Near disaster in rapids

RAFTING GUIDE SAVES LIFE WITH CPR

ALCOHOL contributes to drowning

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Looking back over the last year, it’s encouraging to report that there were just three commercial ship-related fatalities – a record low. This compares with 13 fatalities in 2006 and an average of seven to eight over the last 5 years.

Recreational boating fatalities were slightly up with 11 fatalities recorded in 2007 as compared with the record low of seven the previous year. However, this is still well below the annual average of 22 fatalities recorded in the late 1990s prior to the introduction of the national recreational boating safety strategy.

These figures reflect well on all of you involved in the maritime industry and MNZ will continue to work towards improving safety across the commercial and recreational sectors. Updates on our latest work are provided in our quarterly newsletter, *Safe Seas Clean Seas*, which I encourage you to subscribe to if you’re not already on the mailing list.

In this issue of *Lookout!* the human factors, such as getting distracted, loss of situational awareness, making assumptions and alcohol, all feature. And we are also reminded of the importance of good safety practices when a gas cylinder becomes a “missile” (page 11) and a bumped winch results in a “mutilated hand” (page 6).

And, overall with relation to the safety information MNZ provides, we’ve had some very positive and useful feedback via our survey in the December issue of *Lookout!* (check out the summary on page 13.

Do pass on this issue to your colleagues and crew or contact any one of our offices if you’d like more copies. The full accident reports are available on our website: www.maritimenz.govt.nz or by calling our toll free line 0508 22 55 22.

*Catherine Taylor*
Director of Maritime New Zealand
The maritime investigators:
lifting the lid on accidents

Every year, Maritime New Zealand (MNZ) receives hundreds of incident and accident reports ranging from incidents involving small kayaks to massive bulk carriers. This presents many challenges to the MNZ investigations team. 

Lookout! talks to the new head of Maritime Investigations, Steve van der Splinter, about the role.

Q: You’ve just been appointed as MNZ Manager Maritime Investigations: What does the role entail?
A: My role first and foremost is to ensure that our team of investigators have the appropriate training, resources and ability to carry out robust investigations that result in the successful outcomes that MNZ is trying to achieve. Because our team receives hundreds of accident and incident reports every year, a key part of my role is determining which of these require further action, based on the information available. I also have to consider the best use of the resources that we have and the benefits that an investigation may bring in terms of improving safety for others.

Q: What relevant skills and experience do you bring to the MNZ role?
A: I was a detective with the New Zealand Police and have spent the last 20 years working in the commercial investigation environment. I understand the processes and legalities of investigations and the role they have in the functions of a regulator.

Q: How does MNZ decide which incidents or accidents to investigate?
A: The incidents or accidents occurring across the maritime sector can range in severity from minor incidents to fatal accidents, so each case must be judged on its merits. Decisions are based upon the evidence available and not every incident or accident will involve a formal investigation or follow-up action.

Q: What type of investigations does your team typically cover and what if any impact does this have on the way they are investigated?
A: Generally, they fall into three broad categories of safety (including our responsibility to manage health and safety on board vessels), complaints and enforcement of the Maritime Transport Act.

The prime role is to establish the causation of the accidents or incidents and perform a regulator function only if it is necessary.

The types of accidents or incidents vary greatly over the recreational, commercial and adventure tourism areas of the maritime sector.

Q: What are some of the key issues that face your team in investigating maritime accidents?
A: The challenge in any investigation is that there will always be aggrieved parties who feel that they should not be dealt with in the way they have, or those who feel that the matter should have been dealt with differently.

The issue for MNZ investigators is to maintain a balance between these interests and the need to complete our work.

Ultimately it is about learning from accident investigations and sharing any lessons learnt to improve safety in the wider maritime sector.

It is imperative that any safety investigation or enforcement action we do take is conducted professionally and objectively.

If it is found that people were not following their own safety plans, rules and regulations, this may well have contributed to the accident. In instances like this, a challenge for us is getting people to appreciate why we have taken action and communicating the wider benefits that this may have on improving safety.

Q: So where to now?
A: I think MNZ is doing a great job of promoting maritime safety. A lot of work is going into skipper education and this has resulted in a significant reduction in fatalities in the recreational sector.

It is worth noting that commercial accident statistics have dropped, with the three fatalities reported in the commercial sector for 2007 the lowest ever recorded by MNZ.

However, accidents will continue to happen, the reasons are complex and there are always the competing factors of environment, human factors, training, management and other issues that may all contribute to an accident.

Hindsight is a wonderful thing, and after any accident we may feel things should have been done differently. Nobody goes to work and deliberately tries to have an accident.!!

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Near drowning in rapids

The determined actions of a rafting guide saved the life of a passenger who was tossed into a 200 metre rapid.

The passenger was on the second raft of seven that had entered the rapid in quick succession. The whole party had been trained in safety techniques and had viewed the rapid before entering it.

As the second raft entered the rapid it was shunted off its intended course by the river currents and it surfed in a “hole” (a recirculating river feature) which caused the raft to fold, throwing three passengers into the river. Two passengers were collected by following rafts within about 20 metres, but one was swept well away.

The third raft raced after the missing passenger. Several times as the raft drew close enough to pluck the passenger out of the water, a surge dragged him underwater. Each time the passenger resurfaced well away from the raft.

When the raft caught up with the passenger at the end of the rapid, he was unconscious. The passenger was pulled aboard and CPR started on the pontoon of the raft. After two sets of 30 compressions, the passenger started to respond. He was taken by raft to the evacuation point and transported to hospital by rescue helicopter. The passenger made a full recovery.

The New Zealand rafting guide who headed this rescue had 4 months earlier successfully rescued another rafting passenger – this time in Japan. The passenger had been tipped out of a raft and caught underwater, entangled in a mass of bamboo. The guide swam out to the passenger, wrestled him clear, dragged him to shore and performed CPR on the banks of the river. This passenger too made a full recovery.

1. By entering the rapid in support of each other, those on the rafts were able to render immediate assistance.

2. The guides of the rafts were all well-trained in rescue response and current in first-aid techniques. They managed to revive the unconscious patient with effective CPR.

3. The rafts were carrying effective communications and the guides were able to radio base and have a rescue helicopter en route, while the rafts continued to the evacuation point.

4. The passengers on this trip had been thoroughly trained in rafting survival skills such as how to swim rapids in the white-water position, self-rescue swimming to the raft or shore, how to float through rapids to maximise energy, and how to breathe in the troughs between waves.
Alcohol contributes to drowning

A fisherman drowned after falling out of a dinghy about 100 metres from shore. His blood alcohol was more than twice the legal limit for driving and he was not wearing a lifejacket.

The fisherman had rowed out in the dinghy to retrieve set nets in a harbour, while a companion remained on the shore. The fisherman was hauling in a net when his companion saw him topple into the sea. The dinghy floated away and the fisherman was left clinging to an oar. The companion raised the alarm and a rescue helicopter sighted the fisherman and guided the Coastguard rescue vessel to his location. In total, the fisherman was in the water for about 40 minutes. He was pulled out of the water unconscious and CPR efforts by the crew of the rescue vessel, and the ambulance officers waiting on shore failed.

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

1. Alcohol was a contributing factor in this fatality. It affects judgement and reduces the ability to balance. Further, alcohol causes the blood vessels to dilate, which results in rapid cooling of the body, resulting in loss of muscle strength and drowning soon after immersion. Hypothermia onset is also accelerated.

2. Many small dinghies of this size are not suitable for set netting. They become unstable when weight is shifted away from the centre of the vessel, and particularly so when a person stands up. They are lightly constructed and drift quickly away from a person in the water.

3. This fisherman was not wearing a lifejacket. This would have kept him afloat, and would have also served as a brightly coloured marker and made it easier for the rescue vessel to spot him in the water.

Bumped winch mutilates fingers

A deckhand lost his little finger and broke a second finger after he slipped and knocked the knee-activated lever of a long-line winch.

The deckhand had spent the previous day on the long liner fishing for ling off the West Coast of the South Island, along with another deckhand and the skipper. The deckhand had been hauling in the catch for about 2 hours in rough weather. As he was untangling the line to retrieve the windy buoy, the deckhand slipped and accidentally knocked the knee-operated winch lever. The line tightened around his hand and dragged it into the line lifting block. After discussion with the Rescue Coordination Centre New Zealand, the long liner steamed for port, where the deckhand was airlifted to hospital. The little finger of his left hand was later amputated, and his broken ring finger was fitted with a six-hole plate.

1. Extra care should be taken around leg activated winches. The skipper of this vessel has since required his crew to turn off the winch hydraulics at the flow control valve before untying the windy buoys. This safety precaution would prevent a reoccurrence of this accident and should be given careful consideration by fishermen.
A 166 tonne roll-on roll-off vessel’s starboard drive unit declutched during an emergency stop in a narrow channel about 1 hour before low water.

The vessel was returning to port, retracing its outward passage in darkness after delivering a load of vehicles.

The weather was fine and clear and there was a lot of background lighting from the commercial wharves in the port area. The skipper had opened the door, situated at the forward end of the wheelhouse, to prevent reflection from the shore lights interfering with his vision.

As he approached the port, the skipper was keeping a lookout for other traffic, and was watching another roll-on roll-off vessel that was moored alongside a jetty just south of a channel beacon.

As he looked away from this vessel, the skipper suddenly realised his vessel had been pushed closer than expected to the beacon by the strong tidal stream.

He executed an emergency stop by turning both azimuth drive units through 180 degrees to reverse the thrust. Before this, the two units had been running at 1800 rpm, giving a corresponding speed of about 6.5 knots. The reverse thrust directed the flow of water from the starboard drive unit against the hull, which caused heavy vibration and shook the vessel violently.

The skipper rapidly reduced speed on the starboard unit to stop the vibration. After turning the direction of the drive unit so that the flow of water was no longer against the hull, the skipper moved the throttle in an attempt to increase power, but the unit did not respond.

Meanwhile, the port drive unit was still providing thrust astern, which, with the starboard unit stopped, caused the vessel to swing to port, towards the beacon. The vessel was almost stopped in the water when the port shoulder of the vessel struck the beacon, which was pushed over to an angle of about 45°. As the vessel backed off, the beacon fell over and sank.

The skipper realised that the starboard drive unit had become disengaged as a result of the rpm on the unit dropping very quickly. This in turn had caused the hydraulic pressure in the clutch system to fall and the unit to declutch. After the skipper disengaged and then re-engaged the clutch, the starboard drive unit responded immediately.

After ensuring there was no floating debris to endanger other craft, the vessel was able to continue to its berth. Upon inspection, no significant damage to the vessel was found.

1. A series of factors contributed to this accident. The skipper suffered a temporary loss of situational awareness while watching another vessel. This distraction meant he did not realise until too late how far the tidal stream had set his vessel towards the beacon, and he was then forced to make an emergency stop, resulting in the temporary loss of use of the starboard drive unit.
A charter fishing vessel struck a dangerous underwater rock that was usually marked by an unlit marker buoy.

It was later discovered that the buoy had been missing for about 3 weeks, but no one had reported it. The fishing vessel, with eight people on board, had spent the night sheltering in a harbour from what was forecast to be strong winds. The skipper was a frequent visitor to the harbour and knew about the charted rock close to its entrance, but as he had entered the harbour well away from its position, he had not noticed that the marker buoy was missing.

The next morning, the weather was better than forecast, and the skipper headed for nearby fishing grounds. It was about 1 hour before low water and the depth sounder was showing an under keel clearance of just under 2 metres. The maximum draft of the vessel was about 1.5 metres. Within about 1 minute of clearing the harbour, the skipper felt the vessel strike something. At first he did not think of the underwater rock as it had been marked the last time he had visited.

He immediately stopped the main engine and carried out an internal search for water ingress. On finding no signs of water, but still concerned, the skipper decided to return to the harbour to carry out an underwater inspection.

The vessel was later slipped for inspection and repair. The vessel’s keel and hull were damaged.
A trimaran collided with a 13 metre charter vessel it was attempting to overtake during a harbour sailing race.

The trimaran was on port tack on a broadly south-easterly heading. It was trailing two other trimarans that had passed the charter vessel well clear on the starboard side.

The charter vessel was steering a broadly easterly-north-easterly course. The trimaran’s skipper was aware of the charter vessel, but allowed a converging course to continue. As the trimaran closed to about three metres from the charter vessel’s port quarter, the skipper shouted to the charter vessel to keep clear as the trimaran was racing.

The skipper of the charter vessel assessed that the trimaran was the give way vessel and assumed it would alter course and pass under his stern as the two leading trimarans had done. He decided not to take action to keep clear as he was concerned that any move to starboard might cause the vessel’s port quarter to strike the trimaran.

When the skipper of the trimaran realised the charter vessel was maintaining course and speed, he altered course into wind to try and slow down. He could not do this in time and the bow of the trimaran struck the port side of the charter vessel.

The collision caused minor damage to the trimaran and the charter vessel was undamaged.

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

1. The Collision Prevention Rules (Maritime Rule Part 22) do not confer special rights for vessels racing. Under Rule 22.13 any vessel overtaking any other must keep clear. This obligation overrides Rule 22.18 which describes responsibilities between vessels.

2. A vessel is considered to be overtaking when it is coming up to another vessel from a direction of more than 22.5 degrees abaft its beam. This covers an arc of 135 degrees centred on the vessel’s stern and is the same arc from which the stern light is visible.

3. If there is any doubt, skippers should assume they are the overtaking vessel and act accordingly.
Two jet boats collided when low water levels forced them both into the centre of a fast flowing river.

The vessels were heading toward each other. Both skippers knew the other jet boat was somewhere on the river, but each saw the opposing vessel only a few seconds before impact.

The first vessel was a commercial jet boat that was on its second trip for the day down the technically difficult river. The skipper was experienced and knew the river well.

The second vessel was a recreational jet boat. The skipper had one passenger on board and was returning upriver after aborting a planned camping trip because he felt the river level was too low. He had been down the river twice before, but only as a passenger.

Both skippers had filled out the river users’ safety and intentions log, and had noted the presence of the other.

Both skippers were largely keeping to the river boat rules of remaining on the starboard side of the river, but low water levels forced them into the centre in places.

In the moments before the collision, both vessels had been forced to move into the centre of the river to avoid rocks and exposed shingle. They came upon each other at the round of a densely wooded bend, and so had only seconds to react.

The recreational vessel’s skipper turned to starboard. The commercial vessel’s skipper activated both reverse buckets, causing the vessel’s bow to drop dramatically and slew to port. The recreational vessel’s slowing hull rode up onto the other vessel’s windscreen and both were pushed into the bank.

The recreational vessel’s main engine was shunted off its mounts, the reverse bucket was lost and the bow was damaged.

The commercial vessel’s aluminium windscreen was damaged.

1. The river is considered technically difficult to boat. At low water level, for an inexperienced skipper, it can be treacherous. A Department of Conservation sign at the source of the river states that it is suitable for experienced operators only. This accident shows that a difficult river in ideal conditions can become very dangerous if conditions deteriorate.
A damaged oxy/acetylene bottle shot across the deck of a 77 m long line fishing vessel, which was alongside in port, lacerating a crew member’s head, dislocating his shoulder and causing heavy bruising.

The bottle was one of several that were due to be unloaded for refilling. The bottles were stored together against the port side of the vessel, in a raised steel tray and secured against the ship’s side by a common securing line.

As a crew member was lifting one of the bottles clear of the steel tray, he accidentally knocked the others, causing the whole bank of bottles to tumble over onto the deck. One of the bottles smashed against a fish well hatch, displacing the protective cap at the top of the bottle and exposing the gas valve which then fractured.

Escaping gas under high pressure, propelled the bottle across the deck. Three of the crew were able to keep out of the way but the fourth was unlucky and the bottle struck him with considerable force.

He fell to the deck, lacerating his head and was severely bruised. He was later found to have a dislocated shoulder and was forced to stand down from the next scheduled voyage.

"THREE OF THE CREW WERE ABLE TO KEEP OUT OF THE WAY BUT THE FOURTH WAS UNLUCKY AND THE BOTTLE STRUCK HIM WITH CONSIDERABLE FORCE."

1. Pressurised gas cylinders are potential missiles. They should be handled with extreme care and secured individually.
2. Following this accident, the master gave instructions for each oxy/acetylene bottle to be secured individually. This was completed by the installation of steel clamps around each bottle. Additionally, the accident was recorded in the ship’s hazard register and a specific paragraph was added to the ship’s safety management manual regarding the safe stowage and transport of oxy/acetylene bottles.
3. Heavy bottles, such as those involved in this accident, should always be lifted with cages or slings.
An experienced kayaker drowned when a day paddle in light winds became a battle against near gale force winds and 2 metre swells.

The kayaker had wheeled her kayak to a launch site on a lake near her home, as she regularly did. She let her husband know she was going for a paddle, but did not say exactly where she was going or when she would be back.

Some 4 hours later she had still not returned. Her husband checked the launch site but saw only her kayak trolley. After another hour he checked again, and called the police. A search and rescue mission was launched. A Coastguard volunteer found the kayak after 2 hours of searching, and the kayaker’s body was located by helicopter soon after.

Throughout the day, the weather conditions on the lake had changed markedly. An initial 4 to 6 knot easterly breeze had developed into a 30 to 35 knot south-westerly that was creating an estimated 1-2 metre chop where the kayak was found.

It is most likely that the kayak capsized in these extremely difficult conditions. The kayaker was wearing a personal flotation device, polypropylene long-johns and long-sleeved top, a waterproof long-sleeved paddling jacket and gym shoes.

The clothing was appropriate for winter paddling, but not for prolonged winter immersion. In the 14 degree water, with the added wind chill factor, the effects of the cold would have been felt within about half an hour, with significant loss of strength occurring within minutes.

The kayaker had carried a cellphone in a plastic bag, but when recovered, this had water inside it.

The kayaker had also attempted an unsuccessful paddle float self-rescue. This allows a capsized kayaker to re-enter the kayak from the water. An inflatable paddle float is slid over one paddle blade and inflated. The other end of the paddle is then slid under the decklines, just aft of the cockpit, and this provides outrigger stability while the kayaker re-enters.

In this case, the paddle float was found partially inflated and attached around the paddle shaft, rather than one of the paddle blades. In this position it would have had only limited effect in providing stability. Loss of strength from cold also quickly reduces the chance of reboarding.

1. Once capsized, the kayaker was unable to re-enter the cockpit. Well practised self-rescue skills can save lives.

2. The kayaker was dressed for winter paddling, but not for prolonged immersion. A sleeveless wetsuit, booties, waterproof paddling jacket and neoprene hood would have significantly increased her survival time in the lake. However, as 7 hours and 20 minutes elapsed between when the kayaker launched and when her body was found, immersion clothing may not have prevented her drowning.

3. Emergency communication equipment must be able to be used when a kayaker, or anyone in any boating capsize, is in distress and in cold water. A hand-held waterproof VHF radio is usually the best option for contacting rescue services.

4. In areas with 100% coverage a cellphone in a specialist waterproof pouch or in zip lock bags (if the seal and bag are intact) may result in a timely rescue. The cellphone must be able to be used when in the bag, and if possible carried on the paddler.

5. In some places a red day/night flare will be seen and a 406MHz emergency position indicating radio beacon is an effective alternative.

6. All boat skippers should leave trip details including a destination and return time with a responsible person. Two-minute forms are available for this purpose from Water Safety New Zealand.

7. The dramatic weather changes had been forecast. Kayakers and small boat operators should check local, regional or marine forecasts before launching.
Your responses to MNZ safety survey

“Informative and allows the reader to learn from other people’s mistakes and misfortune” – is typical of the feedback from the recent survey about Lookout! and other Maritime New Zealand (MNZ) safety information such as the safety bulletins.

Overall there was a really positive response to the survey, which had two versions – a print version as part of the December 2007 issue of Lookout! and also an online version linked from the MNZ website.

While the majority of respondents used the print version, those who responded online showed clear preferences for electronic media as a form of communication. For example, regarding being updated about urgent safety information, 72% of online respondents would prefer email compared with only 29% of the print respondents.

Key results from the print replies included:
- 78% found the contents of Lookout! to be very useful
- 86% said it was easy to read
- 83% said the frequency (quarterly) was about right
- 77% said they liked to receive Lookout! as a print publication (compared with an email link)
- 67% rated safety bulletins very useful in terms of alerting you to a safety hazard in the work environment
- 63% had taken follow-up action as a result of reading a safety bulletin
- 74% read and keep safety bulletins.

In terms of improvements to Lookout! there were no really strong themes, but suggestions included a diagram of the incident, the content of the specific rule would be a useful reminder and different language versions electronically (Maori and Chinese were the suggestions).

Safety alerts plus
An important question for MNZ is “what is the best way of alerting the wide range of people in the maritime industry to new or important safety information and/or do safety bulletins change behaviour?”

It was encouraging that a number of replies confirmed that simply “increasing awareness is very important” and gave examples of specific behaviour changes such as:
- updated engine room safety
- purchased VHF Radio
- moved extinguishers
- watchkeeping standards.

As a result of the survey, MNZ will be continuing to evolve and improve all our safety-related information and this will include electronic options for those who prefer that as a form of communications.

MNZ appreciates all the feedback received and has now mailed out Prezzy Cards to 10 lucky people. And, of course, we welcome feedback at any time – just email: publications@maritimenz.govt.nz

“An essential read for anyone in the boating/marine industry that highlights that, in spite of the global drive to improve standards incidents and accidents still occur and are often due to omissions or negligence of people or organisations that ought to know better.”

“It is a good teaching aid for my crew.”

“I work on a container terminal, and some incidents and lessons learned are directly applicable to this environment, so I always check that we will not make the same errors!”

“The information is useful for staff training and safety evaluation.”

“I enjoy the breakdowns of each particular case, ie What went wrong? What contributed to the hazard – whether people or physical factors. And how it may have been seen at the time.”

“The Lookout! points at the bottom of each incident, it is very good tool for learning from other operators’ errors and noting the various situations in which accidents can happen.”
From 1 January to 29 February 2008, there were 3 fatalities in the recreational sector.

Safety Bulletins

Maritime New Zealand 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. We welcome any comment you may have on the recommendations or content in general. The bulletins produced to date are listed below, with a brief description of the latest issue.

Latest issue

**Hamilton Jet Steering Nozzle Pivot Check**
**December 2007 Issue 15**

This bulletin is to alert HamiltonJet owners of the serial numbers HJ-212, HJ-213 and HJ-241 of a steering nozzle pivot failure (top or bottom) that will lead to complete steering failure, potentially without warning.

Those affected are referred to the "HamiltonJet Product Bulletin HJ-212 to HJ-241 Steering Nozzle Pivot Checks". For further information please contact HamiltonJet direct.

Past issues

**Crane controls & communications**
**September 2007 Issue 14**

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

**Lifting slings, loose gear and dunnage**
June 2007 Issue 12

**Cargo vessel cranes – Examination and renewal**
June 2007 Issue 11

**Liferafts and their release mechanisms**
May 2007 Issue 10

**Manpower and responsibilities during mooring operations**
April 2007 Issue 9

**Mooring line hazards: Bights and snap-backs**
April 2007 Issue 8

**Freeing port covers on fishing vessels**
February 2007 Issue 7

**Safe operation of Mitsubishi heavy industries hydraulic deck cranes**
May 2006 Issue 6

**Low sulphur diesel fuel**
November 2005 Issue 5

**Ammonia leakage on fishing vessels**
October 2005 Issue 4

**Bulletin for operators of road vehicles and floating barges**
October 2005 Issue 3

**Recommendations for ships carrying fumigated bulk cargoes**
September 2005 Issue 2

**Senhouse slips used in mooring systems**
August 2005 Issue 1

For more information you can:
- download the safety bulletins from the website: www.maritimenz.govt.nz
- email us at: enquiries@maritimenz.govt.nz

Update your accident forms!

The fax number on all the Maritime New Zealand RCCNZ accident reporting forms has changed to: (04) 577 8038. If you have printed out copies of any of these forms, please go to our website (either the Search & Rescue section or the Publications section) and print out the updated forms: www.maritimenz.govt.nz

And just a reminder ... as soon as practicable after an accident, incident or serious harm injury you should phone the RCCNZ (they are available 24/7) to let them know what happened:
- freephone: 0508 22 24 33
- or contact the Maritime NZ Communications Centre on VHF Channel 16.

Feedback

Your feedback and ideas on Lookout! are very welcome.

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

MARITIME FATALITIES 2008

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