WHALING SKIRMISH IN ICY SEAS
Close quarters leads to collision

VHF RADIO ➤ IF YOU NEED HELP, CAN YOU CALL FOR IT?
Contents

06 Cover story
Whaling skirmish in icy seas
Close quarters situation ends in collision and sinking

08 Overcome by hold fumes
Dizzy and dazed after entering a hold alone

09 Watch your passengers
Don’t overestimate passengers’ sea sense

13 Runabout capsizes crossing bar
Inexperience endangers all on board

14 Catamaran rides over passenger
Rescue attempt goes wrong

15 Use diesel when manoeuvring
Wrong fuel leaves vessel stranded

16 Capsize after snagging propeller
Six on board swam to safety

17 Roll on – but only halfway
A ferry moved off with a car only half on

Features

10 If you need help, can you call for it?
VHF radio – main lifeline to land

18 Fatality and accident statistics

Regulars

03 Introduction

04 Guest editorial:
Key challenges to improving maritime safety
Welcome to the first issue of **Lookout!** for 2011.

It was another busy summer on the water, with a number of accidents, incidents and near misses in the commercial and recreational sectors attracting the attention of Maritime New Zealand (MNZ) and the news media. In the guest editorial the MNZ Authority Chairman David Ledson reflects on some of the more high profile news stories of the summer and looks at the key challenges to improving the maritime safety culture and the way forward for MNZ. The most important of these challenges is personal responsibility and he encourages everyone out on the water to take responsibility for their own actions.

Down the track, some of the accidents that made the news over summer will end up as **Lookout!** stories after they have been thoroughly investigated and the lessons learnt have been extracted. Unfortunately, some of these accidents will also feature in our injury and fatality statistics.

Our March issue contains commercial and recreational accident and fatality statistics for the past year and past decade, along with a breakdown of accidents by vessel type for the past five years.

Many of these accidents could have been avoided by wearing a lifejacket, carrying emergency communications equipment, keeping a lookout, or taking other safety precautions. These are all pretty basic things, but as **Lookout!** readers will know, they’re messages that are all too often ignored by those whose stories wind up on our pages.

This issue of **Lookout!** features a story on the collision between the whaling protest vessel **Ady Gil** and the Japanese whalecatcher **Shonan Maru No. 2**, with lessons to be learnt from this high profile incident.

Our safety feature gives an overview of VHF radio and coincides with the re-release of our popular publication, **Radio Handbook: Your guide to marine communication**, which is available free from MNZ.

In two stories in this issue, people on board recreational vessels were not wearing lifejackets when things went wrong, even though there was a heightened risk at the time from activities being undertaken. While in both cases lifejackets were being carried – as we see all too often – when things go wrong, they generally happen too quickly for people to be able to put them on. Again, these stories highlight the critical importance of personal (and skipper) responsibility on the water.

On a more positive note, a number of people who were out and about on the water over summer commented on the greater general uptake of lifejacket wearing. It’s a step in the right direction. Great stuff.

Please pass this copy of **Lookout!** to your friends, family, colleagues or crew or encourage them to subscribe by filling out the form at the back of this issue.

**Catherine Taylor**
Director of Maritime New Zealand
It’s been a busy summer on the water and in the front of my mind are some of the news stories from the past few weeks that highlight the challenges we face to improving maritime safety.

These stories also reflect our diverse maritime sector, which ranges from vessels out on the high seas, to those we can see from the beach or watch from a lake or river side. This includes everything from international container vessels and cruise ships to interisland ferries and smaller ferries operating in our coastal waters and waterways, and from commercial fishing vessels and recreational fishers to pleasure boats, paddlecraft and jet skis.

The most prominent of these news stories were those involving fatalities – including one about a merchant seaman killed while working on a cruise ship lifeboat in Lyttelton, another about the loss of a man after a small runabout sank near Thames, and one about a young man dying in a jet ski accident on Lake Okareka. While these are the accidents that had the worst outcomes, there were many others over the holiday period in which people suffered serious injuries or had near misses.

One close call that attracted significant media attention occurred when a runabout capsized in heavy seas off Wellington’s South Coast. Three men spent long hours in the water before being rescued, but could have been picked up much sooner if they’d had communications equipment that enabled them to call for help. Their narrow escape could have been avoided altogether if they had taken heed of warnings about deteriorating weather conditions.

MNZ’s fatality statistics for the 2010 year have just been released, showing nine commercial maritime fatalities, compared with four in 2009 and eleven in 2008. There were 14 recreational boating fatalities in 2010, down from 24 in 2009 and 16 in 2008. Most of the boats involved were less than 6 metres long, and these included a number of kayaks and dinghies.

Most of these accidents were avoidable. Despite many of them involving recognised high-risk behaviour and despite the efforts of MNZ and our partner organisations to educate operators of commercial and recreational vessels, people continue to die or be injured on our seas, rivers and lakes.

Key challenges to improving maritime safety
Main and inset: Close call – two men made front page news when they were plucked from the water more than 12 hours after their runabout capsized in heavy seas off Wellington’s south coast. Their companion swam to shore to raise the alarm.

However, improving our chances of success requires more than just personnel. It is also important to have the right safety strategies and to implement them effectively. This is where the second key challenge lies.

▶ A multi-faceted approach

In the past, safety strategies are likely to have had just three strands – regulate, enforce and punish. As is the case with most crude surgery, these blunt instruments delivered variable results and had ‘unintended consequences’. Today’s preferred approach principally uses education to encourage and enable voluntary compliance with safety measures, backed by targeted regulation and enforcement.

If this approach is to succeed, it needs an appropriately resourced and sustained campaign. Ultimately, such a campaign is aimed at changing attitudes and behaviours at sea and on the water throughout the year, and it needs to involve more than an increase in safety messages and temporary change in behaviour over the Christmas holiday period.

▶ Fostering a ‘safety culture’

The third challenge follows on closely from the second. Improving our safety record requires changes in both attitude and behaviour. This means having a foundation safety strategy that will ensure a ‘culture of safety’ pervades and characterises the entire maritime industry.

Achieving a safety culture will depend on having consistent and persistent messages from safety agencies and industry bodies, without individual agendas overshadowing and compromising the effectiveness of the national safety strategy.

▶ Learning from mistakes

Any effective safety strategy needs to have a sound base of evidence at its core. It is sometimes said that no organisation can become great if it does not make a mistake and learn the right lessons from it so it can make changes accordingly. This is the case as we set out to achieve a great safety record.

The usual approach to ‘lessons learned’ from accidents involves two stages. First, details need to be captured, assessed and the results analysed and lessons identified. Second, any changes arising from those lessons need to be implemented effectively. But there should always be a third stage: at an appropriate interval after the changes have been put in place, there should be a review to check they are having the intended consequences and not any unintended ones.

▶ Personal responsibility

The last and most important challenge is for everyone involved in the maritime industry – whether for work or for play – to accept that every person has a role to play and a contribution to make towards achieving substantial and enduring improvements to our safety record.

As a regulator, we cannot be in the wheelhouse of every vessel, and unless everyone who participates in the maritime sector acts responsibly and takes responsibility for their actions, each year will continue to be marked by the tragic stories of those who went out on our beaches, lakes and rivers or out to sea and either returned home scarred by the experience, or did not return at all.

David Ledson
MNZ Authority Chairman

“Most of these accidents were avoidable … despite the efforts of MNZ and our partner organisations … people continue to die or be injured on our seas, rivers and lakes”
The New Zealand-registered anti-whaling campaign vessel \textit{Ady Gil} and Japanese whalecatcher \textit{Shonan Maru No. 2} collided in the Southern Ocean, just 165 nm north of Antarctica. The tri-hull, wave-piercing trimaran \textit{Ady Gil}'s bow was sheared off, and it was eventually abandoned to sink.

One of those on board \textit{Ady Gil} received an injured rib, and others suffered bruising. No one on board the whalecatcher \textit{Shonan Maru No. 2} was reported injured.

\textit{Ady Gil} had been part of a fleet of three that aimed to disrupt the operations of a fleet of Japanese whalers. The campaigners planned to send the trimaran, a faster vessel, on ahead to locate the factory vessel, and disrupt them until the larger campaign vessel, \textit{Bob Barker}, could arrive on scene. All three campaign vessels carried cameramen who were gathering footage for a documentary.

When \textit{Ady Gil} caught up with the whaling fleet, it repeatedly cut across the bow of the factory vessel, \textit{Nisshin Maru}. The trimaran twice dropped lines into the water in an attempt to foul \textit{Nisshin Maru}'s propeller. The campaigners fired apples and kumara at \textit{Nisshin Maru} using a purpose-built compressed air gun. They also fired bottles of foul-smelling butyric acid onto her decks in the hopes of rendering her unable to process whale meat.

The efforts slowed \textit{Nisshin Maru} long enough for \textit{Bob Barker} to arrive in the area. \textit{Ady Gil} then disengaged from \textit{Nisshin Maru}. Two other whalers (\textit{Shonan Maru No. 2} and \textit{Yushin Maru No. 3}) changed position, coming about astern of the trimaran before continuing northbound.

Meanwhile, \textit{Ady Gil}'s skipper had passed the helm to another crewmember and had joined the rest of the crew at the stern to discuss the day’s efforts. By now the trimaran and \textit{Bob Barker} were alongside each other, making about 13 knots.

\textit{Shonan Maru No. 2} was directly astern of \textit{Ady Gil} in an overtaking position. The trimaran’s helmsman had very limited lookout from his position, with only small windows ahead and to the sides, and a very small viewing window astern. The helmsman was not aware of the larger vessel astern, and was not monitoring the radar.

\textit{Ady Gil}'s skipper was aware of \textit{Shonan Maru No. 2}, and as his vessel was running low on fuel, he ordered that it be stopped to idle. At this time, \textit{Ady Gil}'s helmsman was still unaware of the whalecatcher. He had slowed the vessel to less than five knots. At this speed, the trimaran had little manoeuvrability, and began to yaw in the wind and sea swell.

\textit{Shonan Maru No. 2} meanwhile, continued to come up astern. As it approached \textit{Ady Gil}, it began deploying water monitors (cannons) from the bow, midships and stern, all aimed in the general direction of the trimaran. It hailed a warning to \textit{Ady Gil} in English, demanding it stop its obstructive actions.
This was followed by the sounding of a long range acoustic device (LRAD), which emits a shrill high-pitched tone (about 146 decibels at 1 metre) and can cause permanent hearing damage at close range. A close quarters situation developed.

Ady Gil’s skipper and crew immediately focused on Shonan Maru No. 2. Ady Gil’s skipper intended to stare it down as it passed, and took no action to avoid the close quarters situation. However, the LRAD had alerted the helmsman who realised suddenly that the whalecatcher was there. He tried to manoeuvre the vessel out of the way, but the vessel was difficult to steer at low speeds, and he did not have sufficient time. The vessels collided, slicing about 3.4 metres off the trimaran’s bow.

Ady Gil’s crew were thrown onto the afterdeck and a cameraman suffered a rib injury. He was taken on board Bob Barker and attended by a doctor. Shonan Maru No. 2 stood by, available to assist if necessary until it was decided that Ady Gil be towed to the French Antarctic base by its support vessel.

En route, the trimaran began sitting low in the water, and as it was expected to sink, it was cast adrift.

Disclaimer: Lookout! stories usually depict de-identified vessels, people and places. Because of the well-publicised and unique nature of the vessels in this case, the location, and the number of vessels involved, we have included the names of the vessels for ease of reading.

View the full report online at www.marinenz.govt.nz/adygil

Left: Prior to the collision, Shonan Maru No. 2 deployed water monitors (cannons) in response to Ady Gil’s efforts to disrupt operations.

Bottom left: Ady Gil and Shonan Maru No. 2 just after the collision.

Below: The damage to Ady Gil was extensive, with several metres sliced off the trimaran’s bow.

LOOKOUT! POINTS

- Both vessels were bound to comply with the International Regulations for Preventing Collisions at Sea. The Collision Regulations are set out in Maritime Rule Part 22.

- The Collision Regulations required both vessels to maintain an effective lookout, including the use of all available means, and to maintain a safe speed to take proper and effective action to avoid a collision.

- As the give way vessel, Shonan Maru No. 2 was obliged to take early and substantial action to keep well clear of Ady Gil, and take positive and ample action to avoid a collision once the risk of collision existed.

- Shonan Maru No. 2 failed to keep well clear of Ady Gil, did not maintain a safe speed once a close quarters situation arose, and failed to take positive and ample action to avoid a collision.

- Ady Gil, as the stand on vessel also had responsibility to take action to avoid a collision.

- Ady Gil failed to keep a proper lookout. The trimaran’s master did not communicate the situation to the helmsman, and the helmsman failed to keep a proper lookout, which included monitoring the radar. Ady Gil did not maintain a safe speed that would allow it to take action to avoid Shonan Maru No. 2 once the potential for a collision arose and did not take appropriate action when it became apparent that Shonan Maru No. 2 was not going to keep well clear.

- All masters must comply with the International Collision Regulations and practice good seamanship regardless of the politics surrounding their activities. International Maritime Organization (IMO) resolution MSC.303(87) requires safety during demonstrations, protests or confrontations on the high seas. A higher standard of care must be taken by all who are involved in these activities.
A machine operator “felt dizzy and saw stars” after less than an hour in a hold containing logs treated with anti-sap stain.

The hold had been venting for about 25 minutes while the crew held its pre-entry briefing. The machine operator then entered the hold alone, and waited there for the 25 minutes it took for his machine to be lowered in.

He had no means of communication with him, but once the machine was in place, he used its radio to advise his supervisor that the fumes in the hold were “pretty strong”.

Even so, he remained in the hold and started loading operations. After about 15 minutes, the machine operator called his supervisor back saying he was “not feeling too good” and was going to get some aspirin.

He was not seen leaving the hold, but was found a few minutes later in a dazed state. He was taken to hospital by ambulance, but recovered quickly after exposure to fresh air.

“He was not seen leaving the hold, but was found a few minutes later in a dazed state”

Top right: Although the logs were treated with anti-sap stain, a solvent rated as having low-to-moderate toxicity, testing to detect toxic fumes should always be carried out before entering.

LOOKOUT! POINTS

- Although the crew had not carried out an oxygen depletion test before allowing the machine operator to enter the hold, later tests showed the oxygen levels in the hold to be normal. While oxygen tests of confined spaces are a vital first step, further testing is needed to detect toxic fumes. Err on the side of caution, and always carry out relevant testing before entering.

- The machine operator entered the hold unobserved, and without any means of communication. If he had been overcome by fumes before the machine was lowered into the hold, he may not have been able to call for help.

- If you suspect an environment is making you feel unwell, leave immediately. Do not wait until your condition worsens. However, once affected, do not attempt a physically challenging effort, such as scaling a ladder out of a ship’s hold, on your own, unless the situation is urgent. Let someone know you are in trouble and ask for help. Once out of the environment do not assume fresh air will remedy the situation. Toxicity is serious – call an ambulance.

- The contaminated person, and those in contact with them, should be mindful of residual contamination. Thoroughly wash hands before eating, smoking or drinking. Remove and wash any potentially contaminated clothing.

- The fumes were caused by anti-sap stain. This is a wet organic solvent rated as having low-to-moderate toxicity. Overexposure can cause eye and skin irritation and headaches. Inhalation can cause respiratory tract irritation, and pulmonary oedema (fluid on the lungs) in severe cases. Although this stain is not generally considered hazardous, this incident shows that the accumulated fumes can be.

- A pre-entry briefing is the time to ascertain what hazards may be present, and what can be done to eliminate, isolate or minimise these. A thorough briefing in this instance would have included ensuring there was a method of communication, a reminder not to enter the hold unobserved, a discussion of the potential for toxic fumes and appropriate actions to take, a revision of the relevant safety data sheet for the material, and preparation for the appropriate pre-entry testing.
Passengers left hanging in mid-air when a vessel heads over the top of a swell have only one way to go.

On two recent occasions, passengers have been injured after crashing back onto the deck after a sudden drop.

One woman was enjoying a scenic cruise around harbour heads in swells of about 1.5 metres. She was standing on the foredeck when the vessel headed over a wave that dropped away suddenly. She and three other passengers momentarily hung in space before crashing about 30 cm to the deck.

The woman was given first aid and returned to port, where an ambulance was waiting. She suffered a broken leg, and was off work for five months.

Another passenger on board a water taxi was injured when the bow of the taxi, which was riding high, dropped suddenly. The woman had been twisting in her seat to talk to another passenger, and was not aware of the hand rail in front of her. The water taxi was making about 10 knots and was in the process of coming onto the plane. The bow rode high over a cresting wave, and then dropped into the following trough. The woman crashed back into the vessel as it rode up the following wave. She suffered a lumbar compression wedge fracture.

Operators and skippers reporting an accident, incident or mishap to MNZ are encouraged to collect and provide names and contact details for all on board, rather than just the key people involved in the incident. This means that MNZ can corroborate the reported version of events, or gather additional information or another perspective.

Safety briefings are an opportunity for skippers to give non-seafaring passengers safety advice that may seem obvious to mariners. In the first instance, the crew had told passengers the vessel had safety rails and to keep both feet on the deck at all times, but they were not told to hold onto the safety rails and to sit down if feeling unsteady.

In the second instance, a safety rail was directly in front of the passenger, but she did not realise it was there. The skipper had not yet carried out the safety briefing, preferring to first get the vessel under way. The company has since changed its procedures so that safety briefings are given before vessels depart their berth.

Do not overestimate the sea-sense of passengers. Monitor passengers to ensure they are following safety instructions once given.

In swells, skippers should consider closing off foredecks to passengers, as this is where a sudden bow drop will be most pronounced.
We expect to be able to contact people when we’re at home or work and take for granted that we will be able to contact emergency services by phoning 111 when we need them. It’s just the same on the water – but there we only have the resources on board with us.

If you need help, can you call for it?

Reliable communications equipment is an essential part of safe boating – because if you can’t call for help and say you’re in trouble, nobody can rescue you.

Main lifeline to land

MNZ’s maritime radio service maintains VHF (very high frequency) and HF (high frequency) radio services for New Zealand’s coastal waters and much of the South Pacific Ocean and Tasman Sea. These services include monitoring radio frequencies for distress messages around the clock. MNZ also broadcasts maritime safety information, including weather information and navigational warnings.

MNZ’s services are complemented by a network of volunteer private VHF radio operators located around New Zealand and its offshore waters. The radio network consists of 28 coastal stations covering New Zealand coastal waters and two covering the Chatham Islands.

Each of these stations has a designated channel (see the coverage map on page 12). Channel 16 is monitored at all times by staff working at MNZ’s Maritime Operations Centre. The private operators’ radio network, including Coastguard radio, usually has operators who are very familiar with their local area. Some operate 24/7.

Channels 20, 21, 22 and 23 provide continuous weather forecasts and reports from key weather stations. This service is operated by New Zealand Coastguard.

Channels are publicised at vessel launching points. There are a total of 55 channels available for marine VHF radio use. While many channels are dedicated to specific use, there are also channels that provide ship-to-ship and ship-to-shore communications. These channels are not monitored.

The MF/HF (medium and high frequency) maritime radio service is provided by Taupo Maritime Radio, from a site near Lake Taupo. HF and MF (often referred to as SSB or single sideband) frequencies are used for long range marine communication.
Distress channel

VHF distress calls are broadcast on VHF channel 16. This channel is monitored at all times by MNZ, and is dedicated to distress, safety and calling. All VHF stations provide a separate working channel for other communications.

Special calls are used in cases of distress, urgency and safety, and must be properly understood and used. There are three levels of call:

DISTRESS – the distress signal MAYDAY is used to indicate that a vessel, aircraft or person is in grave and imminent danger and requires immediate assistance.

URGENCY – the urgency signal PAN PAN is used to indicate that a vessel has a very urgent message to transmit about its safety (such as loss of steering).

SAFETY – the safety signal SÉCURITÉ (pronounced say-cure-ee-tay) is used to indicate that the calling station has an important navigational or meteorological warning to transmit.

The use of MAYDAY is prohibited except to indicate distress. The distress call has priority over all other transmissions. All vessels hearing it must immediately cease all transmissions that could interfere with the distress communication and maintain a listening watch on the frequency being used.

MAYDAY is a request for immediate assistance. If you hear a MAYDAY call, listen, and if possible write it down. Do not transmit any message that is not associated with the mayday situation. Determine if you’re in a position to help. If not, maintain radio silence. If no other station acknowledges a MAYDAY call, acknowledge it and do as much as you can to assist the vessel and communications.

Distress and urgency calls and messages must be cancelled if assistance is no longer required or when the incident is over.

Coverage

The maritime radio service consists of 30 coastal VHF stations, with 28 providing coverage around the coastal waters of New Zealand. There is no VHF coverage on many of New Zealand’s inland waterways.
CBES is one of these and provides tutorials and learning resources for people who want to study for the Marine VHF Operator qualification. Contact CBES on 0800 40 80 90 or visit www.cbes.org.nz.

If you sell your vessel, you can either keep the call sign or transfer it to the new owner. In both cases, you must inform the new owner and MED or one of its agents.

**Fixed or handheld VHF radio?**

It depends on your vessel type and the radio’s intended purpose. There are a number of handheld and fixed VHF radios available at a range of prices, with some cheaper than a cell phone.

A fixed VHF radio has a greater range than a handheld radio and is better for regular communication, but you will not be able to access it or use it in an emergency where it is damaged by water, such as a capsize. If attached to your person, a waterproof handheld radio will be able to used even if you end up in the water. You should carry at least two reliable forms of communication at all times.

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**RADIO DISTRESS CALLING**

Use only if you are in imminent danger and need immediate help.

1. VHF Ch 16 (or SSB 2182, 4125, 6215, 8291)
2. MAYDAY  MAYDAY  MAYDAY
3. THIS IS [Vessel's Name]  [Vessel's Call Sign]  [Vessel's Identity]
4. CALLSIGN [Once]
5. MAYDAY [Once]
6. Vessel's latitude and longitude, or bearing and distance from a known landmark
7. Nature of distress and assistance required
8. Other information – number of persons on board, description of vessel, liferaft or dinghy carried
9. OVER

Allow a short time for a reply. If no reply is received, work through all frequencies on the radio. If contact is made with a shore station, tell them if you have activated your distress beacon and follow their instructions. Activate distress beacon if carried. Wear lifejackets.

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**Need more information?**

Contact CBES on **0800 40 80 90**, visit [www.cbes.org.nz](http://www.cbes.org.nz) or read the Radio Handbook: Your guide to marine communication available in PDF format (on the MNZ website) or in hard copy by phoning **0508 22 55 22** or emailing **publications@maritimenz.govt.nz**.

**Maritime Radio VHF coverage**

The coverage shown is for vessels with a fully functioning 25W radio using a correctly installed antenna, mounted 4 metres or more above the waterline.

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You should carry at least two of the following at all times, so you can call for help in the event of an emergency:

- **VHF RADIO (Channel 16)**
- **DISTRESS BEACONS** – PLBs (personal locator beacons) or EPIRBs (emergency position-indicating radio beacons)
- **HANDHELD FLARES** – orange smoke, red handheld or red parachute or rocket
- **CELL PHONE** (call 111) – remember keep it on you and keep it dry!

Reliable communications equipment is an essential part of safe boating – because if you can’t call for help and say you’re in trouble, nobody can rescue you.
Runabout capsizes crossing bar

Onlookers watched horrified as a 16-foot runabout’s skipper attempted to cross a bar in poor conditions with two young children on board.

One man watching on shore tried to attract the skipper’s attention to dissuade him from making the attempt. When that failed, the man ran back to his car, retrieved his cell phone and dialled 111, ready to call when the inevitable accident happened.

The skipper’s wife, father and two young children were on board. As the vessel headed toward the bar, no one could be seen wearing a lifejacket.

At the time, Coastguard was broadcasting weather and bar warnings on the prescribed VHF radio channels. A 2–3 metre swell was forecast and lifeguards had closed the beach for swimmers.

The skipper had owned the vessel for about two years, but had operated in these waters only a few times.

At the launch point, a large noticeboard describes which VHF channels to listen to for navigation warnings for the area, and provides bar crossing instructions. The skipper did not read this advice and did not attempt the crossing in the suggested direction.

Part way through the crossing, the skipper told his wife to put a lifejacket on their youngest child. Soon after, the engine cut out. The vessel was then hit by a wave and capsized.

Eight separate calls were made to emergency services to report the capsise. Lifeguards on duty witnessed the accident and rescued the skipper’s father and assisted the two children.

The skipper and his wife were able to make their own way to shore. All five people were taken to hospital and later discharged. The vessel was recovered.

Onlookers were certain the runabout was not suited to make the crossing, given the conditions. The skipper had ample opportunities to heed warnings and abort the crossing. Bar crossings can be extremely dangerous. Skippers should check weather reports, listen to published warning channels, and follow suggested local procedures. If in doubt do not attempt a bar crossing.

Inexperienced skippers should not carry passengers until they are competent and confident in their abilities. Crossing the bar under the guidance of an experienced skipper with local knowledge, taking part in a Coastguard bar awareness day, or attending a Coastguard safety education course are good ways to gain essential knowledge.

Only one of the party wore a lifejacket. Correctly sized and appropriate lifejackets must be worn at times of heightened risk, which includes during bar crossings. Failure to do so is an offence.

The engine cut out because the battery lead became disconnected. It is not known why this happened, but it is possible that the engine hit the sea bed in shallow water as the skipper was not following the suggested procedure for crossing the bar. You should do an equipment check of your vessel before leaving on any trip.

The skipper was convicted under section 65 of the MTA for operating a vessel in a manner causing unnecessary risk to the safety of those on board and was fined.

Read more about bar crossings in Issue fourteen of Lookout! – Beware of the bar or visit the MNZ website.
A catamaran rode over one passenger, who was swimming, while attempting to rescue another from the sea.

The passengers had been on a sightseeing trip, with the option of swimming with dolphins. The vessel was manned with a skipper and one crewmember.

Eighteen passengers entered the water that day. They were supplied with flippers, snorkels and goggles. Wetsuits were available but not required to be worn, and none of the swimmers wore lifejackets. Several young children were swimming.

Those swimming were told to head away from the catamaran to encourage the dolphins, and several moved off toward the stern of the vessel.

One swimmer was enjoying the dolphins at the rear of the vessel when they seemed to disappear. She ducked her head under the water to try to see where they were. Lifting her head up out of the water, the swimmer saw only catamaran. The vessel had been driven over her, and she was in the space between its twin hulls.

The swimmer managed to work out where the rear of the vessel was and edge her way out to the back of the boat, where she was helped out of the water. Although uninjured, she was badly shaken by the incident.

The swimmer later discovered that the vessel had ridden over her while attempting to assist a young child who was struggling in the water. The crew had only realised the swimmer’s plight because they were alerted by someone on another vessel in the area.

Since the incident, the sightseeing operator now requires all those who swim with the dolphins to wear a wetsuit to assist with flotation. Crew are being retrained on a range of rescue options, as moving the vessel may not always be the safest choice with multiple swimmers in the water.

New throw-lines have been added to the vessel, and a snorkel with an in-built whistle is being trialled. The company has also tightened its competency vetting of those wishing to swim, and is reviewing its publicity material.

This incident highlights that legal manning requirements are a minimum only. Had more crew been available, the positions of those in the water would have been easier to establish.

Operators should be aware of the potential difficulties in having multiple people of differing abilities in the water at one time. Corralling swimmers to one general area, and posting a crewmember in the water who is equipped to assist anyone struggling may be useful.
Use diesel when manoeuvring

A fishing vessel’s engine stalled leaving it stricken in the middle of a harbour for more than an hour, after its crew switched fuels.

The crew had used diesel to power the vessel during the first part of its journey out of the harbour, but had changed to heavy fuel oil while still within the harbour confines.

Soon after the switch, the vessel’s engines stalled. The vessel was left with no means of propulsion while the crew replaced the compressor with a spare that was on board, and restarted the engine.

“The crew had used diesel to power the vessel during the first part of its journey out of the harbour, but had changed to heavy fuel oil”

Diesel is a lower viscosity fuel oil, rated 2 on the viscosity scale of 1 to 6. Diesel does not overheat and does not require continual circulation. It is therefore ideal for a vessel that is being manoeuvred. Heavy fuel oil is much thicker – rated 6 (or most viscous). It tends to overheat and must be kept circulating at all times or it can ‘gas up’ and cause engines to stall.

Although heavy fuel oil is more difficult to use, it is significantly less expensive than diesel and is often carried in large quantities. In this case, the vessel was left with no means of propulsion, in a harbour setting with significant risk of collision or running aground while the crew worked to restart the engines.

Since this incident, the vessel has adopted the best practice technique of ensuring diesel is used until after all manoeuvres are completed. In practical terms, this means at least until the pilot has left the vessel.
A 6 metre recreational vessel with six people on board capsized after its propeller snagged on a submerged fishing net.

The weather had been fine for boating, although a ground swell was increasing and a surf break was forming near the shore.

The skipper had taken the vessel into four metres of water to drop a diver onto a reef. As the vessel neared the reef, its propeller became entangled and the engine stalled. With no steering in the shallow surf conditions, the vessel was at the mercy of the incoming waves and soon capsized.

One of the six men swam the short distance to shore and called rescue services.

The remaining passengers clung to the upturned vessel and eventually drifted to shore. Lifejackets were on board, but these were not worn. A manually activated EPRIB was also on board, but this could not be reached once the vessel had capsized.

The men were left cold, bruised and grazed.

Lifejackets should always be worn and communications equipment accessible when undertaking a boating activity with a heightened risk, such as operating in surf conditions. It is fortunate that the tide washed the men ashore. Had they been washed out to sea, this accident could have easily have resulted in fatalities.

Waves will generally increase in height and be more likely to break when a swell runs from deep water into shallow water. This commonly occurs on river bars and reefs and increases the risk of boating in these areas.
A car ferry started to move off, raising its ramp while a passenger was halfway through driving his vehicle on board. The front of the car was lifted into the air with its driver and another passenger still inside. The rear of the car was still on the wharf. None of the crew had been watching as the car started to come on board. Once they realised what was happening, the vessel was reversed back in, and the ramp lowered. The car suffered body damage and the driver was shaken by the event.

“The front of the car was lifted into the air with its driver and another passenger still inside”

A vessel without power or steering will quickly turn broadside to any current, swell or waves, and where the waves are large enough, capsise is inevitable.

- There was very little the skipper could have done once he lost power. An auxiliary engine can be helpful in these situations, although they must be operationally ready.

A vessel without power or steering will quickly turn broadside to any current

- The driver of the car had not been directed to board the ferry. In the absence of any clear direction from the crew, he assumed that boarding was the correct thing to do. The crew, however, had been distracted with other matters, and the skipper was not assisting with the loading.

- Passengers are not crew, and must be precisely directed, and then monitored at all times.

Since this event, the company has required that the ticketing crewmember stands in the centre of the ramp during raising and lowering, to ensure no further cars attempt to come on board. It has also required that both the crewmember and the skipper are on the loading deck during peak times.
Total recreational fatalities for the period 2001–2010 are more than double the total for commercial fatalities (160 recreational fatalities, compared with 74 commercial fatalities).

In 2010 commercial fatalities stood at nine, while there were 14 recreational fatalities. The lowest annual number of commercial fatalities was 3 in 2007, while the highest number, 11, was recorded in both 2001 and 2008. The lowest number of recreational fatalities was 7 in 2006, while the highest number over the period was 24 in 2009.

In the past five years, there have been at least two recreational fatalities involving dinghies each year. In 2009, there were nine fatalities involving dinghies, the highest number of recreational fatalities by vessel type over the period. The second-highest number of fatalities by vessel type was also recorded in 2009, when there were six fatalities involving a motor launch.

In the commercial sector, there has been at least one fatality in the fishing and foreign SOLAS category in each of the past five years, although the total number for the fishing sector (17) is more than double the total for the foreign SOLAS category (8) over the period. None of the commercial fatalities in 2010 involved New Zealand nationals.
SERIOUS HARM ACCIDENTS BY VESSEL TYPE (COMMERCIAL)

ACCIDENTS BY VESSEL TYPE (COMMERCIAL)

ACCIDENTS BY TYPE (2010)
Report maritime accidents and incidents online

It’s now quicker and easier for you to report maritime accidents and incidents to MNZ.

We’ve developed a new online reporting system so commercial operators and recreational boaties can report accidents, incidents or serious harm injuries online by completing and submitting an electronic form directly to MNZ.

All masters and skippers are required by legislation to notify accidents, incidents or serious harm injuries to MNZ as soon as practicable.

We use the information to track trends in accidents, incidents, serious harm and fatality statistics and to get a clearer picture of where we need to focus our efforts or develop resources or rule amendments.

The new reporting system was developed with input from industry stakeholders from the jetboat, rafting, fishing and passenger sectors and from recreational boaties, with their feedback incorporated into the final design.

Feedback from people using the system shows people are finding it easy to use, with comments received so far “well done with it, it’s better than I hoped it would be (not that I’ve been itching to have an incident to try it out…)”, “being over 60 and not up with the new technology that much, I found the online reporting system very user friendly”, and “so much easier to do online”.

New paper forms are also available to use, but we encourage you to try the online forms.

Report accidents online using the link on MNZ’s home page or go to: www.maritimenz.govt.nz/report-online

Maritime fatalities 2010

From 1 January to 31 December 2010 there were 23 fatalities – 9 in the commercial sector and 14 in the recreational sector.

This compares with 4 commercial and 24 recreational fatalities in 2009.

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