identified enough methamphetamine to have contributed to the accident.

No-one saw the accident occur, but the drug may have caused mental confusion, exhaustion or muscle cramps.

The fisherman and a companion had borrowed the kayak from a neighbour and driven to a remote launching area. The plan was for the companion to pay out the line from shore, while the fisherman headed straight out to sea in the kayak. At about 1 km out, the fisherman would anchor the line with sand bags and then attach short lines along its length as he progressed back to shore.

The fisherman wore a lifejacket, but both men had left their cellphones in the car.

The fisherman set off in the kayak, paddling strongly until he was far enough



THE SEA CONDITIONS WERE GOOD.

away that his companion on the shore could make out only a small patch of colour where the kayak was. A passerby also reported seeing the fisherman paddling away. The sea conditions were good.

After a time, the companion saw the line was no longer being fed out. About 20 minutes later he felt the kayak was not getting any closer and ran to nearby houses to raise the alarm.

The fire service, police, local surf life saving team and a nearby private vessel all took part in the search. When the

“THE FISHERMAN WORE A LIFEJACKET, BUT BOTH MEN HAD LEFT THEIR CELLPHONES IN THE CAR.”

fisherman's body was found, his head was being kept above water by his life jacket, but he had already drowned. His face was towards the wind and waves were lapping into his mouth. The kayak was found to be about two-thirds full of water.

It would have been impossible to reboard, and it is thought the fisherman may have exhausted himself trying.



View the full report online at:
www.maritimenz.govt.nz

LOOKOUT!POINTS

1. The use of kayaks to set fishing lines from beaches is becoming increasingly common. Always ensure the craft used is suitable in design and construction for the conditions.

2. Preferably do not go out alone. If you are alone, do not venture too far out as you may have to swim back to shore.

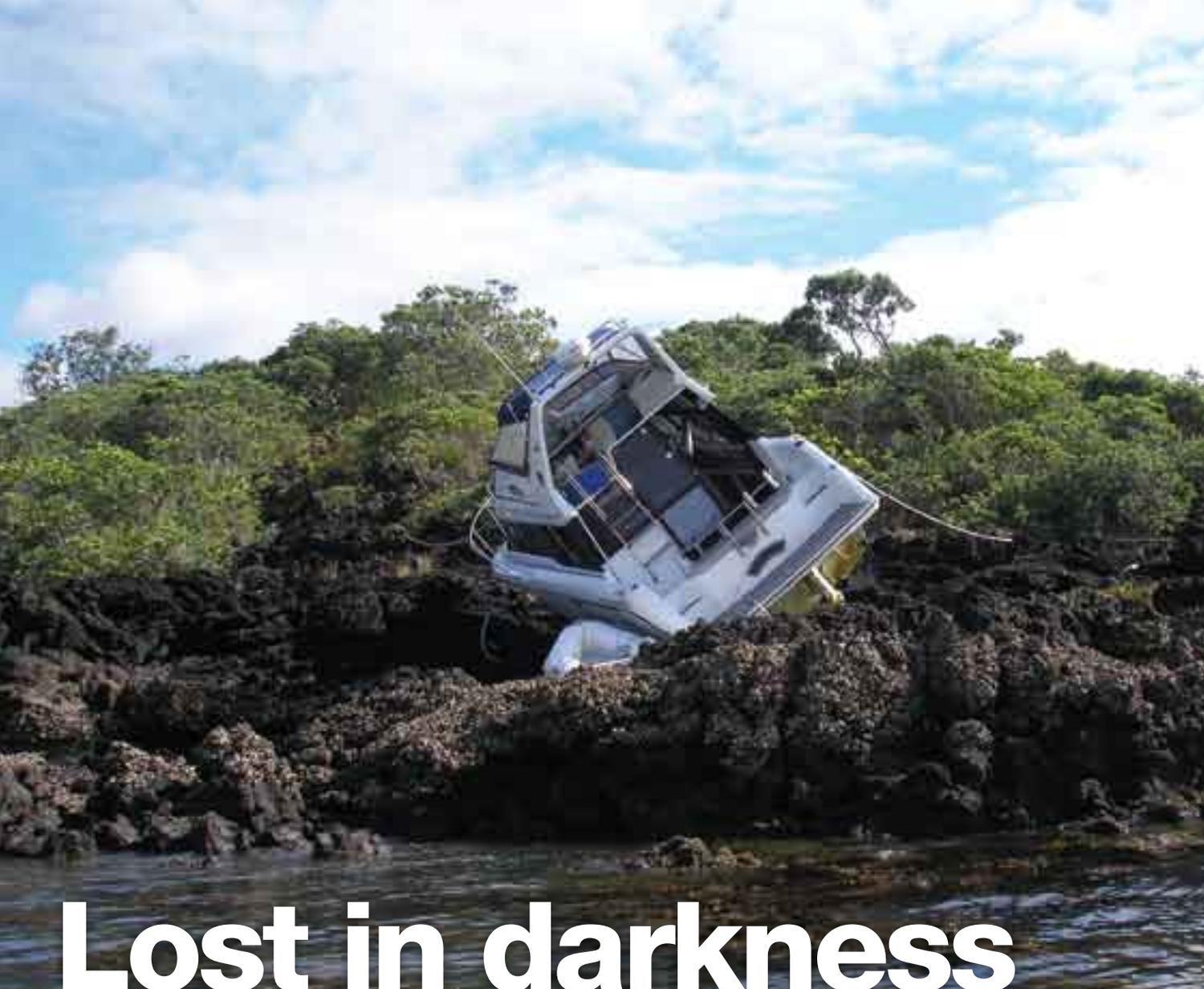
3. Always carry communication equipment to raise the alarm, such as smoke flares and a radio or cellphone sealed in a plastic bag.

4. Carry safety equipment, such as a life jacket and waterproof clothing. To reboard a swamped kayak would require a spray skirt, paddle float and pump. Always ensure you have the skills to reboard in the conditions you are likely

to meet on the sea. A recognised kayak course can teach you these skills.

5. Have someone on shore who knows what to do if you do not return at an agreed time.

6. Never use drugs or alcohol when operating any type of craft as this will impair your judgement and ability to respond to difficulties.



Lost in darkness

A skipper drove a 10 m motor launch straight onto rocks after losing situational awareness in darkness.

The skipper had decided on a late night voyage from a suburban marina to a nearby island after sharing dinner and a bottle of wine with his partner.

It was a calm night, and the pair had originally planned to make the trip in the morning. However, once he was

away from the lights of the built up area, the skipper realised the night was pitch black and decided instead to anchor in a nearby bay for the night.

As the vessel motored toward the bay at about 25 knots, the skipper noticed that the chart plotter screen had frozen. While he was engrossed in resetting the plotter, the vessel ploughed up onto a rocky shore.

The skipper was thrown against the steering console, and his partner was thrown against the windscreen. Both

THE VESSEL PLOUGHED UP ONTO A ROCKY SHORE.

sustained moderate injuries. The impact sent both of their cellphones flying, and they could not find them in the dark. The VHF radio would not work and the pair were forced to spend the rest of the night on the rocks waiting for help, which did not arrive until day break.

LOOKOUT!POINTS

1. The skipper was engrossed in resetting the chart plotter, and was distracted from keeping a proper lookout. In a low visibility situation, such as this, the skipper should have slowed or stopped the vessel until he was certain of its position.



Quick jump to safety



▲ DAMAGE TO THE TRANSON OF THE PLEASURE BOAT.
 ▲▲ THE CHARTERED FISHING VESSEL.

Three people leapt into the sea from their anchored pleasure boat as a chartered fishing vessel bore down on them.

All three were uninjured thanks to their quick decision to jump for safety. The fishing vessel struck the pleasure boat causing extensive damage including internal structural cracks, a damaged transom, loss of the auxiliary outboard engine, damage to the gearbox and bilge pump, and the loss of personal items including fishing rods and a wallet.

The fishing vessel had been on a fishing charter, taking six passengers to various locations within the fishing grounds. At mid-afternoon, the skipper prepared to return the passengers to port. He set a course on the autopilot and set off at about 7.5 knots maintaining his lookout from a seated position in the wheelhouse.

The vessel was equipped with a radar but this was not switched on.

Although the sun was glinting off the sea, it was not in the skipper's eyes.

Spray coming over the bow may have reduced his visibility.

About 20 minutes into the return journey, the fishing vessel hit the pleasure boat. The skipper felt the impact, stopped the vessel immediately and rendered assistance to the three people in the water.

Well before impact, the three people in the pleasure boat had seen the fishing vessel heading toward them and had assumed it would alter course. Their boat was at anchor and by the time they realised that the fishing vessel was not going to give way, they did not have time to start the engine. The pleasure boat was not displaying an anchor signal.



View the full report online at:
www.maritimenz.govt.nz

LOOKOUT! POINTS

1. The skipper of the fishing vessel could not explain why he did not see the pleasure boat, however, it was his responsibility to maintain a proper lookout.

2. When keeping lookout, get up frequently from any seated position. Moving about will help ensure the view is not obscured by window frames or the boat's fittings. Consider using available

radar and binoculars to scan the horizon. Maritime Rules Part 22.5 Collision Prevention requires that a proper lookout be maintained by sight and hearing, as well as by all available means appropriate such as a radar.

3. Skippers of small vessels at anchor should be aware that they are not always easy to see. Be ready to start the engine at short notice. Rig the anchor warp so

that it may be slipped in an emergency. Carry a sound signal and flares. Display an anchor signal by day and an all-round white light by night. A vessel of less than 7 m in length at anchor, not in or near a narrow channel, fairway, anchorage or where vessels normally navigate, is not required to exhibit the shape prescribed for a vessel at anchor.

“ IT WAS FORTUNATE THE SWIMMER’S INJURIES WERE NOT FATAL. ”



High speed strike

A PWC (personal water craft like a jet ski) struck a swimmer at a popular beach, breaking his shoulder blade and knocking him semi-unconscious.

The skipper of the PWC immediately circled back to the swimmer who was floating face down in the water and dived in to assist. Coastguard vessels arrived on the scene and took the swimmer to the beach. He was taken to hospital by ambulance and discharged after 2 days with a fractured right scapula and three fractured ribs.

Numerous reliable witnesses said the PWC was being driven within the

designated 200 m zone marked by yellow regional council buoys.

Despite the evidence of witnesses the skipper of the PWC and his passenger denied being within this zone, inside which no craft was allowed to operate at more than 5 knots.

Skippers of all vessels have an obligation to keep a proper lookout for swimmers and other vessels and to operate at a safe speed at all times regardless of where they are. It was fortunate the swimmer’s injuries were not fatal.

The skipper pleaded guilty and was convicted of charges bought by Maritime New Zealand under the Maritime Transport Act.



▲ PERSONAL WATER CRAFTS ARE OFTEN REFERRED TO AS JET SKIS.
▲▲ THE BEACH IS A POPULAR SWIMMING BEACH WHERE YELLOW BUOYS MARK THE DESIGNATED 200 M LINE. THESE ARE CLEARLY VISIBLE TO VESSELS, SWIMMERS AND PEOPLE ON THE BEACH.

LOOKOUT!POINTS

1. The skipper of the PWC did not keep a proper lookout of the waters in front of the vessel. He said his sunglasses had some sea spray on them, and there was also some sun strike. He was also periodically turning around to see where a companion, also driving a PWC, was located.

2. Given his proximity to the 200 m zone (whether within or just outside it), the driver was not operating at a safe speed that would have allowed him to take action to avoid a collision.

3. The skipper contravened local bylaws requiring the PWC not be operated in excess of 5 knots within 50 m of a person in the water and operating in excess of 5 knots within 200 m of the shore.

Commercial accidents and incidents

Fourteen fatalities and 331 accidents and incidents involving commercial vessels were reported to Maritime New Zealand (MNZ) during the 2004/2006 year period. There were also 157 reports of serious harm to seafarers or passengers.

In general the trend in numbers of reported accidents has been increasing over time. This trend is common across all maritime sectors.

Reported accidents involving fishing vessels have increased 40% since 2004. The fishing vessel population has increased by 15% during the same period.

There was a significant increase in the rate of accidents in the non-passenger sector during 2005. This is believed to be, at least in part, due to increased awareness of reporting obligations across the sector.

A total of 331 accidents were reported between July 2005 and June 2006 – an increase of 76 accidents from the previous year.

Accidents in this period demonstrated an expected trend of peaking in the summer season, most likely due to increased activity on the water.

Fishing vessels

There were 54 reported accidents involving fishing vessels in 2005/06 – up from 38 on the previous year.

SOLAS vessels

A total of 100 accidents were reported in 2005/06. This is a substantial increase from the 39 accidents reported in 2004/05.

Passenger vessels

A total of 95 accidents were reported in 2005/06 compared to 73 reported during the previous year.

The general trends for 2004/05 and 2005/06 were very similar, demonstrating a peak in the March quarter with 35 and 38 accidents respectively. This peak in the warmer months is likely to be due to an increase in operating hours over this

period as passenger vessels typically have the highest degree of seasonal variation in operating hours.

Non-passenger vessels

Non-passenger vessels reported 33 accidents in 2005/06. This is up from the 22 reported in 2004/05.

Adventure tourism

Adventure tourism (jet boating and rafting) recorded an increase during 2005/06 with 16 reported accidents compared to 10 the previous year.

Types of accident

The foremost accident/incident type reported by passenger vessels was close quarters, followed by machinery failure, groundings, and collisions. This differs from the previous 3 years in which collisions were either the main or the second most reported accident.

The predominant accident/incident reported by fishing vessels was machinery failure, followed by groundings, close quarter incidents, and then flooding. The number of groundings in this sector has decreased substantially from the previous year.

Machinery failure was the leading accident/incident reported by international vessels, as it has been for the previous 3 years. Close quarter incidents, followed by rope/gear failures and fire were the next most common types of accident/incidents reported by international vessels.

Non-passenger vessels reported machinery failure most often in 2005/06, followed by collisions, and groundings.

The adventure tourism (jet boating and rafting) sector reported collisions, followed by machinery failure and groundings.

Fatalities and serious injuries

There were a total of 15 fatalities for 2005/06 – an increase from the 9 fatalities reported the previous year.

The highest number of fatalities occurred in May with seven, as a result of the loss of the *Kotuku*.

Statistics for serious injuries on fishing vessels have been consistently high over the past 6 years. This can be partially attributed to an increase in skippers or owners reporting the accidents to regulators. However, it can also be attributed to the demanding working environment of this sector. Commercial fishing vessels report the highest hours of operation with an average of 41 hours per week.

The number of work-related injuries on international vessels has increased to 18, up from 10 the previous year.

There were 11 work-related serious injuries on board passenger vessels, a considerable decrease from the 24 reported in 2004/05.

Non-passenger vessels reported 10 serious injuries, up from the 6 reported in 2004/05.

Adventure tourism (other) reported three serious injuries, down from the 12 reported in 2004/05.

MORE INFORMATION

You can download the full report: *Commercial accidents & incidents – statistical summary & analysis 2004-2006* from the “Publications” section (see Accident reports & publications) of the website: www.maritimenz.govt.nz



Kiwis join *Pasha Bulker* rescue effort

Oil spill experts from Maritime New Zealand's Marine Pollution Response Services (MPRS) say the grounding of the 40,000-tonne coal carrier *Pasha Bulker* during Sydney's storm events further strengthened New Zealand's close working relationship with Australian authorities.

The Panama-registered carrier ran aground on Nobby's Beach in wild weather on 8 June as she waited to load 58,000 tonnes of coal from Newcastle Port. She was already carrying 700 tonnes of fuel oil, 38 tonnes of diesel and 40 tonnes of lube oil.

The Australian Maritime Safety Authority (AMSA) called upon their kiwi neighbours to offer additional expertise on the ground, both in a participating and observing capacity, during what has been described as Sydney's worst storm in nearly a decade.

General Manager of MPRS, Nick Quinn, says their team jumped at the opportunity to work with AMSA following a call at the height of the alert phase when the Australians feared up to five vessels could possibly run aground.

New Zealand is part of the International Convention on Oil Pollution Preparedness, Response and Cooperation.

"If New Zealand had a situation like that, we too would be calling upon our trans-Tasman neighbours for assistance," said Nick.

"It was great to see our reciprocal relationship swing into action and this reinforces our close ties with AMSA in these situations – the experience is invaluable and the cross pollination of trained responders is healthy for both countries."

Oil spill responders, Scott Read and Mark Cavanagh, joined Nick at Nobby's Beach together with two national response team members, Marlborough Harbourmaster Alex van Wijngaarden and Auckland Regional Council's Mick Courtneil.

"The grounding and possible oil spill from the *Pasha Bulker* had been confirmed, but there were several other vessels struggling due to adverse weather conditions," explained Nick.

"Fortunately, they managed to stay out of harm's way which meant we could focus solely on the *Pasha Bulker*," he said.

The team worked in the incident command centre and also with the various field teams deploying environmental protection equipment in support of the response effort. Public interest remained high given the close proximity the carrier was to the beach.

The *Pasha Bulker* was successfully refloated 3 weeks after the grounding with no harm to the environment.

MORE INFORMATION

For more information about Maritime New Zealand's role in oil spill response, see the "Environmental protection" section of the website:

www.maritimenz.govt.nz

“IF NEW ZEALAND HAD A SITUATION LIKE THAT, WE TOO WOULD BE CALLING UPON OUR TRANS-TASMAN NEIGHBOURS FOR ASSISTANCE.”



▲ THE SHORE LINE TEAM DEPLOYING BOOMS.

▲▲ AN EQUIPMENT STAGING AREA WAS SET UP ON THE BEACH WITH CREW ON IMMEDIATE STANDBY FOR A POSSIBLE RELEASE OF OIL INTO THE WATER.

▲▲▲ THE PASHA BULKER RUN AGROUND.

Safety Bulletins

Maritime New Zealand publishes safety bulletins as a means of communicating and encouraging dialogue on a variety of safety issues and proposals relating to these. The bulletins are published as and when required, and are directed to those sectors directly involved. We welcome any comment you may have on the recommendations or content in general. The bulletins produced to date are listed below, with a brief description of the two latest issues.

Latest issues

Lifting slings, loose gear and dunnage June 2007 Issue 12

This safety bulletin describes and highlights the cause of two accidents and recommends how to prevent the reoccurrence of similar accidents.

An accident on board a cargo vessel discharging flat steel bars in Wellington Harbour in September 2006 injured one of two stevedores in the cargo hold. The accident could have resulted in two fatalities.

A similar accident happened on a vessel carrying the same cargo in January 2007; however, the stevedores in the hold were not injured.

Cargo vessel cranes – Examination and renewal June 2007 Issue 11

The purpose of this safety bulletin is to highlight crane wire mechanisms of failure and recommend that both renewal and examination regimes on board vessels need to be improved in order to better prevent accidents.

Within the last 7 years in New Zealand 18 accidents have been reported involving the failure of ships' crane wire ropes. This alarming statistic is highlighted by the most recent of these accidents.

In November 2006 at Mount Maunganui a cargo crane wire rope parted on board a general cargo vessel while unloading. This resulted in the loaded cargo grab falling into the hold of the vessel.

Past issues

Liferafts and their release mechanisms
May 2007 Issue 10

Manpower and responsibilities during mooring operations
April 2007 Issue 9

Mooring line hazards: Bights and snap-backs
April 2007 Issue 8

Freeing port covers on fishing vessels
February 2007 Issue 7

Safe operation of Mitsubishi heavy industries hydraulic deck cranes
May 2006 Issue 6

Low sulphur diesel fuel
November 2005 Issue 5

Ammonia leakage on fishing vessels
October 2005 Issue 4

Bulletin for operators of road vehicles and floating barges
October 2005 Issue 3

Recommendations for ships carrying fumigated bulk cargoes
September 2005 Issue 2

Senhouse slips used in mooring systems
August 2005 Issue 1

For more information you can:

- download the safety bulletins from the website: www.maritimenz.govt.nz
- email us at: enquiries@maritimenz.govt.nz



Feedback

Your feedback and ideas on *Lookout!* are very welcome.

If you'd like a particular topic covered in our next issue, contact us by email: publications@maritimenz.govt.nz or phone **0508 22 55 22**.

From 1 January
to 31 July 2007

09

MARITIME FATALITIES 2007

From 1 January to 31 July 2007, there were **nine** fatalities – **two** in the **commercial sector** and **seven** in the **recreational sector**.

 **MARITIME**
NEW ZEALAND

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