Children drown on first trip

Distress beacon brings successful rescue
Children drown on first trip
Unfamiliarity, alcohol, and lack of lifejackets have sobering result.

Horseplay ends in drowning
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Safety updates
Welcome to our last issue of Lookout! for 2009.

With summer upon us we’re entering a time of increased activity on our seas, rivers and lakes, and it’s timely to take stock and think about what each of us can do to keep ourselves safe when in, on and around the water.

It’s been a tragic year, with a larger-than-usual number of fatalities in the recreational boating sector. This Lookout!’s focus on recreational boaters and lessons to be learnt clearly shows that what we do directly affects our level of risk.

Things can and do go wrong when out on the water, and being well prepared and equipped and making sensible choices can mean the difference between life and death. Two stories in this issue involve fatalities in boats that were poorly maintained. Our “Maintain your boat” safety feature takes a look at what you can do to stay safe on the water this summer.

In the guest editorial Maritime New Zealand (MNZ) Manager Recreational Boating Jim Lott reflects on why people resist change, and why people in boats under 6 metres are so reluctant to wear lifejackets – the most effective form of life insurance available.

“In your words” features an incident from a skipper’s point of view – it’s a compelling read.

Two of the stories from the commercial sector feature fires – one shows how training, preparation and vigilance result in a quick and effective response, while the other story shows how a lack of basic precautions, even on one occasion, can have serious consequences.

Please pass this copy of Lookout! to your friends, family, colleagues or crew, or encourage them to subscribe to print or email copies by emailing publications@maritimenz.govt.nz.

On behalf of MNZ, I’d like to wish you all a safe, happy and relaxing holiday season.

Catherine Taylor
Director of Maritime New Zealand
WHY RESIST CHANGE

Why is it so hard to bring about change when the gains are so obvious? “If it’s not broken, don’t fix it”, “why reinvent the wheel?” History provides us with many good reasons to reject change. Results from what “seemed to be a good idea at the time” and changes driven by ideology often show insufficient attention has been paid to consequences.

Adding fear of the unknown into the mix results in a powerful urge to resist a departure from the familiar. We seek a level of certainty in everything we do.

Huge efforts and expense are focused on the “prediction industry” – forecasting tsunamis, the weather, the stock-market, global warming, and the prognosis of a doctor.

The security that accompanies certainty reduces stress levels. We all crave the comfort of an income we can rely on and a safe haven to return to at the end of each day. Avoiding change avoids stress, but whether we like it, or even recognise it, change is everywhere.

EMBRACE EVOLUTION

While history may provide many reasons to resist change, it also provides the knowledge and evidence needed to develop policy initiatives and strategies to do things better and improve safety. The result is change that makes us feel more secure. We are not only prepared to make such changes, but embrace the development that technology brings.

There is always an element of risk with evolution – mutations occur, and trials and experiments often fail. Thomas Edison’s famous quote “I never failed once. I invented the light bulb. It just happened to be a 2,000-step process” underlines that change is a move forward, even if the outcome is initially negative.

Whenever we go into the trial of a new system or make a change to attempt to advance, we must always be prepared to fall back to what did work and not see the trial as a failure.

However, the element of uncertainty that comes with change and the feelings of those involved, along with the inevitable lack of focus and drive that occurs during a time of change has to be weighed against the possible benefits.

Jim Lott – Musings after about 10 years at MNZ and 35 years of teaching in the maritime field.

The Safety Paradox
Change has to have a clear goal, rationally linked to improvement. Unless that goal is apparent and clearly enunciated, the chance of a change having a positive outcome is greatly diminished.

MNZ’s review of maritime qualifications, which is currently underway, is tacit recognition of the need to change. The world has changed but, like many maritime jurisdictions, until now have we retained “the tried and true” or just buried our head in the sand and refused to change with the world around us?

THE PARADOX

We embrace change all the time. Sometimes change is costly, and it can be inconvenient, but provided we believe there is a benefit, there is little resistance. Why then, is there such reluctance to modify the way we act? What is it that makes us resist some simple changes while we accept others?

Wearing a lifejacket costs nothing (we have to have it on board anyway). There is minimal inconvenience, and it is as effective in reducing fatalities in an accident as a car seatbelt is.

Most of us would not consider being in a car without wearing a seatbelt. Certainly it has taken some years to get to this point and many will recall the initial reluctance to wear a seatbelt, with all manner of excuses.

We pay significant sums for life insurance to protect our families from loss, but we are reluctant to use the best life insurance available in a small boat – wearing a lifejacket.

There have been great improvements to safety equipment over time. For example, lifejackets have evolved from the hulking cork vests worn a century ago to comfortable, easily-worn garments that really work. Even greater comfort can be had with inflatable models – with increased levels of safety.

We recognise the advances in lifejacket design but we have a marked reluctance to put them on. Changing our behaviour in this simple way could have saved the life of over 100 people since 2000.

The CEO of Club Marine Insurance, the prime insurer of small craft in Australia says “behaviour is the key driver of risk”. Behaviour change is effective and costs nothing. Can we learn this lesson from history and adopt lifejacket wearing as the norm without the need for regulation, enforcement and penalties? It seems not, even if this behaviour change would provide us with a more predictable outcome – a safe return after a day out in the boat.

THE TOOLS WE USE

The requirement to carry lifejackets in boats was introduced in 2003, and we know that there is very high compliance on the approximately 450,000 recreational boats in the country.

The wearing of lifejackets, which is still optional most of the time, has only been adopted by an estimated 15% of those most at risk – namely middle-aged males in a boat less than 6 metres. Not wearing a lifejacket is illogical, but aren’t males supposed to be the more logical gender?

The tools available to improve safety behaviour are limited to regulation and education. Education and promotion of lifejacket wearing has been successful in reducing the number of fatalities over time. While we see headlines informing us of yet another casualty, we have not yet seen the headline “Lifejacket saves life” although there are many who owe their lives to this simple and effective device.

Over the past decade, approximately two-thirds of boating deaths could have been avoided by wearing a lifejacket, so the need for additional regulation is apparent. However, even if a significant level of policing and enforcement were possible, regulation is effective only when there is willing compliance from the majority.

Regulation can lead a change in behaviour, and enforcement can accelerate the change. Few would not wear a seatbelt in a car today even if the regulation were not in place.

MNZ’s role in leading safety on the water relies on both regulation and education. If we do not have in place regulation that is evidence-based and proportional to the risk, we have failed. If we do not ensure that everyone who takes a vessel out on the water is aware of the risks and has sufficient understanding to keep themselves safe, we also have failed in what we are responsible for.

But once on the water, the responsibility for safety must always lie with those on board – the skipper and crew. The rest is up to you.

The opinions expressed in the Lookout! guest editorial are not necessarily the opinions of MNZ.
The crew had been preparing to shoot the trawl doors. The trawl net was in the water and dragging against the trawl doors in 4–5 metre seas and 25 knot winds. A safety chain was holding the doors fast to the vessel until they could be hooked to the trawl warp.

The trawler man was trying to hook the trawl warp to the trawl door on the starboard side of the vessel. As he reached up inside the trawl door with the hook, he pushed his forearm through a gap between the safety chain and an angled gantry pole.

As the vessel heaved, the safety chain tightened against the pole, crushing the trawler man’s forearm.

The injury was assessed by the skipper, and appeared to be only severe bruising. There was no broken skin or any obvious fractures.

The vessel steamed to port, and almost 24 hours after the accident the injured man arrived at hospital. His injuries were found to be more serious than originally thought and he underwent four surgeries to remove dead tissue from his arm.

Despite years of experience, the trawler man’s moment of complacency resulted in serious damage to the muscle of his forearm and required multiple surgeries. The trawler man later said that he “had been told a hundred times not to put his arm in that area”.

**LOOKOUT! POINTS**

1. The trawler man did not know why he had tried to hook the trawl warp by shoving his arm through a gap that he knew was a hazard. The correct technique would have been to reach around forward of the chain. A moment’s complacency has significantly impacted on his life and career.

2. Although the trawler man was experienced and fully aware of the dangers, the vessel’s hazard identification and training was later found to be deficient.

In fact no vessel-specific hazards relating to fishing operations had been identified, and this had not been picked up in subsequent surveys and inspections. Had an inexperienced crewmember relied on the vessel’s hazard and training system, their safety would have been at significant risk.
The skipper and crew on a large passenger ferry reacted quickly to a fire in one of the engine rooms.

The vessel was en route to an island, with 83 passengers and four crew on board, when the skipper noted the starboard engine was losing power.

A certified deckhand heard a bang in the starboard engine room and saw black smoke coming from the exhaust. She went aft to investigate, along with a senior crewmember.

Meanwhile the starboard engine fire alarm sounded in the bridge and the skipper shut down the starboard engine.

After testing the engine room door for heat with the back of his hand, the crewmember entered the engine room.

He observed smoke and a fire engulfing the turbo charger. The deckhand handed him a dry powder fire extinguisher, which he decided to use after establishing it was safe to do so.

Keeping low to avoid smoke, he discharged the extinguisher at the source of the fire and then left the engine room, closing the door to starve the fire of oxygen.

In the meantime the deckhand had shut off all vents and fuel lines. With the engine room sealed, the skipper was advised of the situation. He was able to berth the vessel some minutes later using the port engine.

The crewmember then re-entered the engine room and extinguished a small remaining flame on the turbo-charger.

The skipper called the local fire brigade, who checked and confirmed the fire was out.

Throughout the fire the passengers remained seated as instructed by the skipper. The passengers disembarked without further incident.

“KEEPING LOW TO AVOID SMOKE, HE DISCHARGED THE EXTINGUISHER AT THE SOURCE OF THE FIRE AND THEN LEFT THE ENGINE ROOM, CLOSING THE DOOR TO STARVE THE FIRE OF OXYGEN.”

1. The crew were well trained to deal with emergency situations and responded to the emergency quickly and effectively.
2. This incident highlights the importance of having regular emergency training. The vessel’s log showed that regular training, including fire drills, was carried out.
3. All of the crew had received fire-fighting training, and two had attended advanced fire-fighting courses.
4. Due to the quick response, damage to the engine room was minimal – even plastic light fittings above the source of the fire were not damaged.
5. The decision to enter an engine room to fight a fire should always be carefully considered and should only be undertaken by trained crew.
6. All mariners should be aware of the danger of confined space entry where they can be overcome by dangerous fumes or gases. The crewmember’s decision to enter the engine room and fight the fire was based on his extensive maritime background and fire-fighting training.
7. Closing off sections of a vessel to starve a fire of oxygen is a well-recognised and accepted means of fire fighting.
8. The vessel had fixed fire-fighting systems, which could be externally activated if required. In this case they were not needed.
9. Well-trained crew and effective fire-fighting equipment and procedures are a good investment for any operator.
A pilot boat came within close quarters of a roll-on roll-off ferry after its skipper made assumptions about which route the ferry would take.

When the ferry deviated from its usual route, the skipper of the pilot boat lost situational awareness and did not fully recognise the risk of collision.

The ferry involved is a ship of 11,000 gross tons with a length of 120 metres. The pilot boat is an 8 metre rigid-hull inflatable boat powered by two outboard motors mounted on the transom.

The ferry had been following its normal track into a busy sound. The master had made contact over VHF radio with a bulk cement carrier that he knew was due to depart the sound. The two masters had agreed where they were likely to meet, and that they would on this occasion pass green to green (starboard to starboard).

Meanwhile, the pilot vessel was heading out of the sound, intending to collect the pilot from the bulk cement carrier once it had been navigated out of the sound. The master and helmsman had not heard the VHF radio conversation between the two larger vessels, and so were expecting the incoming ferry to follow its usual track.

The master of the ferry noticed the pilot boat approaching from the ship’s port side at a distance of about 2 nautical miles (3.7 kilometres). He could tell it was moving quickly, although it was not plotted on the ferry’s radar.

The master maintained a visual watch but was not initially concerned, as pilot vessels often turn away quite late in such situations.

However, as the pilot vessel came abnormally close, the master tried to raise it on VHF radio. At just that moment his attempt was blocked by another radio transmission. He sounded the ship’s horn in a continuous blast and then lost sight of the smaller vessel beneath the ferry’s bow. Moving to the starboard bridge wing, he saw it tracking away, unscathed.

**LOOKOUT! POINTS**

1. The master and helmsman on the pilot boat do not agree that their vessel came within 50 metres of the ferry, although data from an Automatic Identification System (AIS) report places the two vessels as close as 24 metres.

2. The pilot vessel’s VHF radio had been set to scan, and the master later said the radio tended to stick on a particular channel, which may have resulted in the crew not hearing the deviation from the normal passage plan that had been agreed by the masters of the two larger vessels. Despite this known fault, the VHF radio had not been replaced.

3. The pilot vessel’s radar screen was small for a vessel that typically operated at 20–26 knots in the sound. Because of the small screen there was little detail when the radar was set at extended ranges. It was also difficult to read the screen from the master’s position at the time on the port side of the wheelhouse. A more appropriate screen size would have made better use of this safety equipment.

4. The master of the ferry was late in reacting to the pending situation. His first action was to attempt to raise the pilot boat by VHF radio, rather than to reduce speed and prepare to stop. When he did call the pilot boat his communication was blocked, and he only had time to sound the ship’s horn in warning.
Unseen fire below

Thick, acrid, black smoke billowed unseen in a fishing vessel's engine room while a contractor welded pipes in the deck above.

The welder was an external contractor brought in to finish off repairs to the vessel's refrigeration plant. He was working on pipes that descended through the factory deck to the engine room below.

There was no one stationed as a fire spotter because the welder had considered the risk of fire to be low. As work progressed, the vessel's on-board fire detection system activated.

Those on board initially tried to combat the fire, but were soon beaten back by the thick smoke. The fire service was called, and the fire was soon extinguished.

"THERE WAS NO ONE STATIONED AS A FIRE SPOTTER BECAUSE THE WELDER HAD CONSIDERED THE RISK OF FIRE TO BE LOW."

1. The vessel typically used a fire spotter while repairs were being done, but on this occasion the contractor had felt the risk of fire was low and this was not required.

A person watching for signs of overheating below would have been able to stop the work well before any damage was done.

2. The contractor's assessment of the fire risk was based solely on his judgement on the day, and was not verified or documented. Had a methodical analysis of the job's safety been completed, a higher risk of fire would have been identified and appropriate safety measures would have been taken.

3. Portable fire extinguishers should be positioned close to hand during any hot work with potential risk of fire. This basic safety step was not taken.
Poor maintenance leads to drowning

A skipper knew his aluminium runabout leaked, but that did not stop him taking it into open seas, and both he and his passenger drowned as a result.

The skipper frequently took the 4.4 metre runabout on fishing trips, and a small electric bilge pump had been fitted to control the water that would leak into the 25-year-old vessel. His usual practice was to switch on the pump while returning to shore. The skipper was aware the pump was not always reliable, but considered it adequate to handle the leaks.

On the day of the accident, the skipper and his passenger set off at mid-morning for a day’s fishing about 2 miles (3.7 kilometres) off the coast.

1. The aluminium runabout was about 25 years old. While it appeared generally sound, poor maintenance in the transom area meant the vessel routinely took water on board. Earlier damage had been welded, but there were several missing rivets and unplugged holes where fittings had been screwed and then removed.

2. The water that had leaked in reduced freeboard and the free-surface effect reduced the vessel’s stability. This was compounded by additional weight in the stern from the auxiliary engine and a retrofitted steel rod holder. Two pedestal helm seats had also altered the vessel’s centre of gravity. Unless the water was pumped out regularly, the vessel quickly became very unstable.

3. Once they were in the water, the skipper and his passenger had no means of communicating their distress. The vessel had been fitted with VHF and CB radios, but these were fixed units, and it is likely that the vessel sank too quickly...
Both men told family that they were going fishing, but did not say where they were going or when they would be back. They did not log a trip report with Coastguard or the Maritime Radio Service.

The pair carried fishing gear, a VHF marine radio, some date-expired flares, a CB radio, and both had a cell phone.

The vessel was fitted with an auxiliary engine on the port side of the stern, a depth finder, and an anchor and warp.

The skipper’s usual practice was to head seaward to an area where the water deepened quickly, and then anchor so the vessel would remain in position against the moderate tides that ran parallel to the shore.

About 12 hours after the men departed, a neighbour recognised the vessel’s trailer sitting empty on the shore, and raised the alarm.

Police launched a search and rescue effort that involved helicopters and fixed-wing aircraft, and seven vessels joined the search.

The runabout was found in the early hours of the next morning about 2 nautical miles from the coast, with the bow just protruding from the water. About an hour later, the two men’s bodies were discovered. They were separated and both were wearing lifejackets, floating face-up in the water.

It is most likely that the vessel sank rapidly within an hour of heading to sea. It would have started taking on water as soon as it was stopped, or when it slowed right down.

THE SKIPPER WAS AWARE THE PUMP WAS NOT ALWAYS RELIABLE, BUT CONSIDERED IT ADEQUATE TO HANDLE THE LEAKS.

THE TRANSOM-WELL SUPPORT BRACKET WAS FOUND TO BE CRACKED AND MISSING RIVETS. THIS DAMAGE DID NOT APPEAR TO BE NEW, AND ALLOWED WATER IN THE TRANSOM-WELL TO DRAIN DOWN INTO THE FLOOR SPACE BENEATH THE FLOORBOARDS.
Horseplay ends in drowning

An evening of fishing and drinking in a small fibreglass dinghy ended with one man drowning.

The man and his fishing companion spent about 4 hours fishing about 100 metres from shore from a 2.1 metre dinghy. By midnight they had drunk all of their alcohol and decided to row back to shore. On the way back, the man, who was by now heavily intoxicated, started using his body weight to rock the boat from side to side, allowing water to slop in over the sides.

His companion tried to get him to stop, but the man carried on until the vessel swamped, and it sank quickly. Without lifejackets, the pair began swimming for shore. The companion called out to the man to come and hold on to the chilly bin for help with flotation, but the man ignored him and carried on towards shore.

After about 20 minutes, the companion with the chilly bin reached the shore, stripped off most of his wet clothes and started walking along the shoreline, calling out in the dark for the other man.

After searching for some time he ran back to their parked car and drove off in search of a petrol station to borrow a phone. After failing to find a petrol station, he drove back to the beach and came across another fisherman. This man did not have a cell phone either, but they were able to flag down a passing motorist and raise the alarm.

A Police and Coastguard search by sea and air ensued. After several hours, the man’s clothes were found on the shoreline, and an hour later his body was found washed up on the beach. The companion was treated for hypothermia at the scene.

His companion tried to get him to stop, but the man carried on until the vessel swamped, and it sank quickly.

1. The vessel was very poorly maintained, and was far too small to be used for fishing by two adults.

2. The pair had no effective means of emergency communication. The vessel carried no distress beacon (EPIRB or PLB), no portable waterproof VHF radio, no flares, and the man’s cell phone was not kept in a watertight plastic bag (and therefore would have been inoperable as soon as it entered the water).

3. Alcohol played a significant part in this tragedy in three ways. In his intoxicated state, the man had made a game of deliberately rocking the vessel. Once in the water, the alcohol would have increased disorientation. Alcohol would also have impaired his ability to make good decisions and to physically swim for shore.

4. The men did not carry any lifejackets on board. Maritime Rule 91 and local bylaws require lifejackets to be carried on all boats and worn unless the risk is low. On this occasion, the following were significant risk factors:

   - an undersized vessel
   - a vessel in a poor state of repair
   - fishing at night
   - no effective means of communication in the event of an emergency
   - a high level of intoxication.
Maintain your boat

Whether you are buying a boat, taking it out again with the arrival of summer, or using it frequently, regular checks are the only way you will have trouble-free boating. Ensuring your boat is well maintained and equipped, and knowing how and when to use your equipment will help you stay safe.

- Get your engine serviced – make sure your boat’s engine is up to the job. Schedule an annual service and make regular visual checks.

- Change your fuel – if your boat’s been out of the water for a while it pays to replace old fuel with clean, fresh fuel. Never assume your trip will run exactly according to plan – always plan to use a third for the trip out, a third for the trip back, and keep a third in reserve to allow for the unexpected.

- Give your boat a once-over – take a thorough look and make sure everything on your boat is in good working order. Start in one place and work your way around the boat checking everything inside and out. If you find anything that is damaged or worn, repair it properly or replace it.

- Change your fuel – if your boat’s been out of the water for a while it pays to replace old fuel with clean, fresh fuel. Never assume your trip will run exactly according to plan – always plan to use a third for the trip out, a third for the trip back, and keep a third in reserve to allow for the unexpected.

- Check your lifejackets – before re-use make sure that lifejackets are still the correct size (especially for children) and in good condition. If you have an inflatable, make sure it’s checked and serviced regularly and regularly check that the gas cylinder is properly screwed home and not corroded. Lifejackets do not work unless they are worn.

- Check your equipment – look at all of the equipment on your boat and make sure it’s in good working order. Check expiry dates on flares and fire extinguishers, and replace them if they’re out of date. Make sure the boat’s battery is professionally checked so that it will be capable of operating all electric equipment and have enough strength to start the motor. Check batteries on portable equipment such as torches, radios and your GPS, and replace them if you need to. Make sure your distress beacon’s registration is up to date.

- Think about your emergency plan – look at where your safety equipment is stored. Can you access it easily in an emergency or after a capsize? Put together a floating “grab bag” that contains all the emergency gear you will need should your boat capsize. Remember, the best place to store a lifejacket is on your person with a means of communication in your pocket! Brief the crew on what to do if things go wrong and practice different scenarios – be mentally prepared for the unexpected.

Ensure you stay safe

1. Wear your lifejacket or PFD. Maritime law requires ALL skippers to carry enough lifejackets of the right size for everyone on board. Lifejackets currently must also be worn in any situation where there is increased safety risk.*

2. Check the marine weather forecast before you go. If in doubt don’t go out.

3. Carry at least two reliable forms of marine communication. A distress beacon (EPIRB or PLB) and a handheld, waterproof marine VHF radio are the most reliable forms of emergency communication. Red handheld, orange smoke and red parachute or rocket flares are another good means of signalling you need help. If carried, cell phones should be inside a resealable plastic bag, but should not be relied on as your only form of communication.

4. Don’t go overboard on alcohol. Alcohol impairs judgement and balance, and its effects are exaggerated on the water. Consumption of alcohol will also reduce your survival time if you end up in the water.

5. Make a trip report. Let someone responsible know where you’re going and when you expect to be back.

6. Be considerate to other water users. Keep a lookout, stick to safe speeds, and be patient, so that everyone can enjoy the water.

* MNZ is, however, recommending a law change that would make it compulsory for lifejackets to be worn at all times, unless the skipper gives permission for them to be removed.
Children drown on first trip

Two children drowned during a family’s first trip out in their father’s new boat.

The father was skippering the 6.8 metre recreational vessel for the first time. His only other experience with the vessel had been a sea trial with the seller a few days earlier.

During the sea trial, the seller had tried to ensure the skipper knew how to operate the vessel, and had showed him some basic handling practices. The seller had finalised the transaction feeling some disquiet that the skipper had not seemed to pay close attention to the detail of the operation and functions of the vessel.

On the day he collected the vessel, the skipper invited two others to join him, as well as his partner and their two children aged 5 and 8, on a fishing trip. On the way to the boat ramp they stopped to stock the boat with alcohol.

Full of enthusiasm for his new purchase, the skipper initially tried to launch the vessel while it was still lashed to the trailer and with the trailer light-board still in place. He also reversed into the side of the wharf, damaging the concrete.

Witnesses later said they felt concerned about the skipper’s skill level as they watched him launch the vessel. He did not complete any pre-launch checks.

The party of six left the bay just before midday, intending to do some fishing and return later that afternoon. However, the day stretched on, and while at anchor the party fished, swam and drank alcohol.

At one point the bilge pump was turned on. It ran for about 10 minutes and pumped water continuously.

About this time someone on board found a bung in a seat pocket. After a general chat, they concluded that it should probably be in the vessel somewhere.

One of the party checked around the back of the boat, but was unable to find the bung holes. Not knowing where it should go, the bung was put in the seat pocket.

As the tide ebbed, the vessel grounded, so the party waded ashore to have dinner at a local restaurant and wait for the vessel to refloat. Eventually it did so, and they motored to a nearby island to continue drinking and fishing, and some of the party smoked cannabis. They all slept on the boat.

In the small hours of the morning, the skipper woke up and, looking around him, realised the vessel was taking on water and was sinking.

He decided to motor toward land and try to beach the vessel. Had he done this slowly, he may have succeeded. Instead he accelerated hard, forcing the bow up. The vessel then struck a rock, forcing the bow up further.

It sank rapidly by the stern, trapping the two children in the cabin. Despite the adults’ repeated efforts at diving to free them, the children drowned.

Exhausted, the adults managed to clamber onto rocks, and were winched off the island by rescue helicopter the following day. The bodies of the children were later recovered by divers.

1. There were not enough lifejackets for every person on board, and the lifejackets that were on board were not being worn.

2. After the event, it was found that no pre-launch checks had been done, and a bung had not been secured in the vessel.

3. A considerable amount of alcohol was consumed by the adults on this trip. Cannabis was also smoked by some of the party. Alcohol is involved in about 30 percent of fatal boating accidents. It impairs co-ordination, judgement and decision making, and can lead to disorientation and confusion.
Had those on board not been under the influence of alcohol, they may have realised sooner that the vessel was taking on water. They may also have shown more concern at finding a loose bung on board.

4. The skipper was excited about taking his new purchase out for the day. However, he was not experienced with this type of vessel, did not allow himself time to become familiar with it, and was unsure how much of the equipment worked. It would have been prudent to take several short familiarisation voyages with someone experienced before carrying children on board.

5. Once the skipper had discovered that the boat was taking on water, he should have taken safety steps before attempting to motor to shore. He should have ensured all available lifejackets were put on, and made an accurate distress call giving the vessel’s position and number of people on board.

6. Once the vessel had sunk, the party had no means of calling for help, such as a distress beacon (EPIRB or PLB), a handheld VHF radio, or even a cell phone in a watertight plastic bag. A float-free kit, containing these items, flares, a first-aid kit, and other basic survival gear, is invaluable on a boat.

7. The skipper was convicted of operating a vessel in a manner causing unnecessary danger or risk, and sentenced to 250 hours of community service.

At the sentencing, the district court judge said a sentence of imprisonment was inappropriate given the suffering the skipper had already endured with the loss of his children.
The pair had set out for a day’s fishing in their 5 metre Stabicraft vessel. Before leaving they let a family member know where they were going and also contacted their local marine radio station via their VHF radio.

After about 20 minutes the vessel was just outside a reef, and the pair was deciding where to set a cray pot before heading further out to fish. As they discussed the options, the wife turned to see a large wave heading toward them. She called out, but as her husband tried to turn the vessel it was struck by the wave and capsized.

They clambered onto the upturned hull and checked for injuries, before the husband dived back under the vessel and retrieved and activated their distress beacon.

Some time later they could see a vehicle had stopped on shore, and later a Police car arrived and sounded its siren. The pair waved from the upturned hull and the Police car maintained watch over them until a rescue helicopter arrived and winched them to safety. One of the pair was suffering from mild hypothermia, but they were otherwise well.

### LOOKOUT! POINTS

1. The Rescue Coordination Centre New Zealand (RCCNZ) received the pair’s distress beacon signal and immediately called all of the contact numbers that were registered to it. One of these reached the couple’s daughter, and she was able to confirm who was on board and where the vessel was headed.

   A rescue helicopter was sent to the area, and a Police vehicle was able to maintain a visual watch of the pair as they waited. The pair was located easily and successfully rescued, however, they have since decided to replace their distress beacon with a model that provides an immediate GPS position to searchers, to provide even more peace of mind.

2. By staying with the vessel, the pair made the rescue effort easier. An upturned vessel is much more visible from the air than two people in the water struggling against choppy seas. They also significantly reduced their loss of heat by remaining out of the water.
Nearly drowned twice

Hi all. I heard that the fishing was good at dusk near Pakiri so off I went last Saturday. Dropped the longline – only one as I was by myself. Floated around and tried a few spots but zilch on the rods.

Picked up the long line after dark, one good snapper, close to 20lb. Headed back in towards Omaha and thought I would try a dark lure drag across back beach on the way in.

All was well until I saw I had gone about 10 feet too far and was on the land side of the breaking waves. Buga. Tried to turn but motor touched the bottom and the first wave broke into the boat. Full throttle to get around ended with about a 20 degree increase towards the sea, but not good enough.

The next four waves all came over the side. Up and over I went, as quick as that. As I saw it happening I switched on the 406 EPIRB and then all hell let loose. Upside down at 1 minute before midnight, no lights, thrown around and trying to get hold of the cord loose in the front of my lifejacket to pull to inflate it.

It seemed like ages before I got hold of the cord and it was good to feel the inflation happen. Most of this happened while I was upside down and underwater and didn’t know which way was up – not a scene I would recommend to anyone.

Somehow I got the EPIRB out of its bracket and held on to it, as it was my only hope. I couldn’t orientate my way around to see how to get out from under the boat. Each wave that came left a surge inside the hull, which came over my head.

I ended up with my head jammed hard up on the floor, which was now the roof. As the boat settled the water never dropped below my chin. The boat seemed to settle and the level began to get to the nose. This is my goodbye, I thought to myself, this is it.

Then the other side of the boat dropped/settled and I could see a bit of light to where the gunwale was and got nearly out from underneath. Buga again, one leg got caught in some rope/lines and I was again under boat and waves breaking and swallowing mr. salt water. I couldn’t free my leg with one hand. S### I thought, this time I am a goner.

I stuck the EPIRB aerial into my mouth, which freed up my other hand and somehow I got my leg free.

Up onto the beach I got. I went up the sand and found some soft grass or something and laid down. Pitch black, tried the phone – dead.

My EPIRB was my only hope. I was holding the EPIRB with both hands, I was shaking so bad by then. I don’t know how long it had taken me to get out of the boat, but now it seemed to really drag. I was buggered and even though I knew there were two houses above me I was going nowhere. I started to think the EPIRB wasn’t working as even though the light was flashing it seemed to be taking too long for some help to arrive.

Then, about 2.00 am Sunday I saw a welcome sight and sound – a chopper. It landed on the beach and took me into Warkworth. I was told I had mild hypothermia. I had a shower, put on winter clothes and slept in them and shivered all the rest of Sunday until about 6.00 pm.

We found out that the first satellite picked up the signal but didn’t get the GPS co-ordinates. The search and rescue centre only got the co-ords 1 hour later when the next satellite orbited across, but at least I had done everything right until I made a mistake on the water.

Just a word to anyone who reads this – I have always worn my lifejacket on my boat, when it turned to sh## there was no time to try to put it on, so would you all please wear yours. I nearly died twice that night, the boat is futterued, but at least I am alive. There won’t be any reports from me for a while now, but at least I have insurance on the boat.

Note: this is from a blog first published on The Fishing Website Forum and is reproduced with the author’s permission.
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**Volunteer health and safety**
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This bulletin informs organisations, public entities and companies of their health and safety responsibilities for volunteers who are involved in any water-based or maritime work activity.

For the full safety bulletin visit our website: [www.maritimenz.govt.nz](http://www.maritimenz.govt.nz)

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This advises how crewmembers can be readily distinguished from passengers during an emergency.

**Prescribed medication and safety**
November 2009 – issue 14

This guidance notice provides advice on the management of risk associated with prescribed medications.

**Material safety data sheets for SSM ships**
November 2009 – issue 13

The purpose of guidance notices 12 and 13 is to make ship owners and seafarers aware of the danger of exposure to chemicals, marine fuels and lubricating oils, and to highlight their responsibility to take all practical measures to ensure the safety of all on board.

**Advises on amendments to ISM Code**
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**Large coastal ships – safety requirements**
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