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Welcome to the latest issue of Maritime New Zealand’s quarterly Lookout! publication featuring the lessons to be learnt from maritime accidents or incidents.

You may be interested to learn that this year’s World Maritime Day (to be celebrated around the globe in late September) will celebrate 60 years in the service of shipping.

World Maritime Day was created by the International Maritime Organization (IMO) to publicly draw attention to maritime issues such as safety, security and sustainability.

This year’s theme is a fitting one given New Zealand’s proud maritime history and the huge impact that sea-going transport has had on the development of our nation. The movement of people and cargo by sea is every bit as important today as it was when the first seafarers crossed the ocean and discovered Aotearoa.

MNZ plans to mark the day on 26 September, in recognition of the significant impact the shipping sector continues to have on New Zealand.

The diversity of New Zealand’s maritime sector is reflected in the stories in this issue of Lookout! which include a yacht in a near miss with a large cruise ship, a collision between a mud barge and a launch, and a couple of fishing crew accidents leading to some nasty injuries.

While there are stories with tragic endings, it is always encouraging to read about the positive outcomes when things go wrong. Well-rehearsed safety procedures led to the quick rescue of a crewmember swept overboard from a trawler (page 8), and a fast response by emergency services to a boat capsize with six on board was possible because the grandfather and skipper was well-equipped (page 13).

In this issue, there is also an overview of what’s involved in accident reporting with a reminder to be sure that you have the most recent version of the forms (page 17); and a summary of MNZ’s latest safety bulletins and guidance notices (page 16).

Do pass on this copy of Lookout! to your colleagues and crew or contact any one of our offices if you’d like more copies. If you’re interested in more detailed accident reports or safety information, check out our website: www.maritimenz.govt.nz.

Catherine Taylor
Director of Maritime New Zealand
Looking out and watching over

“Each accident tells its own story” says Chief Executive, Transport Accident Investigation Commission, Lois Hutchinson, as she explains the work of the Commission and its powers to launch inquiries.

Folk who have experienced transport-related accidents or incidents may feel set upon by bureaucratic paparazzi all clamoring to know what happened. Accidents tend to play out in public, and sometimes, involving bystanders in their dreadful consequences. This propensity alone will attract an array of potential actions from state agencies each with their own particular mandate requiring some action on their part.

In New Zealand there are at least four mandated agencies entitled to ask questions about transport accidents in general. These are the Regulator, the Police, the Coroner and the Transport Accident Investigation Commission (the Commission).

The Regulators and the Commission

In terms of roles the Regulators and the Commission share a common purpose – that of improving transport safety. In this respect we complement each other. However, our tasks are quite different.

The Regulators’ concerns are proximal to the day-to-day operations of their respective modes with a focus on safe behaviors, safe systems, compliant vehicles, vessels or aircraft, whereas the Commission’s focus is more distal, its interest activated only after the safe system has failed, sometimes, involving bystanders in their right to silence and cannot self-incriminate, unless they themselves choose to “go public”.

You will encounter the Commission, often alongside the Regulator, and sometimes the Police, when an adverse event has occurred that the Commission believes the circumstances of the event have, or are likely to have significant implications for transport safety, or may allow the Commission to establish findings or make recommendations which may increase transport safety.

This approach assumes the knowledge obtained through inquiry will benefit the wider system of practice. Discrete accidents and incidents are rich fields of learning because similar outcomes may be the emergent result of quite diverse contributing factors. Each accident or incident tells its own story which may have common elements, or not.

It is the Commission’s task to reveal the differences so new learnings may advance overall understandings about similar types of events.

“No blame” accident investigation

The Commission is often referred to as New Zealand’s independent accident investigation agency. This reference comes out of requirements on New Zealand, having ratified the International Convention on Civil Aviation (ICAO) and the International Maritime Organization Convention, to have “no blame” accident investigation capability. Here “no blame” means non-prosecutory functions. The Commission is not an adversarial agency, it is an inquisitorial agency.

The Commission is a standing Commission of Inquiry. Its terms of reference are its statute, the Transport Accident Investigation Commission Act 1990 (TAIC Act). The Commission derives its powers of inquiry pursuant to section 11 of the TAIC Act, from the Commissions of Inquiry Act 1908. The Commission conducts its inquiries through factual investigation, and may hold hearings, although it has not been its practice to do so.

All the provisions of the Commissions of Inquiry Act apply to the Commission except those provisions allowing the Commission to award costs. This makes for a powerful entity supported by statute to make whatever inquiries it thinks it needs to make to get at the truth.

The Commission prefers not to rely on all its powers when conducting inquiries. It is exercising specific powers when investigators arrive at a site, undertake interviews, collect evidence and so forth. It can do other things like seize evidence, retain records, enter premises, restrict or prohibit access to evidence or a site, and subpoena witnesses. Investigators are warranted to exercise these powers of entry and seize as they believe appropriate.

Bound by protected disclosure requirements

There are constraints on the Commission. While it has strong administrative powers of State to support its inquiry function, it is limited in who it can itself speak to or share information with. The Commission is bound by protected disclosure requirements where affected parties who choose to speak to the Commission can do so with the full confidence that their express comments cannot be disclosed to others without their permission. This is a permanently binding duty on all members and staff of the Commission, and once the Commission treats seriously. This ensures affected parties conserve their right to silence and cannot self-incriminate, unless they themselves choose to “go public”.

Some transport sector commentators believe the Commission should hold all its inquiries (Investigations) in public. It is the Commission’s practice to hold inquiries in camera.

In part this is because the protected disclosure requirements make it difficult for the Commission to ensure it is not revealing disclosures unwittingly by the line of questioning it undertakes. Also it can be difficult not to lapse into adversarial behaviours when the environment takes on the form of a court. It is also expensive to hold hearings of any form.

However, the Commission does believe in open government and being accessible. Over the last 2 years the Commissioners, Chief Commissioner...
A yacht was involved in a near miss with a cruise liner after it circled in the path of the ship.

The yacht was motor-sailing under headsail and engine, and was towing a tender.

While the pilot was boarding the ship, the bridge team observed the yacht’s track and assessed that it would pass clear ahead. The ship increased speed to 10 knots as control was passed to the pilot.

As the ship closed on the yacht’s port quarter, the pilot sounded five short and rapid blasts to alert the yacht’s skipper to the ship’s presence.

At the same time, the tender the yacht was towing came free and started drifting very fine to starboard of the ship’s intended track. The yacht turned to port and the bridge team assumed it was positioning to pass down the port side of the cruise liner to recover the tender after the ship had passed. But the yacht stopped and furled her headsail. By now she was just 300 m ahead of the ship.

The pilot called on VHF radio to clear the yacht from the ship’s path. The yacht turned again, coming head-on to the ship. It was now in imminent danger of a collision.

The pilot sounded a further five short and rapid blasts and the yacht turned and passed within 15 m of the ship’s starboard side. The pilot ordered a starboard helm correction to help swing the ship’s stern away from the yacht.

Hon Bill Jeffries, Deputy Chief Commissioner Pauline Winter and Commissioner Bryan Wyness, have endeavoured to get out into transport communities to better understand issues before them.

They have visited Milford Sound to gain a direct understanding of unique climatic conditions in the Sounds and the impact on the tourist vessels operating in the Sounds. They have spent a day with crew on the Interislander Ferries to better understand sailing conditions in the Strait, and they have travelled the Auckland Rail network. They also will receive oral submissions from affected parties.

**A more active Commission**

Looking ahead you will experience a more active Commission. It is consolidating its position as systems inquirer looking into the performance of safety systems – are they performing appropriately? The Commission is already watching over reported accidents and incidences in the transport sector (not road).

Remember it has the discretion to launch inquiries where it believes the circumstances may have significant implications for transport safety, or might make findings of recommendations that may increase transport safety. Patterns and trends in particular types of events may hold our interest.

If seemingly low level incidents persevere, or circumstances change elevating the risk of a particular type of adverse event then the Commission may choose to investigate. We may not investigate every occurrence but will reserve the Commission’s prerogative to investigate if new information comes to light, or on the next reported occurrence. In this way, the Commission provides active feedback to the transport community, and the public at large on the state of the affected transport system.

Whether or not you agree with the Commission, at the very least, at every level, the Commission’s work should prompt personal inquiry as to the safety of one’s own systems – vessel, organisation or regime, under similar conditions.
Difficulty berthing against a strong tidal stream led to a collision between two commercial passenger ferries.

The master of the first vessel was attempting to berth after the second trip of the day. During the first trip a strong tidal stream had made berthing difficult.

When berthing at the chosen pier, a short fixed line must be placed over the top horn of the door cleat, which requires the vessel to be close alongside. There was a second line available, but on a previous trip the master had noticed this line had been cable tied, and had assumed that meant it was not to be used.

On this occasion the master was struggling to get close enough to use the short line. After making three approaches he directed a crewmember to use a dock line from the vessel instead.

The crewmember tried three times to get that line onto the bollard, but each time the vessel was swept away by the tidal stream. On the fourth attempt the line was secured, but was too long, stretching about 2 or 3 m from the bollard to the vessel’s door cleat. The master attempted to manoeuvre forward and reverse to bring the vessel in closer, while the crewmember attempted to shorten the line. As the master was using the wing controls, they were awkwardly trying to work in the same confined space.

The master had applied considerable power when he noticed the line start to slip. Realising he was in danger of being hit by the loose end, he stepped back out of the way and lost control of the vessel, which surged forward in the tidal stream.

At the same time a second passenger ferry had begun positioning for the berth behind and the two vessels collided before the master of the first ferry could reverse it clear.

It was a violent impact, however, there were no injuries and both vessels were subsequently berthed successfully.

"REALISING HE WAS IN DANGER OF BEING HIT BY THE LOOSE END, HE STEPPED BACK OUT OF THE WAY AND LOST CONTROL OF THE VESSEL, WHICH SURGED FORWARD IN THE TIDAL STREAM."

1. Operations need to be tailored to the conditions. The crew knew of the prevailing conditions but had to amend their normal procedure “on the fly”.

2. Don’t be afraid to pull back from a situation which isn’t working, reassess the problem and think about the issues before trying again. A delay to the vessel with a safe arrival is better than a collision.

3. Though events were moving quickly, had the master of the other ferry been aware of the difficulties being experienced he could have stood clear until the berthing operation had been completed. Communication is vital.
An experienced yachtsman apparently drowned while trying to cross a harbour in a small powered dinghy.

Earlier in the day the yachtsman had sailed from the marina to dry dock for maintenance. He then returned the 15 km to his car, by taxi, only to discover he’d left his car keys back at the yacht.

The yachtsman set off from the marina in his dinghy to return home directly across the harbour rather than take another taxi ride back to retrieve his keys. He was not wearing a lifejacket, and had no waterproof communications equipment on board.

As he made his crossing, the yachtsman was seen by witnesses who described the waves as 1.5 m high, with breaking crests, and winds gusting up to 22 knots. The stretch of harbour that the yachtsman was last seen in is noted for steep, standing seas when the wind opposes the tide.

Family members became concerned when the yachtsman did not come home that afternoon, and the police were called later in the evening. Initially police began a shore-based search, expecting that the yachtsman would be travelling home by car. It was not until the next morning that searchers realised the yachtsman may have tried to cross the harbour by dinghy.

Later in the morning a Coastguard search found the dinghy, some equipment and some of the yachtsman’s clothing along the shoreline. The yachtsman’s body was found washed up on an island within the harbour 11 days later.

Inconvenience leads to tragedy

1. The yachtsman had made the crossing in a powered dinghy several times before. On this occasion he was not wearing a lifejacket. A lifejacket was later found locked in his car at the marina. All people who operate boats, including tenders, are required by law to carry lifejackets for each person.

2. He carried no means of communication. A cellphone in a zip-lock plastic bag and kept in a clothing pocket, or a waterproof hand-held VHF radio would have allowed him to raise the alarm. A red flare would almost certainly have been seen.

3. It is not known whether the dinghy was equipped with a bailer. In the seas described, it is likely that water was shipped into the dinghy. Without a bailer, the dinghy would have rapidly lost stability and swamped.

4. Small dinghies of this type are suitable only for sheltered, calm waters. Eighty-five percent of boating fatalities occur in boats less than 6 m in length.

5. Nearly all fatal pleasure boat accidents involve one of the following factors – no lifejacket, no way to communicate distress and bad weather. This tragedy involved all three.
Overboard but safe

A crewmember was swept overboard from the stern of a fishing trawler in 3 m seas.

The crewmember was working aft in readiness to haul in the net when a large wave hit the stern of the ship and the crewmember was lost overboard.

Immediately, the master and crew responded, following well-rehearsed safety procedures.

Three liferings were thrown to the crewmember in the water, and the master made a radio call to all vessels in the vicinity, alerting them the vessel had a man overboard. He then brought the vessel hard to starboard while the crew got the lifesaving equipment ready.

Within 5 minutes the crewmember, who was wearing a lifejacket and hard hat, was spotted on the ship’s foreside. The crew threw him a line, and he was brought safely back on board. He was warmed, and within an hour had fully recovered.

“IMMEDIATELY, THE MASTER AND CREW RESPONDED, FOLLOWING WELL-REHEARSED SAFETY PROCEDURES.”

1. This is a good example of a well-trained crew saving the life of their crewmate. Safety drills must be repeated regularly so that they can be carried out swiftly and automatically if ever needed. There is strong evidence that not enough vessels carry out safety drills. Fatal accident statistics show that once a person is in the water, a lack of safety equipment and emergency planning is a major contributor to the death.

2. The crewmember was wearing a lifejacket and a hardhat – the correct personal protective equipment for the role he was undertaking.
No communications, no position reporting, no rescue

Two crewmembers spent between 11 and 14 days clinging to life before dying at sea in a fishing vessel’s liferaft. The vessel and its skipper were also lost at sea.

While the crew drifted on board the liferaft, a massive aerial and sea search was underway, co-ordinated by the Rescue Coordination Centre New Zealand.

Sadly, due to a complete lack of position reporting, and a long delay before the alarm was raised, the search could not be centred on an accurate last-known position. The vessel’s 121.5 MHz beacon did not activate, and no distress message was received via VHF radio. Neither the fishing vessel, nor the liferaft were equipped with a 406 MHz beacon.

The liferaft was found 2 days after the official search had been suspended by a helicopter pilot on a sightseeing flight. The fishing vessel and the 52-year-old skipper’s body have never been found.

The skipper made no contact with the owner throughout the voyage, and as the holder of only an Inshore Fishing Skipper’s Certificate, was not properly qualified to carry out the intended trip.

Both of the vessel’s crew had some experience, but neither was formally trained.

The vessel departed with only a casual expectation from its shore-based owner of where it was going and when it would be back. It was stocked with food, fuel and freshwater provisions for 10 days, but the owner had calculated that with extra tinned supplies and fish, it could be away for up to 14 days.

The skipper made no contact with the owner throughout the voyage, and made no scheduled radio calls to any person on land. Two text messages and a social cellphone call received from the vessel early into its voyage were the only communications made. A small number of sightings were made of the vessel, but these too were early into its voyage.

This lack of communication and position reporting meant that when the owner raised the alarm, some 14 days after the vessel left port, there was very little firm information on which to base the search.

Analysis of the salvaged liferaft suggested it had been in the water for between 3 and 4 weeks. The two crewmembers were thought to have died some 7 to 10 days before the liferaft was found. It is not known what happened to the fishing vessel.

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

1. The owner did not maintain contact with the vessel after she left port, and had no firm idea of how long she would be away. As a result, the alarm was not raised until 14 days after the vessel left port.

2. The skipper made no regular position reports, and left no information as to where he was intending to fish. With no firm last known position, search efforts were significantly hampered.

3. Neither the fishing vessel nor the liferaft carried a float-free 406 MHz beacon, which would have pin-pointed the position of the survivors.

4. The crewmembers were likely to have spent several days alive in the liferaft. Survival courses are a common sense tool that anyone going offshore should consider.
An 800 tonne mud barge was preparing to pass under a major traffic bridge at night when the master realised a large recreational launch was approaching on an almost reciprocal course.

As the two vessels closed, the launch altered course to port and aimed straight at the barge.

The master of the barge could not alter course without colliding with a bridge span, but was able to cut the engines. The launch struck the barge’s port and then starboard bow before passing down her starboard side.

Both vessels were stopped and the launch’s pumps were employed to keep her afloat despite substantial structural damage and water ingress. The 15 partygoers on board were safely transferred to a Coastguard vessel.

Despite excellent visibility from the helm position, the skipper of the launch did not see the barge before the collision. It took several seconds after the impact before the skipper identified the barge’s aft navigation lights and realised what had happened.

The launch was a total loss. There was no damage to the barge.

1. Inspection showed the barge was not displaying the correct forward navigational light. Despite this, the skipper of the launch did not keep an effective lookout. The skipper of a nearby vessel said although the barge was not brightly lit, it would have been visible to a vigilant watchkeeper.

2. The barge had right of way as a vessel over 500 tonnes operating within harbour limits. The launch skipper was obliged to take particular care in an area where other vessels could reasonably be expected. He should have specifically instructed his crewman to keep a lookout, turned the music off on the bridge, used the bridge window to check before turning to port, and sounded two short warning blasts before altering course.

3. When operating at night, all mariners should maintain a particularly vigilant lookout.
Although all hatch covers on the vessel had been documented as hazards, the crew had not latched the cover. A fishing vessel at sea is a moving platform and all moving objects should be secured.

A crewmember’s hand was crushed when he lunged to stop a hatch cover from falling on a crewmate.

The pair had been using a pneumatic rattle gun to remove excess rust from a hatch cover on the forward wet deck of a fishing vessel. They had lifted the hatch cover to work on the hatch combing.

When open, the hatch cover would normally have been secured by a line to a foredeck support behind it, however neither crewmember had done so.

As the vessel heeled in the sea, the crewmember on the deck saw the hatch cover begin to fall. Realising it would fall on his crewmate, the crewmember lunged out to try and catch it. His left hand was caught between the falling hatch cover and the combing.

Two bones in the crewmember’s hand were broken. The injury caused significant pain, nausea and subsequent swelling. He was administered first-aid, pain relief and antibiotics at sea following advice from the company’s shore-based doctor, until he could be delivered to hospital.

“REALISING IT WOULD FALL ON HIS CREWMATE, THE CREWMEMBER LUNGED OUT TO TRY AND CATCH IT.”
Fire is one of the worst dangers sailors face at sea. Unless controlled, a fire is more likely to lead to total loss of a vessel than even extreme weather.

As these photographs show, the heat a fire can develop on board should never be underestimated. Aluminum does melt and burn.

A common cause of fire is when fuel, such as petrol or diesel is ignited by an electrical source, or leaking LPG gas explodes. This fire was caused when poorly-installed electrics caused a short, igniting the fuel in the tanks.

Any onboard fire, no matter how small, is extremely serious.

1. Experience shows key points that will help reduce your risk of fire.
   - Ensure all fuel, LPG and electrical equipment is correctly installed using approved products.
   - Maintain fuel systems with regular checks.
   - When refueling, take extra care to avoid fuel spills.
   - Have a range of extinguishing options on board. Water puts out many fires, but a fuel or electric fire requires a purpose-designed extinguisher. A fire blanket can quickly extinguish a cooking fire.
   - Consider where your extinguishers are placed. If the fire starts to spread, can you reach them without putting yourself at risk?
   - Smoking on board is courting fire.
Good seamanship saves grandchildren

A grandfather’s good seamanship may have saved the lives of his three grandchildren.

The three children, the skipper and two other adults had spent the day enjoying a fishing trip in a recreational powerboat that the skipper had owned for about a month.

The party had anchored to refuel about 200 m from shore when the fibreglass-coated plywood hull suddenly started filling with water. The crew donned their lifejackets and the skipper started bailing while one of the adults raised the alarm using the powerboat’s water-resistant VHF radio.

A nearby vessel came alongside and took the children off just before the boat capsized, spilling the three adults into the water. The skipper was briefly lodged under the vessel, but was able to swim clear.

Within minutes the Coastguard and Maritime Police arrived in response to the VHF call, and took the crew to a nearby wharf where an ambulance was waiting.

1. The skipper had bought more lifejackets that day to ensure there was enough for everyone on board.

2. The vessel was properly equipped with a hand-held, water-resistant VHF radio. These can cost as little as $200. A cellphone in a water-tight plastic bag, kept in a clothing pocket on the body is another good communications option. Use the cellphone through the plastic to ensure it stays dry.

3. The powerboat was found to have a 40 cm-long area of soft wood running along the keel that had started to rot out, allowing water into the hull. This was probably caused by fresh water lying in the hull. It can occur in older wooden boats, which should be thoroughly checked for softness (preferably by a boat builder) before purchase.
A truck deck was being installed when it swung into a fishing vessel’s skipper, breaking both of his legs.

The truck deck was being installed on the vessel in preparation for the coming trawling season. The aft end of the deck was suspended from the gantry, using the gilson winch, while the forward end was being manoeuvered by the shore crane. During efforts to move the truck deck forward slightly, it lodged against the gantry base. Unaware this had happened, the skipper signaled for the shore crane to be stopped and ordered the crewmember operating the gilson to continue lifting the aft end of the truck deck.

As the aft end was raised, the truck deck cleared the gantry and slewed forward on the wires with some force. The leading edge of the truck deck smashed into the skipper, pinning him against the edge of the freezer hold. He sustained two broken legs, a broken ankle and a puncture wound from the thread of the hatch dog, which penetrated right through his lower leg and stopped the truck deck’s forward momentum. The skipper was off work for 3 months.

1. Analysing the accident, the skipper later said that the angles of the lifting wires had been wrong. During the lift, both wires had been leading aft, creating a pendulum effect once the truck deck dislodged from the gantry. He said the shore crane should have been moved so that the forward wire ran in line with the gantry. This would have avoided a forward swinging motion.

2. The skipper had thought he was standing well clear of the operation at the time, as were other crewmembers. He was saved from more severe injuries only because the thread of hatch dog stopped the swinging truck deck. This highlights the need to be standing well clear at all times and to carefully assess any potential swing should a break or unforeseen movement occur.

The conviction of two Auckland boaties following a collision with a lit beacon sends a strong message about the dangers of over-relying on GPS and failing to keep a proper lookout.

A farmer and a company director were recently convicted and fined $1,500 and $500 respectively in the Auckland District Court after admitting a charge each under the Maritime Transport Act of causing unnecessary danger to persons and or property. The men were each ordered to pay $250 in solicitor’s costs and court costs of $130.

The charges were brought by Maritime New Zealand following an incident when a 13.8 m cabin cruiser collided with the Illiomana beacon in Auckland Harbour. The two men and several others had been out on the harbour watching the departure of the cruise liner Queen Elizabeth II. It was a dark night, but despite this, the man who was at the helm, was not using radar to assist his lookout.

Some time after 11pm, the helm was passed to the other man while the skipper went below, without giving him any instructions regarding the vessel’s position or course. Shortly afterwards, the vessel, travelling at considerable speed, hit the beacon, whose light had a range of 5 nautical miles (9 km). All those on board were rescued by the nearby launch, but the skipper suffered serious injuries requiring hospital treatment. The cruiser suffered major damage and was a total loss.

Both men subsequently said they thought they had already passed the beacon, and acknowledged their vision was impaired by the dark conditions and the lights from the many other vessels in the area.

Judge Paul ruled the skipper was significantly more culpable than the other man in operating the vessel with what he knew to be an unreliable GPS system, no radar and no paper chart. He noted the handover procedure was poor and there were issues with the lookout procedure. The judge also accepted the helmsman failed to slow down and fix the position before proceeding.

A CLEAR EXAMPLE OF THE NEED FOR SKIPPERS TO MAINTAIN A VIGILANT LOOKOUT AT ALL TIMES, INCLUDING USING RADAR AT NIGHT.

The media release relating to this story is on the News section of the website: www.maritimenz.govt.nz

1. The case is a clear example of the need for skippers to maintain a vigilant lookout at all times, including using radar at night.
2. Even in familiar waters, charts are needed to remind skippers of where dangers exist. GPS is a very useful aid to navigation but this serious accident reminds us all that it is not safe to rely solely on GPS.
3. It also highlighted the need for good communication when handing over control of the vessel. The decision to hand over the helm without telling the helmsman the vessel’s course and position in this case could have resulted in a fatality.
4. It is essential to slow down to a safe speed in harbours where visibility is affected by background lights on shore. There were a number of other vessels on the harbour that night, and if the vessel had collided with one of them the consequences could have been far worse.
Be up to speed with the latest safety info

Maritime New Zealand (MNZ) puts out a range of safety information updates (including safety bulletins and marine guidance notices) targeted at the needs of different audiences in the maritime industry.

Past safety bulletins are listed on the back cover, however, more details about recent issues follow.

All these safety notices can be downloaded from the website: www.maritimenz.govt.nz

Small craft wire cable steering controls

The September 2008 safety bulletin (Issue 17) recommends that all operators of boats fitted with a cable and pulley type steering system consult with the cable manufacturer or supplier of the system to ensure that the pulley (also referred to as a sheave) diameter is within acceptable limits.

The information was developed as the result of a steering cable failure on a commercial jet boat. MNZ carried out extensive testing and analysis into the cause of the failure. The bulletin includes a table with sample recommended sheave/cable ratios.

The notice also reminds operators of the importance of inspecting cables and pulleys for signs of wear; and the importance of lubrication, which may prolong the fatigue life of a cable.

Can your liferaft be released?

The June 2008 safety bulletin on Liferafts and their release mechanisms (Issue 16) supersedes an earlier version by providing additional information and diagrams.

The bulletin is aimed at owners and operators, skippers and crew, ship surveyors, safe ship management companies, maritime safety inspectors and liferaft servicing stations.

The key message is this: if your vessel capsizes, can the liferaft be released?

You need to make sure:

• the hydrostatic release unit (HRU) is connected correctly
• the liferaft is not prevented from release by extra lashings or rigging on the vessel, or by a cover on the liferaft.

Are your bulwarks/guardrails high enough to stop you falling into the sea?

Marine Guidance Notice Issue 9: Bulwark and guardrail height reminds fishing vessel owners and skippers of the maritime rule requirements for bulwarks and guardrails.

The aim is to get skippers and crew to critically look at the bulwarks and guardrails on their vessels and assess whether they feel adequately protected from accidentally falling overboard, and if not, take steps to improve their protection.

The notice recommends the following:

• look at the bulwarks and guardrails on the vessel you work on and assess if they give you adequate protection from falling overboard
• confirm that the bulwarks comply with the requirements of Maritime Rules Part 40D
• talk the options over with your surveyor
• make the necessary modifications to your bulwarks and guardrails.

ECDIS and ECS – what is the difference?

Marine Guidance Notice Issue 8: Use of electronic charts, ECDIS and ENCs in New Zealand (June 2008) details the technical requirements relating to Maritime Rules Part 25, the different types of chart display systems and the need to maintain and use paper charts.

Information relating to Land Information New Zealand’s release of Electronic Navigational Charts (ENC) vector charts for New Zealand chart areas (starting in August 2008) is also included in the notice.

Join our email mailing list

In the future, we aim to send out advice about MNZ safety updates primarily by email.

If you would like to be added to our mailing list, please email your details to: publications@maritimenz.govt.nz

Note: If you are a vessel owner/operator, you may have recently updated your details on receiving safety bulletin issue 16.
Masters/skippers/employers and principals have a 24-hour 7-day a week verbal reporting channel to quickly and easily tell Maritime New Zealand (MNZ) what has happened, before completing and sending an accident report form.

Make sure you have the most up-to-date forms and copy them and put into your manuals:

- MAR AI 1 Information sheet – summarises the accident reporting process
- MAR AI 2 Report of serious harm injury/other injury/illness or disease on board a commercial vessel
- MAR AI 3 Report of serious harm injury/other injury/illness or disease on board a recreational vessel
- MAR AI 4 Commercial vessel – accident or incident report
- MAR AI 5 Recreational boat – accident or incident report
- MAR AI 6 Rafting – accident or incident report
- MAR AI 7 Jet boat – accident or incident report
- MAR AI 8 Sea kayak – accident or incident report
- MAR AI 9 River/lake kayak/canoe – accident or incident report

How do I report an accident, incident or serious harm injury?

First of all you make an initial verbal report to the Rescue Coordination Centre New Zealand (RCCNZ) by phone or VHF radio:
- freephone: 0508 22 24 33
- Maritime Operations Centre on VHF Channel 16.

Then complete an accident/incident form or serious harm injury form as soon as practicable. You can request the forms by phoning: 0508 22 55 22 or download from the website www.maritimenz.govt.nz.

Complete the form and then:
- fax to: (04) 577 8038 (or)
- mail to: RCCNZ
  PO Box 30 050
  Lower Hutt (Attn: Reporting Form)

Why should I report?

A master/skipper must report, as soon as practicable, any accident, incident or serious harm injury under section 31 of the Maritime Transport Act 1994. This applies to all New Zealand vessels, including recreational boats.

Accident reporting 24/7

**Accidents** include events such as any damage to a vessel that may affect its strength or seaworthiness, groundings, collisions, machinery failures and steering loss. **Incidents** include near misses such as a near collision or a near grounding. If there is any doubt as to whether an incident should be reported, you should report it to MNZ. **Serious harm injuries** include (but are not limited to) death, amputation of a body part, burns, loss of consciousness; and any harm that causes a person to be hospitalised for a period of 48 hours or more.

Full definitions can be found on the website: www.maritimenz.govt.nz

Note 1 – complete industry specific form for Commercial Vessels eg use MAR AI 4 or Jet Boat, Rafting, Kayak forms
Note 2 – complete sector specific form for Recreational Vessels eg use MAR AI 5 or Jet Boat, Rafting, Kayak forms
Safety Bulletins

Maritime New Zealand (MNZ) publishes safety bulletins as a means of communicating and encouraging dialogue on a variety of safety issues and the proposals relating to these. The bulletins are published as and when required, and are distributed to those sectors directly involved. We welcome any comments you have on the recommendations or content in general. The bulletins produced to date are listed below.

For more details about MNZ’s safety updates including how to be added to the new email mailing list, see page 16.

Latest issues

Small craft wire cable steering controls
September 2008 Issue 17

This bulletin recommends that all operators of boats fitted with a cable and pulley type steering system consult with the cable manufacturer or supplier of the system to ensure that the pulley (also referred to as sheave) diameter is within acceptable limits.

Liferafts and their release mechanisms
June 2008 Issue 16

This bulletin makes the following recommendations:
• during maintenance checks, make sure your liferaft and its connections comply with the advice in this safety bulletin
• the procedure for connecting each of your liferafts and how to care for them should be in your SSM safety management plan, ie manual
• use an “off-the-shelf” liferaft cradle that suits your type and size of liferaft whenever possible.

Past issues

HamiltonJet Steering Nozzle Pivot Check
December 2007 Issue 15

Crane controls & communications
September 2007 Issue 14

Shore-based pre-slung cargo slings
September 2007 Issue 13

Lifting slings, loose gear and dunnage
June 2007 Issue 12

Cargo vessel cranes – Examination and renewal
June 2007 Issue 11

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

Customer satisfaction survey

Maritime New Zealand is committed to meeting the needs of its customers and stakeholders. If you would like to take part in our short online survey, please go to: www.maritimenz.govt.nz

MARITIME FATALITIES 2008

From 1 January to 22 August 2008, there were 12 fatalities - five in the commercial sector and seven in the recreational sector.