FIRE down below

SMOKE AND FLAME BILLOWED FROM JET BOAT

GPS gets it wrong

OVER-RELIANCE ON GPS RESULTS IN GROUNDING
Fire down below

- Smoke and flame billowed from jet boat.

Man overboard in heavy seas

- An oil tanker's deckhand is swept into heavy seas.

Autopilot with no lookout

- A fishing vessel on autopilot almost collides with anchored recreational vessel.

GPS gets it wrong

- Over-reliance on GPS results in grounding.
What will catch your fall?

> A seaman suffers serious spinal injuries on a cargo ship.

Overconfidence causes night-time collision

> Water taxi motored into anchored vessel.
Welcome to issue #4 of Lookout! - our quarterly safety newsletter. I cannot help but think of the period of change that Maritime New Zealand (MNZ) is experiencing at present – a pace of change that is here to stay.

We are upgrading our IT capability – allowing us to operate in a better and smarter way. The Rescue Coordination Centre NZ is implementing new software that will assist in search planning, and our Wellington office has relocated providing a more efficient and cohesive environment.

It is interesting to observe the changes in maritime activity on the New Zealand coast as the industry responds to changes in the international market. It is clear that transporting more goods around the New Zealand coast by ship instead of sending by road or rail is now being seen as a viable and sensible alternative.

MNZ continues to assess how good or bad our communication is, so I do not mind receiving feedback on what we do well and what we “could do better.” That is part of being a “learning organisation,” particularly as change is going to be with us for a while.

To move ahead, to grow and survive in the current environment we all need to adapt and I aim to ensure that MNZ does just that. My overall objective is to encourage voluntary compliance for safety, security and environmental protection rather than compliance by regulation.

I plan to be out of the office one day per month, so that I can meet with MNZ staff and local operators as part of knowing what is happening out there. Any suggestions as to people I should meet or things I could learn about would be gratefully received.

Enjoy this issue – keep safe and have a great quarter.

Catherine Taylor
Director of Maritime New Zealand
In 1969 Jack Hutchings went to sea as a deck cadet, leaving behind a small farming village in South West England. For the next 30 years he stayed at sea before taking up a shore job.

I spent 23 years on chemical tankers carrying everything from liquid phosphorus to the so-called easy chemicms like toluene and xylene, which accounts for the twitching and the fear of loud bangs and obtaining among other things a Class 1 (Deck) Certificate of Competency or to us older ones, a Master Foreign Going.

The last nine years of my sea-going career was as Master. The smallest ship I was Master of was 56 metres long, the largest 280 metres long – the difference in deadweight being 900 tonnes to 150,000 tonnes.

In 1997 the family came out to New Zealand, and in 2000 I came ashore to work for the former MSA as Manager, Ship Safety Inspections. I stayed there for nearly five years, then spent eight months in Christchurch as the Regional Harbormaster with Environment Canterbury, eventually ending up with Strait Shipping in November 2005.

My official title at Strait is Marine Manager. My main function is to provide a link between the Masters of our vessels and the senior management. My most important task is to ensure our vessels are operated in a safe and efficient manner.

In carrying out this task, I have to balance the needs of the office and the need to engage with the ships’ staff on a regular basis. I attempt to spend at least one day a month on board one of our vessels. I also try and visit the vessels at least once a week when they are in Wellington.

The other balancing act is the need for equipment to be maintained to a very high standard by on board staff on our vessels that work on a 24/7 basis where the routes they ply are mostly pilotage waters. This means that staff work a 12-hour day, much of which is spent either loading, discharging or on watch, giving very little time for tasks outside of these duties. We do attempt to give our vessels at least a 12-hour layover on a weekly basis so that routine maintenance can be carried out.

Risk management is a major task I undertake. Whenever a ship puts to sea there are risks. This is why in the marine insurance world shipping is described as an adventure.

Many of the risks that are encountered on our vessels have been mitigated through our Safety Management System, and the provision of internal publications such as route guides. To ensure that our vessels are sailed in the safest manner possible, the company has implemented a peer review process where the Bridge Staff are audited and reviewed on a regular but random basis for compliance with best practice in regard to bridge resource management and with company operational instructions. Our vessels undergo an annual internal audit of their compliance with the company’s safety management system.

Maybe because of my background I have also become the main point of contact with Maritime NZ, which usually is a pleasant experience, though occasionally frustrating as one forgets that things don’t happen at once in government agencies.

The life at sea has definitely become safer since I originally went to sea. A statistic quoted when I was sitting for my Mates’ Ticket in the late 70s was that anyone over the age of 25 at sea should have been involved in at least one serious accident. There must have been some accident-prone people out there as I don’t think that statistic holds good now.

Along with the safer environment has come a dramatic increase in the bureaucracy on board ships. Whether one has driven the other is debatable. I personally think that the safer environment is a result of the average age of seafarers increasing. People become far more risk adverse once they settle down and have family commitments and of course with age officially comes wisdom. Though this part of aging seems to have escaped me!

Jack Hutchings
Marine Manager, Strait Shipping
Autopilot with no lookout

A 15 metre fishing vessel on autopilot almost motored into an anchored recreational vessel. The fishing vessel’s skipper was distracted with equipment maintenance.

The recreational vessel’s skipper had anchored his vessel within harbour limits to enjoy some fishing. He noticed a fishing vessel that appeared to be heading directly toward him, and could make out a person bent over on its foredeck.

As the fishing vessel drew close, the skipper of the anchored recreational vessel realised collision was imminent and ordered his crew to weigh anchor.

A COLLISION WAS NARROWLY AVOIDED WITH THE FISHING VESSEL PASSING WITHIN THREE TO FIVE METRES.”

He soon saw there would not be enough time and instead ordered the anchor warp be released and applied full astern power. A collision was narrowly avoided with the fishing vessel passing within three to five metres.

The skipper of the fishing vessel said he first noted the recreational vessel on his port bow at a distance of about half a mile. As his vessel approached, he thought the recreational vessel was underway and bearing 20 degrees on his port bow. He left the vessel on autopilot, making about 6 knots, and started greasing bearings on a surface long line drum on the port side in front of the wheelhouse.

Moments later, he went to the side of the vessel and saw an anchor warp in the water directly across the vessel’s path. Running to the wheelhouse, the skipper took the engine out of gear and coasted over the warp. Only then did the skipper see the smaller vessel about 15 to 20 metres off his starboard side.

1. The fishing vessel’s skipper breached two important maritime rules. He failed to keep a proper lookout and he was travelling too fast to take action to avoid a collision. When he first noticed the recreational vessel, the skipper should have determined whether or not it was on a steady bearing with a consequent risk of collision. He should also have called a deckhand to take over the lookout while he worked on deck.

2. The skipper was also in breach of local bylaws by operating on autopilot within harbour limits.

3. He should have ensured there was a crew member on the bridge ready to respond immediately to any need to slow or stop the vessel.

4. If the skipper of the recreational vessel had not released his anchor warp and gone full astern there would have been a collision.

View the full report online at: www.maritimenz.govt.nz
Alcohol involved in man overboard

A man drowned early on New Year’s morning after an evening of drinking and celebrating with friends.

The man’s recovered body showed a blood alcohol level of almost five times the legal driving limit.

He had spent the evening with three friends and his wife at a yacht club, and the party had returned to their motor launch via water taxi. After a few more drinks, the group had gone to bed. The man’s wife was woken about two hours later by the sound of bottles rattling at the stern of the vessel, and assumed it was the sound of her husband going to the toilet. When he had not returned about five minutes later she went to check on him, but he was not on board, nor visible by torch in the surrounding waters.

The rest of the party joined the search using torches and calling out, but to no avail. Almost two hours later the man’s body was found close in to shore, in about one metre of water.

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

“THE MAN’S RECOVERED BODY SHOWED A BLOOD ALCOHOL LEVEL OF ALMOST FIVE TIMES THE LEGAL DRIVING LIMIT.”

1. The accident was not witnessed, however, the post mortem found the man had died from drowning in association with ischemic heart disease and acute or chronic alcohol abuse.
An oil tanker’s deckhand was swept into heavy seas while trying to unlash the base of the accommodation ladder from a lashing point on the hull plating as the vessel departed a harbour.

The decision to raise the accommodation ladder had been left late because the pilot had originally planned to return to shore once the vessel had been manoeuvred out of the harbour. Once under way though, the pilot decided this would be unsafe, because of the high seas and that he would remain on board until the next port.

The deckhand had descended the ladder to unlash the base many times before and wore no life jacket or safety harness. His progress down the ladder was not monitored, although another crew member had said they thought the weather conditions were too dangerous at that time.

Shortly after the deckhand had begun his descent, a loud bang was heard.

Rushing to the top of the accommodation ladder, a second crew member was not able to see the deckhand and guessed he had been swept into the sea. After throwing a lifebuoy with a light into the water, the crew member could just make out the deckhand about 50 to 100 metres astern of the vessel.

On finding the phone to the bridge engaged, the crew member stood shouting and gesticulating at the top of the accommodation ladder until he was noticed by the pilot. The man overboard alarm was sounded and the engine slowed.

As the vessel was still in the harbour channel, there was no room for the ship to turn around. The Master put out a MAYDAY call on VHF channel 16 and the local pilot boat arrived about ten minutes later. Within a further 15 minutes a helicopter had joined the search.

The 23 year old deckhand was never found.

1. The ship’s manual stated that a deck officer should supervise every raising or lowering of the accommodation ladder. None was present on this occasion, and the Maritime New Zealand investigation showed this was not unusual. Because the deckhand’s descent was not monitored, crew were alerted to his fall only by a loud bang.

2. Although the company had recently installed procedures requiring crew to wear a “flotation device” when working over the side of the vessel, no life jackets had been provided for this task. There was no requirement that a safety harness be worn.

3. The accommodation ladder was visible from the starboard bridge wing.

4. The delay in deciding to raise the ladder meant the deckhand was ordered to operate over the side of the vessel in exposed and dangerous conditions.

View the full report online at: www.maritimenz.govt.nz
Knowing more about how and why accidents happen means more can be done to prevent them.

Call our 24hr accident line to report all accidents 0508 222 433
HELP US TO PREVENT ACCIDENTS
Two ferries were forced to reduce speed and alter course to maintain a safe distance from a fishing vessel whose navigational lights had failed.

The fishing vessel was being repossessed and the skipper was manning it for the first time. The only other person on board was a repossession agent.

The skipper was taking the vessel from a secluded bay to a busy nearby port, frequented by passenger ferries. En route, the vessel’s navigational lights failed twice, but were repaired by the skipper, who was able to replace the fuses. When the lights failed a third time, the skipper again replaced the fuse, but the lights failed again immediately. The skipper turned on all available deck lights, but continued the passage. He did not broadcast a warning over VHF to other vessels.

At this time, one ferry was leaving the port while another was inbound. The fishing vessel was between the two.

Both ferry Masters were aware of a vessel displaying only white lights. They were forced to slow considerably and acquire the vessel on radar in order to determine which direction it was taking.

The fishing vessel continued to approach the outbound ferry. The ferry’s Master sounded five short blasts, which the fishing vessel’s skipper later said he did not hear. Both vessels went hard to starboard to avoid a collision, and they eventually passed within about 300 metres of each other. The outbound ferry then continued out of the port without further incident. Meanwhile, the inbound ferry, which was following the fishing vessel, was forced to reduce speed to establish a substantial safe following distance out of concern at the fishing vessel’s erratic behaviour.

LOG STANCHIONS AT THE PORT SIDE OF NO. 2 HATCH.

What will catch your fall?

A seaman suffered serious spinal injuries after falling about four metres to the deck of a cargo ship.

The seaman was part of a gang securing portable stanchions in preparation for loading logs. Donning a safety harness, the seaman climbed a fixed stanchion ladder carrying a shackle and the end of a rigging wire. A fellow crew member stood below feeding out the rigging wire as the seaman climbed the ladder.

When he was about four metres up the ladder, the seaman suddenly slipped off, hitting the bottom of the stanchion, and then the deck below. He had not attached his safety line to the ladder before he fell.

An ambulance was called and the seaman was hospitalised with serious spinal injuries. He was advised not to return to work for three months.

LOG \[\text{STANCHIONS AT THE PORT SIDE OF NO. 2 HATCH.}\]

LOOKOUT! POINTS

1. The fishing vessel’s skipper said he did not announce the navigational light failure via VHF radio because he was carrying out a sensitive repossession. However, the safety of his own vessel and those around him was compromised because of this.

2. The fishing vessel had no other experienced crew member on board. Given that this was the skipper’s first time on board the vessel, a second experienced crew member would have provided additional assistance, particularly when dealing with unexpected events.

3. The fishing vessel impeded the progress of both ferries. Local bylaws required that the skipper keep out of their way because they were over 500 gross tonnes.

LOOKOUT! POINTS

1. Although the fixed stanchion ladders were in good condition, their rungs were wet with morning dew, and slippery.

2. The seaman was carrying a shackle and the end of a rigging wire while climbing the ladder. Three points of contact (such as both hands and one foot) should be maintained on ladders at all times.

3. The seaman should have given his full attention to climbing until he reached the point where he planned to work and the safety line was attached.
Smoke and flame billowed from a commercial jet boat during pre-trip river checks.

Carrying out checks before the next scheduled passenger trip, the driver had noticed the starboard engine revolution counter was reading about 200 revolutions low. He turned both engines on and off to see if they would reset spontaneously. When the low reading continued, the driver returned the boat to the jetty and contacted both the company’s operations manager and technician for help. While waiting for them to arrive, the driver refuelled in preparation for the next trip.

Arriving at the jetty, the operations manager and technician boarded the jet boat with the driver and started the engines in succession. Within seconds they heard a “backfire” sound inside the engine bay, and then saw smoke and flames behind the rear seats.

They activated the fixed fire fighting system, and less than 30 seconds later lifted the hatch to the engine bay to discharge a fire extinguisher at the flames. The fire was extinguished briefly, but then reignited and the crew were forced to climb back onto the jetty to avoid the smoke and fumes.

The Fire Service managed to extinguish the fire, but the boat sank due to the amount of water used to fight the fire. It was later recovered to allow for a thorough safety inspection. There were no injuries resulting from the fire.

1. The day before the incident, another driver had noticed that the jet boat’s starboard engine was not firing correctly. The workshop foreman had decided the spark plugs needed to be replaced due to lead erosion, which had been an ongoing problem since the company had switched to using 100 octane AVGAS. The investigation found that a loose spark plug lead, one end of which had fallen into the engine bilge space, had ignited the fire when the engines were started.

2. Fuel had been regularly spilling over the side of the jet boat during refuelling, which had been noted as “blow back” and “slow filling problems”. Due to the design of the filling system, any spillage would run between the filler housing and the inside of the hull, and then into the engine bay. The hose clamp connecting the filler hose to the fuel tank was also the wrong size, and was held only loosely in position. The fuel tank’s cap was also leaking around the securing screws.

3. The fixed fire fighting system failed to fully discharge into the engine compartment because it had been mounted at an incorrect angle. In opening the engine bay hatch and aiming an extinguisher at the flames, the crew had allowed oxygen back into the engine bay, feeding the fire, and had also blown the flames forward under the fuel tank, which contained the collected spilled fuel in the bilge space.
A skipper would have drowned if not for the determination of his crew to rescue him after he grounded his recreational vessel at speed onto a reef at night.

The skipper was travelling at 25 knots and navigating by eye on a very dark night. He and his crew of two were all experienced recreational boaters, and were returning from a diving trip. The skipper was looking ahead through a viewing opening in the vessel’s canopy. He was searching for a kayak that he knew frequently fished off a nearby reef. The vessel's GPS was switched on, but was not being monitored.

The skipper lost awareness of how close he was to the reef and the vessel grounded at speed. As it rolled to starboard and capsized, all three on board were trapped under the hull. The two crew members soon swam clear of the hull and popped up to the surface, but the skipper did not. His crew immediately began diving under the hull in search of him, but after about two minutes they had still not located the skipper. The crew considered a wider search, but decided to dive under the hull one more time. On this final dive, they found the skipper and hauled him to the surface.

He was not breathing, and after dragging him onto a rock, the crew managed to administer successful CPR. The skipper suffered seven broken ribs, a broken shoulder, lacerations to his face and damage to his lungs. One crew member also required stitches to his face. The vessel was a constructive loss.

1. The skipper broke local bylaws and Maritime Rules by travelling faster than 5 knots within 200 metres of shore and showed poor seamanship. The vessel’s speed did not allow the skipper time to properly determine its position.

2. The skipper also did not keep a proper lookout in navigating by eye alone. As the vessel was equipped with GPS, he or one of his crew should have been monitoring it.

3. An increasing number of recreational vessels are grounding at night at high speed. On this and some other occasions persons on board have been seriously injured. Failure to keep a proper lookout on a high speed vessel endangers the safety of not only the crew, but other mariners. In this case the skipper of the vessel was severely censured by Maritime New Zealand.

View the full report online at: www.maritimenz.govt.nz
GPS gets it wrong

Over-reliance on GPS caused an otherwise experienced and prudent skipper to ground a passenger boat on rocks.

The skipper and crew were returning from an evening’s fishing in calm conditions. As night fell, the skipper motored home relying mainly on his GPS, but with a crewmember posted at the bow as an additional lookout.

The skipper knew the section of the coast well, including the position of some hazardous rocks. He used the GPS frequently and was confident in the readings it gave.

“HE USED THE GPS FREQUENTLY AND WAS CONFIDENT IN THE READINGS IT GAVE.”

Just as the skipper was about to consult his paper chart to confirm a suspicion that he needed to be further off shore, the lookout at the bow called out that there was broken water ahead.

About 10 seconds later, the vessel’s hull and port propeller ground over the top of a rock. The bilge alarm and automatic pumps activated immediately, and inspection showed the vessel was taking on water around a drive leg seal that had been shunted astern on impact.

Fortunately, pumps controlled the water ingress long enough for the vessel to be beached on a nearby island.

The vessel was later found to have suffered extensive port hull damage and a lost propeller blade.

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

1. Over reliance on GPS data is bad navigational practice, especially while operating close to the coast. The day after the accident the skipper noted the unit positioned the vessel over an island even though they were well clear. The manufacturer’s agent for the GPS checked the unit and determined there was no cross track error. Also, the position of the rocks as displayed on the chart plotter corresponded with their position on the official paper chart.

GPS derived positions often are more accurate than the positions for charted data. Navigators should be aware of all the factors that may affect the use of GPS positions. Prudent mariners should pass charted hazards, such as shoals or isolated dangers with utmost caution and at a safe distance, no matter what navigational method is used.
A yacht with an inoperable mainsail rolled twice in breakers after it came too close to the shore while attempting to reach the nearest port for repairs. The mast was lost and the yacht’s life raft was damaged during inflation.

The accident occurred at night in violent seas, close to a lee shore. The yacht was struck by a large breaking wave that caused it to broach and capsize before returning to the upright. The vessel was partly flooded, and the motor had stopped running.

A MAYDAY message was sent advising that the yacht was sinking. Before the message was completed a second wave struck, causing the yacht to roll 60°. In the course of this, the mast was lost and with it the yacht’s VHF communication.

Also, the life raft had broken loose from its location on the deck and became inflated. A short while later the canopy was torn off and the raft started to deflate while still tethered to the yacht.

Two of the crew managed to climb on board the life raft and haul it close to the yacht, intending to hold it there until the remaining crewmember and the skipper climbed in. Several large waves then broke over the deck of the yacht, sweeping the skipper and the crew member into the sea. At the same time the life raft capsized. The three crewmembers were able to swim back toward the life raft and clamber on board, but the skipper was lost in the heavy seas.

The damaged life raft was deflating rapidly, and as it was driven towards the coast, it served only as an object for the crew to cling to. The crew began to suffer hypothermia in the 12 degree water. They were eventually washed up on a rocky shoreline.

The crew fired a hand held flare from the life raft’s emergency bag. It was spotted by the search and rescue helicopter that had been tasked by the Rescue Coordination Centre NZ following the yacht’s MAYDAY call. About an hour later, the helicopter located the skipper’s body, washed up on rocks about 100 metres from the life raft.

The survivors were taken to hospital and treated for mild hypothermia. The yacht was declared a constructive loss.

THE ACCIDENT OCCURRED AT NIGHT IN VIOLENT SEAS, CLOSE TO A LEE SHORE.”

1. The skipper had just purchased the yacht and this was a relocation voyage. Thorough preparations and safety checks had been made prior to departure. However, en route the main halyard had wrapped around the radar scanner on the mast, rendering the mainsail inoperable. The working jib had also been damaged and was furled. The rough sea state meant the crew could neither replace the jib nor ascend the mast to free the halyard. It was because of these rigging problems that the skipper decided to head for a port of refuge.

2. As the vessel had just been purchased, none of the crew had experience in her handling. This is a situation common to many delivery voyages.

3. Due to severe seasickness for some six hours before the accident, the skipper had been unable to monitor the yacht’s track. Although two of the crew were experienced navigators, the yacht was much closer to the coast at the time of the accident than the skipper had intended. It is also possible that the crewmember navigating during the final stages of the journey may have been following an incorrectly entered GPS waypoint. The rough seas also made it difficult to hold a steady course, with the compass varying as much as 40 degrees due to the movement of the vessel.

4. The navigators were both plotting the yacht’s position regularly, but this was more to determine the vessel’s position than to ensure she was following a steady, pre-determined course. Failing to plan a course that would keep the vessel clear of the coast was a key factor in this accident.

5. The coast where the accident occurred is characterised by shallow waters. In heavy seas breakers are encountered well offshore.

6. Keeping well offshore to avoid dangerous coastal seas is often a safer option provided the vessel is capable of safely doing so. Skippers may find this an unpopular decision with crew that are seasick and tired but the safety of the vessel and crew should always be paramount in determining what action to take.
Loss of control in 65 knot gusts

An enclosed water vessel with 130 passengers on board slewed out of control for about 1500 metres after being struck on the starboard quarter by a 65 knot wind gust.

During the three to four minutes that the vessel slewed out of control, the skipper displayed the vessel’s Not Under Command lights to alert other passenger vessels in the area that he could not control the vessel. The skipper was able to regain control only as the wind abated. He headed straight back to port and the passengers were safely disembarked.

However, the incident was not isolated. Two months later the same vessel was struck by a 70 knot gust in otherwise 20 to 30 knot winds. This time the gust struck the port side of the vessel, again causing the vessel to slew out of control. There were several other passenger vessels nearby, but the skipper managed to regain control and avoid collision.

The company commissioned its own safety report into the incidents, as well as a naval architect’s report.

1. The owning company had no operating limits for strong winds. Because of the nature of the surrounding terrain, which created localised and varied wind conditions, it had determined that each skipper should make this decision based on the forecast and the actual conditions found at the time, as well as usual operating determinants. Immediately following the incidents, the company made the decision to install an interim operating limit of 45 knots on the vessel.

2. The vessel’s directional control was questioned following the two incidents. In particular, its skippers pointed out that the vessel handled quite differently to a sister ship. The company decided to trial using additional ballast and positive trim to increase lateral resistance, and to commission a naval architect to examine the results.

3. After the trials, the company fitted a keel bar to the vessel that was the same depth as that used on the sister vessel. This then acted as a “spoiler” to break up the lateral flow of water under the hull.

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

Diagram of the incident drawn by the skipper of the vessel at the time of the incident (the diagram does not necessarily accurately reflect the actual times and distances).
Overconfidence causes night-time collision

The skipper of a water taxi motored straight into the port quarter of an anchored recreational vessel in a quiet bay at night.

The recreational vessel was extensively damaged, and eventually sank in shallow water.

The skipper of the water taxi had delivered some fuel to a friend’s yacht, moored in a nearby bay and was returning home. He knew the area well, including the position of two anchored vessels that were often unlit at night, and kept his searchlights trained on them to ensure he would not collide. As his passage progressed, the skipper increased his speed.

Just as the vessel reached about 15 knots, the skipper was suddenly thrown from his chair. Standing up, he realised he had collided with another vessel.

The skipper stepped out onto the other vessel to check for any casualties, but found it was at anchor and unmanned. He manually weighed the anchor of the recreational vessel, and towed it to shallow water, where it continued to take on water and eventually settled on an even keel.

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

1. There is disagreement as to whether or not the recreational vessel was displaying an all round white light as is required for vessels of its size at anchor. The skipper of the water taxi had radar on board, but had left it in standby mode. Although he knew the area very well, usually passing through on a daily basis, he had been away for a week preceding the accident, and so was unaware that a new vessel was now at anchor. His lookout was obviously degraded by his over-confidence.

2. The skipper was travelling at about 15 knots when the collision occurred. This is well in excess of both the safe speed required by the Maritime Rules and the local bylaw restriction of 5 knots.
Collision with bridge

A container vessel collided with a harbour bridge during a botched wharf departure, in strong winds and a flooding tide.

The vessel was berthed with its port side against the wharf. Owing to the prevailing conditions, the Master ordered a tug, and devised a plan for the tug to first pull from the stern of the vessel to clear it from its berth, and then pull from the starboard bow to swing the vessel’s bow to starboard. However, wind conditions meant the vessel could barely travel astern, even at full power and using the tug. Realising this, the Master decided to abort the plan and to bring the vessel back alongside the berth.

However, before he could do so, the wind caught the port side of the stern and swung the vessel’s stern to starboard. The starboard quarter collided with the bridge, and the starboard bow hit a mooring dolphin. The tug managed to remain clear, but could do little to assist as it was trapped in an area of clear water between the berth, the vessel and the bridge.

Although the vessel suffered minor damage to her shell plating, no water ingress was found, and over the following four hours, the turning tide allowed the vessel to be manoeuvred back to the wharf to berth on its starboard side.

“WIND CONDITIONS MEANT THE VESSEL COULD BARELY TRAVEL ASTERN, EVEN AT FULL POWER AND USING THE TUG.”

1. This was the third time in seven years that vessels had collided with the bridge whilst departing the wharf in strong winds. The company had no wind operating limits in place and relied instead upon Masters’ discretion. Documented guidelines would have assisted the Master with this decision.

2. The Master was aware that the tug had a low bollard pull. Given the weather conditions the Master should not have attempted the departure.

3. The Chief Officer should have challenged the Master’s decision. Good Bridge Resource Management is intended to create an environment where challenges of this nature are welcomed.

4. The vessel was equipped with a Becker rudder. It’s flap had been temporarily welded into position following a problem with the bearings. This meant the rudder was not fully functional, a definite manoeuvring disadvantage. The Master was aware of this limitation and should have factored it more heavily into his decision to depart.

View the full report online at: www.maritimenz.govt.nz
Maritime NZ publishes Safety Bulletins as a means of communicating and encouraging dialogue on a variety of safety issues and the proposals relating to these. The bulletins are published as and when required, and are directed to those sectors directly involved. They are also available to the wider maritime industry via our website. We welcome any comment you may have on the recommendations or content in general.

SAFETY BULLETIN – ISSUE 7, 2007

Freeing Port Covers on Fishing Vessels

Imagine being at sea on your fishing vessel at night in bad weather. Water is being shipped on deck and it is dark. Can you be absolutely sure that the sliding covers on your freeing ports have not slipped down and are stopping the water escaping off the deck?

A recent review of Maritime Rule Part 40D Design, Construction and Equipment – Fishing Ships has highlighted that a considerable number of fishing vessels have blocked freeing ports. The freeing ports are being blocked by sliding covers, locks on hinged covers, or other means.

The accumulation of water on the deck reduces stability and exposes the ship and the crew to considerable risk.

It is acceptable to have covers on freeing ports, as long as they are arranged in such a way that they do not prevent the rapid escape of water from the deck.

Maritime NZ has invited a group of surveyors and members of FishSAFE/ Federation of Commercial Fishermen to help revisit rule part 40D.

The working group’s objective is to produce a clear interpretation of the rule. They will evaluate each applicable rule (31 in total) and then recommend if each rule is valid, or whether amendments should be considered.

MNZ says it needs to better educate fishermen on why compliance with the rule is so important. To kick start the education process, a safety bulletin on freeing port covers has been produced and circulated.

For more information about the working group, or a copy of the safety bulletin, please contact Jessie Fillmore on 0508 22 55 22 or email Jessie at: jessie.fillmore@maritimenz.govt.nz or for a copy of the bulletin go to the MNZ website: http://www.maritimenz.govt.nz/publications/safety_bulletins/sb_issue7.pdf.

Feedback

Your feedback and ideas on Lookout! are very welcome.

If you’d like a particular topic covered in our next edition, then please contact the publications team by email: publications@maritimenz.govt.nz or phone 0508 22 55 22.

New location for MNZ Wellington

Our Wellington office has moved. We are now located at:

Level 10, Optimation House, 1 Grey Street, Wellington 6011

Our postal address and all contact numbers and emails are the same:

PO Box 27006, Wellington 6141

Tel: 0508 22 55 22 (04-473 0111) Fax: 04-494 1263.

MARITIME FATALITIES 2007

From 1 January to 15 March 2007, there were four fatalities – one in the commercial sector and three in the recreational sector.