Jet boats meet head-on while travelling blind
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In the first issue for 2013, we will launch a combined LOOKOUT! and Safe Seas Clean Seas publication, bringing you maritime news from the commercial and recreational sector, and environmental, oil pollution response, and search and rescue stories, along with our regular LOOKOUT! stories.

It’s been a busy year for Maritime New Zealand (MNZ), both on and off the water, which I reflect on in my editorial “The year in review – casualties, compliance and collaboration in the New Zealand maritime industry”.

My editorial looks at the response to the Rena grounding, significant projects underway at MNZ, and what is being done to achieve our goal of safe, secure and clean seas.

As a regulator, there is a range of tools we can use to reduce risk and achieve compliance, from liaison to enforcement. It’s important that we choose and use the right tool, at the right time, to achieve the best possible compliance outcomes. Changes underway at MNZ will enable us to do this more effectively.

Following on from the September LOOKOUT!’s safety feature on lifejackets, we continue to highlight the need for emergency communications in this issue. There’s no question that lifejackets are lifesavers. If people end up in the water, their chances of survival are significantly increased if they are wearing a lifejacket, but lifejacket wearing is not enough.

As the September issue’s story “Men drown after large wave sinks catamaran” showed, even if you end up in the water with a lifejacket, having a way to call for help can mean the difference between life and death. All five survived the first four hours in the water while wearing lifejackets, before two of the party succumbed to hypothermia and drowned. It is important to carry at least two reliable ways of calling for help that will work when wet. This applies to commercial and recreational boaties. As we’ve seen all too often, trouble on the water can happen to anyone at any time and it usually happens very quickly.

In three of our LOOKOUT! stories, the people had no way to call for help when things went wrong. In both of the recreational accidents they had no working way to raise the alarm. In the first story, “Ignoring basic safety steps has tragic result”, a man died. This group had broken all of the rules. They didn’t have enough lifejackets for all on board, didn’t have any way to call for help, didn’t check the weather and drank heavily. It could easily have ended in multiple fatalities.

In “Capsize survivors have lucky escape”, two men on a commercial fishing boat had lifejackets and a fixed distress beacon on board, but were unable to reach them when their vessel suddenly capsized. With no way to call for help, they were lucky to have been picked up by a nearby boat.

Two other stories involve falls into or around an unguarded hatch on a commercial vessel. In both cases, these accidents could have been prevented by taking simple steps and following procedures.

In MNZ’s compliance toolbox, LOOKOUT! sits at the education end of the spectrum. We hope that by reading LOOKOUT! you will learn from the mistakes of others and reflect on and improve your own safety practices. We know from feedback that it is an effective tool.

Please take care out there on the water over summer. I wish you a safe and relaxing festive season.

Keith Manch
Director, Maritime New Zealand
I began my role as Chief Executive of Maritime New Zealand (MNZ) at the beginning of December 2011 – two months after Rena became a household name in New Zealand.

The impact of the Rena event on the Bay of Plenty and surrounding regions, iwi, the wider community and businesses has been profound and is ongoing.

As the incoming Chief Executive, I was able to observe the first part of the response prior to officially taking up the role. The first two months were of course a most intense and challenging period. Although it would be better if this event had never happened, I was pleased to have been invited into the organisation to observe during those first two months.

This enabled me to get a feel for the way MNZ responded both to the incident itself, and to the immediate opportunities to change and improve its approach – especially in the area of iwi and community engagement. I doubt that anyone could experience a more realistic induction into a role.

Subsequently, I have been more directly involved in the multiple dimensions of the ongoing response activity, including oil pollution response, salvage oversight, investigation and prosecution activity, and negotiating for recovery of costs paid by government.

MNZ’s overall response is subject to an independently led review, which will, no doubt, identify further opportunities for improvement in dealing with matters of this nature. I welcome that. It is critical that we learn lessons and improve.

It’s also important that I acknowledge what has been achieved by people and organisations – staff at MNZ, the numerous central and local government organisations, the New Zealand Defence Force, iwi and communities – and individuals involved in the response and recovery effort, to date.

We have come a long way in 14 months. The Bay of Plenty beaches are in good condition for the coming summer. Those responsible for the event – the master, 2nd officer and owners – have been held to account through our justice system. The owners and their insurers have taken a positive approach in responding to this unwelcome event, including repaying substantially more of the Crown’s costs than they were required to by law.

The event is not over, but is well under control. Projects are underway (led by the multi-agency Rena Recovery team) to monitor and assess what can be done to support the ongoing environmental recovery, and there is still considerable work to do on the wreck itself.

The ongoing risk remains of debris being released and causing navigation hazards and being washed up on beaches. The level of response from everyone involved over the
To reflect on the functions, roles and team structures that we have in place to ensure successful delivery of the new systems.

Focusing on this has highlighted the opportunities we have to improve other aspects of our compliance capability – that is, the way we bring all elements of the organisation to bear on supporting, encouraging, assisting and enforcing requirements to comply with the laws, regulations, rules and codes that support safe, secure and clean seas and waterways in New Zealand.

There is significant effort going into bringing our policy, legal, maritime, environmental and front line skills together. This has included developing a Maritime Advisory Group made up of people from different parts of MNZ, with experience across the maritime spectrum, who discuss key issues and overall organisational direction directly with me.

In particular, changes we are making to our roles and team structures, we are looking closely at how we collect, collate, analyse and use information across all of our functions to ensure that our actions are targeted where they will have the most impact (often referred to as being intelligence-led). Our approach is being informed by developments in compliance thinking from other regulatory and compliance organisations, both in New Zealand and internationally.

MNZ will be increasingly intelligence-led, with a strong focus on the achievement of safety, security and environmental outcomes.

As we move into 2013, MNZ will use this intelligence-led approach, with a strong focus on risk (after all, regulation is essentially about risk management) and the achievement of safety, security and environmental outcomes. MNZ’s work is underpinned by a number of international and domestic frameworks that have elements of prescription and/or provide for a more performance-based, or outcomes-based approach. There is a range of compliance tools available that we can use, from liaison to enforcement. Our goal is to ensure that we use the right tool, at the right time, to achieve the best possible compliance outcomes.

A critical part of achieving compliance in a way that supports effective safety, security and environmental outcomes is through engaging effectively with those we regulate. Regulatory relationships are always challenging – especially where the system operates on levies, fees and charges as ours does, to a large extent. We deliver privileges and obligations rather than ‘customer services’, in the usual sense of that phrase. We are here to protect the safety of seafarers, passengers, clients, cargo and society at large (including the environment) rather than ‘delighting’ those we engage directly with in most cases. None of that means that we shouldn’t engage with respect, be courteous, fair, reasonable and responsive – nor indeed that those we engage with shouldn’t behave in a similar manner.

This year we have made significant efforts to build on the quality of the industry relationships that have been established through the Sector Reference Group (that has put so much time into the Funding Review work), and build on relationships that have been at the heart of the Rena response.

The engagement relating to the Funding Review has had the added benefit of bringing together representatives of the multiple elements of the maritime industry, leading to the establishment of a New Zealand Maritime Forum. This excellent initiative should help to ensure that the maritime industry’s relationships with MNZ are constructive. More importantly, it supports the industry in engaging with government more broadly, and recognises the vital importance of the maritime industry to New Zealand.

The Rena incident has highlighted the critical nature of our engagements with iwi, local communities and businesses, local government agencies, the emergency management community in government, and the New Zealand Defence Force. Incidents like those involving Rena highlight the importance of planning, preparation and execution of response activities – none of which can be successful without strong relationships between people that may have to work together effectively in times of extreme stress.

As 2012 comes to a close, and 2013 kicks off, our focus will remain on completing the Rena response, and on making sure we are in the best possible position to succeed as an effective maritime regulator – by ensuring we are well organised, capable of doing what’s required and working well with others. I look forward to working with you all to achieve our vision of safe, secure and clean seas.

Keith Manch
Chief Executive and Director
Maritime New Zealand
Ignoring basic safety has tragic result
A relaxing fishing trip in idyllic surroundings ended in the death of a friend and a criminal conviction for the owner of a dinghy who ignored basic safety precautions.

The party, including the owner of a 4.9 metre dory-style dinghy, set out for a fishing trip on a South Island high-country lake. They arrived at a fishing club bach in the early evening and spent the rest of the evening drinking beer and a bottle of whiskey.

At around 9am the next morning, they set out in the dory, carrying only two lifejackets – despite the fact there were four people on board. None of the men actually wore a lifejacket, and no effort was made to check the weather forecast, despite the notoriously changeable nature of conditions on the high-country lake. No one in the party took any means of communicating with anyone on land.

The men said they took a dozen cans of beer and a bottle of whiskey with them, consuming the alcohol as they paddled slowly around the lake fishing. At around 2pm, having finished the beer, they called in to visit a friend at another bach, where they had snacks to eat and more alcohol, this time rum.

Some time between 3pm and 4pm, the party left for the return trip, leaving behind one of the lifejackets for the friend, at his request.

By this time, however, the wind had picked up to an estimated 16 knots (30km/h), with gusts of 27 knots (50km/h) recorded. The men rowed towards the middle of the lake where, for some reason still not established, the dinghy capsized.

All four ended up in the cold lake water, clinging to the upturned boat, without any means of calling for help. Two of the men were good swimmers – two were not. No one was wearing the remaining lifejacket, which was later found by Police in the upturned vessel.

Once in the water, the men drifted with the boat for two hours, with the boat's anchor occasionally snagging on the bottom of the lake.

At one point the men managed to right the vessel, but with no bailer it was impossible to increase its freeboard. They decided to capsize it again and use the air trapped under the hull to keep the boat afloat.

Eventually, one of the stronger swimmers elected to swim to shore to raise the alarm, reaching land and crawling through scrub before walking for help to the bach visited earlier in the day.

While he was away, the other strong swimmer helped the owner of the dinghy to shore, returning to the upturned boat for the last man.

At that point, however, the remaining man panicked, pushing his rescuer under and forcing him to abandon his rescue attempt and return to shore to recover.

The panicked man disappeared below the surface and drowned only 5–10m away from being able to stand up. His body was not found by the Police dive squad until the next day.

The water of the high-country lake where the party went boating is very cold and conditions are notoriously changeable.

The lake with the upturned dinghy. The orange buoy shows the approximate place the drowned man was found.
LOOKOUT! POINTS

- MNZ has four key safety messages for boaties – all were ignored in this case. Wear lifejackets; avoid alcohol; carry two forms of emergency communications that will work when wet and check the weather. These are simple steps, but they can save lives.

- The law requires recreational boaties to carry enough lifejackets of the correct size for everyone on board, but there was just one lifejacket on board at the time of capsize and nobody was wearing it.

- MNZ recommends that everyone on board a boat under six metres in length wears a lifejacket at all times. Lifejackets must also be worn in situations where there is heightened risk (such as when crossing a bar or in rough weather) and should be worn at all times by children and non-swimmers.

- The men had been drinking a considerable amount of alcohol – the blood alcohol level of the deceased man was well in excess of the legal limit for driving. This is inconsistent with the amounts of alcohol the men reported they had consumed, and indicate that the man who died had consumed between 8 and 15 standard drinks (one standard drink is a can of beer or a double measure of spirits).

- MNZ recommends that boaties avoid drinking alcohol on board boats or limiting its consumption. Alcohol impairs reaction times and ability to survive if people end up in the water.

- The men had no means of communicating with anyone ashore and no way to call for help when they got into trouble. It is unlikely that cellphones would have had coverage in the area, but the party could have carried a waterproof VHF radio, a distress beacon (personal locator beacon (PLB) or emergency position-indicating radio beacon (EPIRB)) and flares.

- Despite the well-known changeability of conditions in the area, the men did not check the weather forecast prior to setting out, or alter their plans when the weather changed. Check the weather before you decide whether to go out and monitor conditions and the forecast while you are out. If the weather turns rough, make sure everyone on board is wearing a lifejacket and head for shelter as soon as you can.

- The men were in an area where the water was very cold and expected survival times in the water were therefore shorter. The simple act of wearing a lifejacket would have reduced the wearer’s tendency to panic once they entered the water, and it would have supported them. Lifejackets also keep the wearer buoyant and allow them to conserve energy, enabling them to remain conscious in the water for a longer period of time.

- Although the exact cause of the capsize was not determined, the dory style of dinghy is well known for its stability, so some event (such as someone standing up in the boat) is likely to have taken place. Boaties should exercise caution when moving around in boats.

- Skippers are responsible for the safety of those on board their boats. An investigation by MNZ led to a criminal prosecution, with the owner of the dinghy found guilty of permitting the operation of a boat in a manner that caused unnecessary danger or risk to others. He was fined $500 and ordered to pay $2,500 reparation to the widow of the deceased man.
The area where the fishing boat was working has recently been the scene of other vessel capsizes in which people have died. In each case, the crews met the requirements for their class of vessel – they carried lifejackets and a manual distress beacon or EPIRB (emergency position-indicating radio beacon) on board. However, these are the minimum requirements, and fishers can do more to be prepared in the event of things going wrong.

The chances of survival and rescue once people are in the water are seriously diminished, but wearing lifejackets will keep them afloat and having the right communication devices ensures the alarm can be raised.

Fixed EPIRBs are a minimum requirement for commercial vessels, but these need to be accessed to be activated. If something goes wrong, they often can’t be reached in time. A float-free EPIRB can quickly alert rescuers when a vessel capsizes and people are in the water. The float-free EPIRB is a hands-off version that will look after itself and deploy should you get into trouble. This needs to be mounted where it will not get wet under normal circumstances and where it can float free of the vessel.

Portable waterproof communications devices, such as a VHF radio or personal locator beacon (PLB), are also recommended. With a PLB or VHF radio in your pocket, you can easily signal for help when something unexpected happens. While not mandatory, adopting these measures ensures all practicable steps have been taken to keep crew safe.

Although the two men were unable to call for help, they were fortunate that other vessels spotted something in the water, went for a closer look, raised the alarm and began the search. Keeping a lookout could not only save your life, it could help save the lives of others. Had the men not been spotted, it is unlikely they would have survived a night in the water.

Vessels that are loaded incorrectly or being operated in a way that doesn’t account for their cargo, and how it is loaded, can become vulnerable to capsize. Operators must understand the stability limitations of their vessels and load them in a way that will avoid capsize. For more information about how stability works on boats, read MNZ’s Vessel Stability Guidelines. Go to MNZ’s website: maritimenz.govt.nz and search under ‘vessel stability’ or order a copy by emailing epublications@maritimenz.govt.nz.
HELP – can you

The trouble with trouble is that it can happen anywhere, at any time, to anyone. It doesn’t matter how experienced you are or how many years you’ve had on the water – if you can’t call for help, no one can rescue you.

The last issue of LOOKOUT! featured a story about five people on a boat who found themselves unexpectedly in the water. All managed to climb out and all were wearing lifejackets. They had an EPIRB, flares, VHF radio and cellphones within arm’s reach, but these all went down with the boat. They survived four hours in the water with no means to call for help before two of the group lost consciousness and drowned. The remaining three struck out for a distant boat and were eventually rescued. If one or more of the people on board had carried some way of calling for help, the outcome could well have been very different.

Make sure you can reach communications equipment in an emergency

There are several ways you can signal that you need help. One of the critical factors in a survival situation is being able to tell emergency services that you are in distress and where you are.

You should carry at least two of the following:

- VHF radio
- distress beacon (EPIRB or PLB)
- flares (orange smoke (day time), red handheld (night time))
- cellphone (if in range and protected from water)
- waterproof torch (to attract attention at night).

Remember, if your boat goes down or capsizes, some or all of the above need to be accessible. They are no good if you can’t reach them or water has damaged them. Make sure you and everyone on board knows what emergency communications you have, and how to access and use them.

VHF RADIO

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

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

A mayday call is a request for immediate assistance. If you hear a mayday call, listen, and if possible write it down. Determine whether you’re in a position to help. If not, maintain radio silence. If no other station acknowledges the mayday call, acknowledge it and help as much as you can.

Coverage The maritime radio service consists of 30 coastal VHF stations providing coverage around the coastal waters of New Zealand. There is no VHF coverage on many of New Zealand’s inland waterways, so VHF radio is not suitable in all areas where people go boating.

Call signs A call sign is a unique identification code. It is registered on a database and means that search and rescue authorities can access information about your vessel to help locate you faster in an emergency. Any person can make a mayday call when in distress, but there are penalties for improper use.

Fixed or hand-held VHF?

A fixed VHF radio has a greater range than a handheld radio and is better for regular communication, but you may not be able to access it or use it in an emergency if it is damaged by water. If attached to your person, a waterproof handheld radio will be able to used even if you end up in the water.

DISTRESS BEACONS

A distress beacon is a portable electronic device that you can use to alert rescuers that you are in a life-threatening situation and need help. It is one of the most reliable ways of signalling that you need assistance.

Distress beacons operate on the 406MHz frequency, which the Rescue Coordination Centre New Zealand (RCCNZ) monitors around the clock.

The two types of beacon used on the water are:

- EPIRB (emergency position-indicating radio beacon) – for use on boats and ships

These are waterproof and designed to float upright to optimise their signal. They can be activated manually, and some are self-activating in water and may float free of a vessel in an emergency. Many have strobe lights and lanyards, with brackets to fit them to your vessel.

- PLB (personal locator beacon) – for use in remote locations

These are smaller portable devices and are increasingly being used on boats, but may not be fully waterproof or able to float. They are activated manually and usually have a shorter battery life than EPIRBs once activated. Attach your PLB to your lifejacket or clothing where it can be reached easily in an emergency.
How does the distress beacon system work?

RCCNZ usually receives alerts from distress beacons within minutes, after being detected by satellite. Depending on the type of beacon you’re carrying, it can take two hours or longer for satellites to pinpoint your location. It can also take time for emergency resources to be launched and to reach you.

A beacon with built-in GPS is highly recommended and can greatly speed up a rescue response. It sends geographical coordinates that are accurate to within about 120 metres of your position, whereas a non-GPS beacon is accurate only to about 5 kilometres.

Be prepared

If you get into difficulties when the weather is very bad, be prepared to wait – rescue services may not be able to reach you at night or in extreme conditions, even when they know where you are.

Why you should register your beacon?

Register your beacon so that, in an emergency, RCCNZ can find your contact details, information about your vessel, and names of people who may be able to provide valuable information about your party and your plans. This will help ensure RCCNZ can launch the most appropriate response.

Having your beacon registered also prevents search and rescue resources being needlessly sent out if there is a false alarm.

If your beacon is set off accidentally, phone RCCNZ immediately on 0508 472 269. There is no penalty for accidental activation.

Register now – it’s free

Registering your beacon is free. It is also a legal requirement. Phone: 0508 406 111, email 406registry@maritimenz.govt.nz or visit the beacons website www.beacons.org.nz.

Bag your phone

Most people take a cellphone along when out boating. Your cellphone is useful as a back-up means of calling for help if there’s reception where you are boating, but it will become useless once wet. The simple act of putting your phone in a ziplock bag and in your pocket means that you’ll be able to access and use it if you end up in the water. And if you get your phone wet by accident on your boat, it will save your phone too.

If you need to call for help, dial 111.

Will your EPIRB float free in an emergency?

In September a fishing vessel went missing off the coast of Fiordland with two people on board. After days of searching, the vessel was located, but the men have not been found. They had a fixed EPIRB on board their boat as part of the minimum equipment requirements on a commercial vessel. These work well when there’s time to activate them, but if things go wrong very quickly, they often can’t be reached or there’s no time to set them off. A float-free EPIRB will self-activate and let people know you need help, even if you can’t. It needs to be mounted where it will not get wet under normal circumstances and where it can float free of the vessel.

1. A distress beacon is activated.
2. Its signal, with its unique identification no., is transmitted to the nearest satellite.
3. An alert is sent to the nearest user terminal.
4. The alert is processed by the nearest mission control centre and forwarded to the rescue coordination centre.
5. The rescue coordination centre mobilises resources and directs them to the beacon’s position.
A free MNZ training DVD “Container lashing and de-lashing” is available. Contact epublications@maritimenz.govt.nz to order a copy or watch it online: visit www.youtube.com/user/CommercialVesselsnz.

Measures should be taken to protect or cover any opening on a deck where employees are working and at risk of falling.

- The fall and subsequent serious injury would not have occurred if the worker had been equipped with an appropriate safety harness. Maritime safety codes and health and safety regulations require workers in locations where there is a risk of falling more than 3 metres to wear a restraint, such as a safety harness or belt with a shock absorber attached to a lifeline.

- The ship’s master was ordered to take action to improve safety procedures, including having crew work in pairs when lashing cargo, and ensuring lighting is adequate in areas where deck operations are carried out. Orders were also issued for duty officers to comply with operational procedures, and to properly supervise crew and ensure they wear appropriate safety gear.

- The company undertook to develop and implement procedures for working with containers, and purchased portable lights for work locations. New deck lights were installed and where practicable grates installed to cover holes in decks.
This incident illustrates how complacency about using safety guards on vessels can have serious consequences. The skipper, who was experienced and had worked for the company for many years, chose not to follow the vessel’s safe operating procedures. Instead of propping up the hatch lid as a physical barrier and warning sign – as it was designed to be used during times when the hatch was opened – he slid it out of sight, leaving the opening to the hold unprotected and exposed.

The Health and Safety in Employment (HSE) Act 1992 requires employers and employees to take all practicable steps to avoid causing harm in the workplace. The company had robust operating procedures for dealing with hazards such as open hatches. The skipper failed to comply with these procedures, which constituted a breach of the Act. The Director of MNZ was satisfied with internal measures taken by the company.
A breakdown in communication led to two jet boats speeding towards each other in a narrow stream and colliding on a blind corner. The collision occurred while friends were enjoying a day out exploring local waterways.

The jet boats, one fibreglass and the other alloy, were travelling along a river when they came to a smaller side-stream they hadn’t explored before. A chainsaw was used to clear a gap through a fallen tree, so that the boats could access the stream.

The alloy boat passed through the gap to check out the stream first, while the fibreglass boat waited at the tree. On its return, arrangements were made for the alloy boat to stay at the tree and film the fibreglass boat as it travelled through the gap in the trees.

The fibreglass boat headed off, expecting the alloy boat to follow along after the filming. However, the alloy boat waited at the tree, expecting the other boat to return.

Both drivers waited for each other to arrive, and after a while they separately concluded that the other must have had some sort of problem. They had no means of contacting each other to check their assumptions.

The fibreglass boat headed back downstream at the same time as the alloy boat headed upstream.

The boats met at a narrow corner of the stream and crashed, injuring three people on board. The driver of the alloy boat suffered a broken leg, and he and a passenger were knocked unconscious.

They had no way to raise the alarm and one of the passengers had to walk to an area where there was cellphone coverage to call for help.

The injured driver and passenger were taken to hospital. Injuries sustained by people on the other boat included loose teeth, broken ribs, back pain and bruising.

The two jet boats were boating on a river together, but had no way of checking each other’s position.
This was a completely avoidable accident that could have resulted in multiple fatalities. The local council charged the jet boat drivers under the Maritime Transport Act 1994 with operating their vessels unsafely. The men faced potential maximum penalties of $10,000 and one year’s imprisonment. Each driver was fined $1,500 and ordered to pay $500 costs to a passenger who sustained a brain haemorrhage, concussion and lacerations. The judge stressed that people operating powerful vessels, such as jet boats, need to take extreme care to avoid putting themselves and others at risk.

Had the drivers planned their trip properly, the accident need not have happened. By failing to clearly and fully communicate their intentions to each other, a situation developed where each assumed to know what the other intended. Travel plans on the water should be clearly set out and repeated back to the other party to make sure they are understood.

Vessels should always carry at least two forms of communication that will work in the area, especially when operating as part of a group or in an isolated environment.

There was no cellphone coverage in the area and the drivers had no way of contacting each other when they were in different parts of the stream. Had someone on each boat carried a hand-held VHF radio, the accident could have been avoided. Unable to communicate or check each other’s plans, they went in search of each other and collided.

Lacking a means of calling for help after the accident, one of the passengers had to walk to an area that had cellphone coverage before the alarm could be raised. This delayed the rescue, which in different circumstances could have proved fatal.

Had they carried a distress beacon (PLB or EPIRB), they would have been able to raise the alarm and summon help more quickly.

The stream had a speed restriction of 5 knots. Had the drivers adhered to this speed restriction, it is likely they would have been unable to boat the stream and the collision would not have occurred.

“\textit{They had no means of contacting each other to check their assumptions.”}
Injury caused by passing boat’s wake

A woman was thrown into the air and landed hard, injuring her back, when a boat crossed the wake of a larger vessel heading in the opposite direction.

The woman, visiting from overseas, was a passenger on a fishing charter boat. The boat had slowed to approach a harbour channel and needed to pass behind a more powerful boat heading in the opposite direction.

The wake struck the charter boat heavily and the woman, who was sitting on the step of the cabin and leaning forward preparing to get up, had just got hold of the handle to her left. She was reaching for the handle on her right and didn’t have the opportunity to brace herself. She became airborne, jarring her back as she landed.

The charter trip was immediately abandoned and the boat tied up at the closest wharf, but the woman couldn’t stand up and was unable to disembark at the jetty.

The boat travelled slowly to another port in more sheltered waters, where it was met by an ambulance.

The woman suffered a fractured vertebra and, for some time after the incident, had to wear a body brace to support her back and eventually allow her to travel home.

 ― The operator of the larger vessel had not fully appreciated the effects of the large wake it created...”

LOOKOUT POINTS

- This incident highlights the importance of larger vessels being aware of the effects of their wake on other boats, especially when leaving harbours and restricted waters. Skippers and helmsmen of bigger boats need to take the proximity of other vessels into account when deciding what speed they will travel at.

- The larger vessel was accelerating as it departed from the harbour. Its skipper said he had checked whether any other boats were in the immediate vicinity when the helmsman said he was increasing speed. The fishing charter boat was some distance away, but the size of the wake created by the larger vessel and the choppy sea state on the day had a big impact on it.

- The operator of the larger vessel had not fully appreciated the effects of the large wake it created, but has since taken steps to prevent smaller vessels being adversely affected in future. The larger vessel’s operator has changed its procedures, and now requires the person at the helm to double check with the skipper that no other vessel is close by, before increasing speed.

― Search called off for missing crew...”

Don’t add to the stats! Plan for emergencies.

► practise safety drills
► plan for weather
► do radio skeds
► maintain safety equipment

For more info go to
maritimenz.govt.nz
newzealand.govt.nz
A bulk carrier heading into a busy commercial port suddenly lost power and steerage in the main shipping lane, when a crewman adjusted the wrong valve.

The incident occurred as the ship approached the harbour entrance, when the watchkeeping engineer noticed the main generator fuel temperature was too low. He instructed the oiler to adjust the steam valve, in order to boost the temperature of the fuel to the generators. However, rather than opening the steam valve, the oiler mistakenly shut the fuel oil supply valve, which shut the generators down.

The pilot had just boarded the ship and was travelling at about 10 knots when it blacked out, losing propulsion and steerage. The emergency generator immediately kicked in, and anchors were made ready and a request sent for tug assistance.

Within about five minutes, the steering was able to be restored. Full power was returned within 10 minutes, and the main engine was restarted without the ship drifting from its course. The carrier continued to its berth without further incident.

The watchkeeping engineer instructed the oiler to adjust the steam control valve (centre) but the oiler mistakenly shut down the fuel oil supply valve, which shut the generators down.

The fuel oil heater outlet supply valve (centre) was mistakenly shut down.

LOOKOUT! POINTS

- The simple act of adjusting the wrong valve shut the vessel down and potentially put people’s lives at risk. As it was entering a busy port when the blackout occurred, there could have been serious repercussions for other vessels, as well as the bulk carrier.

- The ship’s crew completed all necessary emergency procedures for blackout and, after berthing, the chief engineer reviewed the incident with the engine room personnel. To prevent any future occurrences, he educated all engine room personnel about the generator fuel systems.

- The ship’s operating procedures were also modified and updated to reduce the risk of any repeat incident. An engineer officer is now required to open the steam valve and perform similar operations, rather than these tasks being delegated to the oiler.
Passengers take a dip when bow goes underwater

Children were among a group of passengers who got an unexpected dousing when the bow of the catamaran they were on dropped into a wave.

Up to 10 of 50 passengers on a morning swim-with-the-dolphins cruise were sitting on the catamaran’s foredeck when it dipped without warning. As part of their safety briefing before departure, passengers had been advised to stay seated and hold on when travelling on the bow. While no injuries resulted from their abrupt dive underwater, the passengers were soaked and one person struck their shins on the railing.

The catamaran trip had been underway for about two hours when the incident occurred, as a result of the vessel changing its angle to the sea in swells about 1.5 metres high. The engines were immediately cut and a crew member came up front to check that no one had gone overboard, before the catamaran continued to a beach where people could disembark and dry off.

**LOOKOUT!POINTS**

- The vessel’s operator failed to record the incident, and it was a passenger who brought it to authorities’ attention. Skippers are expected to keep proper records of all incidents and report them as soon as possible.

  Although no harm resulted, the Maritime Transport Act 1994 still requires skippers to report any accidents, incidents, near misses or mishaps within a reasonable time after the event (usually on the same day, unless exceptional circumstances prevent it).

- It is quick and easy for skippers to report incidents using MNZ’s online accident reporting tool: maritimenz.govt.nz/report-online.

- The passengers received a proper safety briefing before setting out on the catamaran, but no explanation was provided to them after the incident occurred. It is vital for the skipper to clearly communicate with passengers when a distressing and potentially dangerous incident like this has occurred.

- Operators of passenger vessels should consider the safety of people on the bow at all times, and only allow people to ride up front when there is a low risk of the bow dropping underwater or large waves hitting them. Unless the skipper says it is safe for passengers to ride there, the foredeck should be considered a ‘no go’ area.
Wharf workers sickened by pitch fumes

Five men were affected by toxic fumes after pitch/bitumen vapour was released from a cargo vessel alongside the wharf where they were working.

The ship was preparing to unload pitch – a viscous mineral residue that is semi-solid when cool and needs to be heated to temperatures up to 200°C to become liquid enough to pump. A sudden failure in the vessel’s 24 volt DC power supply automatically closed all the cargo control valves. When the power supply was restored, all of the valves opened. This, in turn, caused the liquid pitch cargo to flow from the forward to the aft tanks, causing a pressure spike in the tanks and lifting a pressure/vacuum relief valve, which then released vapour into the atmosphere.

Stevedores on the wharf inhaled toxic fumes from the vent, and had to be taken to hospital for treatment. None of the five men suffered serious harm in the incident.

Although the ship would usually discharge its cargo of pitch on arrival, the receiver had discussed and agreed changes in the arrangements for pitch discharge and vessel loading for this visit. With any change of plans, it is important to consider any potential or new health and safety issues.

Management of the ship had recently changed, resulting in a change in crewing arrangements. The crew on the day had little experience in using the ship’s cargo systems and were not aware of the potential for cargo valves to fully open after a power interruption. Investigation of the incident indicated that the Programmable Logic Controller (PLC) back-up battery, which maintained the system memory, had failed. Had the ship’s personnel known, they may have been able to prevent the sudden release of vapor.

After the incident, remedial work was undertaken on the power control system, to reduce the risk of future power cuts. The ship’s operators were also instructed to monitor the cargo temperature and pressure on a more regular basis than they had previously.

It is important for operators to ensure that all workers are kept safe at all times. Crew in environments involving dangerous substances must be properly educated about how to manage any risks their work might pose. Since this incident, employers and staff at the port have been given medical training about the hazards involved with a ship discharging pitch. The wharf operator is also considering the use of gas-sensing devices.
Watch commercial and recreational safety clips on YouTube.

Commercial and recreational safety clips are now available in bite-sized chunks on YouTube.

There are almost 40 clips on the recreational channel and footage is being regularly reviewed and new footage uploaded. The most popular clips are: launch and retrieval of your boat; navigational lights; boats near big ships; and navigational rules of the road.

There’s a wealth of information available, including regional clips. You can go to YouTube and search for Boat Safety New Zealand or use the URL or QR code opposite.

www.youtube.com/user/boatsafetyinnz

We’ve also set up a channel with commercial safety information and have three clips available: lashing containers; de-lashing containers; and noise-induced hearing loss. This channel will be expanded in 2013.

www.youtube.com/user/CommercialVesselsnz

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**LOOKOUT! magazine is combining with Safe Seas Clean Seas**

We are changing the format of **LOOKOUT!** and Safe Seas Clean Seas magazines. Starting in March 2013, we are launching a combined **LOOKOUT!** and Safe Seas Clean Seas publication, bringing you maritime news from the commercial and recreational sector, and environmental, oil pollution response, and search and rescue stories, along with our regular **LOOKOUT!** stories.

Current subscribers to **LOOKOUT!** and Safe Seas Clean Seas will automatically be signed up to receive the magazine in its new format, but you can add or remove your name from our list by emailing epublications@maritimenz.govt.nz, or visiting our website: maritimenz.govt.nz/subscribe

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**Maritime fatalities 2012**

From 1 January to 30 September 2012 there were 22 fatalities – 14 in the commercial sector and 8 in the recreational sector.

This compares with 3 commercial and 18 recreational fatalities for the same period in 2011.

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