



Report 00-203

passenger charter launch *Kiwi Cruiser*

grounding and sinking

Tapeka Point, Bay of Islands

5 April 2000

Abstract

On Wednesday 5 April 2000, at about 1945, the passenger charter launch *Kiwi Cruiser* was returning to Paihia from a fishing charter with 9 passengers and 3 crew on board, when it struck rocks off Tapeka Point. The vessel was holed at the bow and began taking water. As the *Kiwi Cruiser* began to list heavily and settle on the rocks the skipper transmitted a mayday call. The crew and passengers donned lifejackets and launched the rigid life raft before abandoning the vessel. They were subsequently picked up by a vessel that was responding to the mayday call and taken to Paihia. The skipper and trainee deckhand suffered minor injuries in the accident, but none of the remaining people on board was injured. The *Kiwi Cruiser* subsequently sank.

Safety issues identified included:

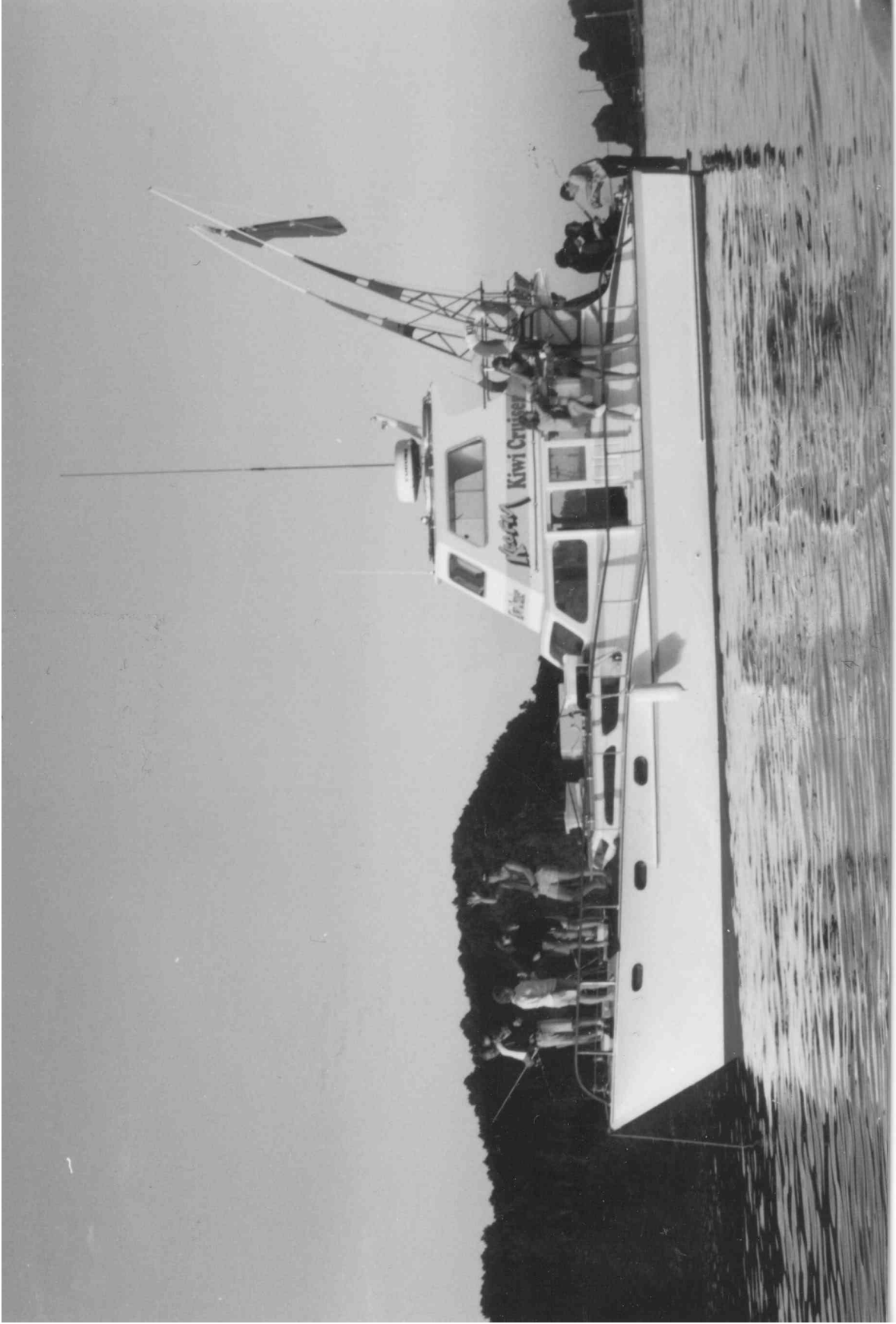
- the low level of crew experience aboard the *Kiwi Cruiser*
- the level of supervision of unqualified and inexperienced deckhands
- the inefficient use made of the available navigation aids to monitor the position of the vessel
- the number of lifejackets required to be carried on board restricted limit ships
- the *Kiwi Cruiser* operating with one engine removed without the approval of an authorised surveyor.

Safety recommendations were made to the operator, the safe ship management provider and the director of Maritime Safety to address the safety issues.

The Transport Accident Investigation Commission is an independent Crown entity established to determine the circumstances and causes of accidents and incidents with a view to avoiding similar occurrences in the future. Accordingly it is inappropriate that reports should be used to assign fault or blame or determine liability, since neither the investigation nor the reporting process has been undertaken for that purpose.

The Commission may make recommendations to improve transport safety. The cost of implementing any recommendation must always be balanced against its benefits. Such analysis is a matter for the regulator and the industry.

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Kiwi Cruiser

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List of Abbreviations

CLM	Commercial Launch Master
EPIRB	emergency position indicating radio beacon
GPS	global positioning system
ILM	Inshore Launch Master
kW	kilowatt(s)
m	metre(s)
SSMS	safe ship management system
t	tonne(s)
UTC	universal time (coordinated)
VHF	very high frequency

Glossary

aft	rear of the vessel
cable	one tenth of a nautical mile
bulwark	solid rail around the deck of a vessel to prevent entry of the sea
flying bridge	control station above main cabin area
gross tonnage	a measure of the internal capacity of a ship; enclosed spaces are measured in cubic metres and the tonnage derived by formula
knot	one nautical mile per hour
list	angle of tilt caused by internal distribution of weights
mayday	radiotelephone distress signal requesting immediate assistance
port	left-hand side when facing forward
starboard	right-hand side when facing forward
track	the path intended or actually travelled by a ship

Data Summary

Vessel particulars:

Name:	<i>Kiwi Cruiser</i>
Type:	passenger charter launch
Operating limits:	Northland, Great Barrier Island and Bay of Plenty Inshore Limits
Passenger limit:	28
Length overall:	14.69 m
Gross tonnage:	12 t
Construction:	timber
Built:	1967 by Oliver & Gilpin, Tauranga
Propulsion:	two 60 kW Ford diesel engines, each driving a fixed pitch propeller
Service speed:	8 knots

Owner/operator: Bay of Islands Overnight Cruises Limited

Persons on board:
crew: 3
passengers: 9

Injuries:
crew: 2 (minor)
passengers: nil

Damage: vessel sunk

Location: Tapeka Point, Bay of Islands

Date and time: Wednesday, 5 April 2000, at about 1945¹

Investigator-in-charge: Captain W A Lyons

¹ All times in this report are New Zealand Standard Time (UTC + 12 hours) and are expressed in the 24 hour mode.

1. Factual Information

1.1 History of the trip

- 1.1.1 At about 1500 on 5 April 2000, the skipper and trainee deckhand (the trainee) began preparing the *Kiwi Cruiser* for an evening fishing trip. The skipper conducted the pre-sailing checks, while the trainee prepared the fishing equipment. At about 1530 they shifted the *Kiwi Cruiser* from its mooring to the wharf. The hostess arrived and as it was her first trip the skipper showed her around the vessel, explaining her duties and where the safety equipment was stowed.
- 1.1.2 The trip was promoted as a dusk fishing trip and was scheduled to depart Paihia at 1600 and return at 2000. At about 1545, passengers began arriving at the *Kiwi Cruiser*. The skipper welcomed the passengers on board and offered them refreshments. He gave them a description of the intended trip but did not give them a safety briefing, as was stipulated in the safe ship management manual for the *Kiwi Cruiser*. The intention was to fish at various locations in Te Rawhiti Inlet (see Figure 1).
- 1.1.3 At about 1600 the *Kiwi Cruiser* departed Paihia Wharf with 3 crew and 9 passengers on board. The crew comprised the skipper, trainee, and hostess. The passengers comprised individuals and small groups, including a relative of the owner who had been aboard the *Kiwi Cruiser* on many previous occasions.
- 1.1.4 The weather was fine and clear with light variable winds. There was a slight sea with a low northerly swell. High tide at Russell was predicted for 2024. Sunset was at 1812. The night of the accident there was a new moon; consequently it was a dark night.
- 1.1.5 The trip initially proceeded without incident. The skipper navigated the *Kiwi Cruiser* to various fishing spots in Te Rawhiti Inlet using the radar and global positioning system (GPS), which were situated at the main steering console on the starboard side of the flying bridge.
- 1.1.6 At about 1915, the vessel was stopped and drifting off the eastern tip of Roberton Island. The skipper decided it was time to proceed back to Paihia and started the engine while everybody wound in their fishing lines. He then headed the vessel in the direction of Tapeka Point at about 6 knots.
- 1.1.7 After about 5 minutes the trainee came up to the flying bridge and the skipper asked him to take the wheel while he went below to check on the passengers and clean their fish. He pointed out Fraser Rock light which was fine on the port bow at a distance of about 3 miles, and instructed the trainee to “make a big loop to the starboard side” of the light.
- 1.1.8 The skipper told the trainee that he would monitor the track of the *Kiwi Cruiser* from the after deck and make any necessary alterations to the course using the second wheel situated on the starboard side of the after deck. Before going below the skipper opened the sliding window on the starboard side of the flying bridge and told the trainee that they could communicate over the side through the open window.
- 1.1.9 The trainee was not steering a compass course; he was steering visually to clear the light as he had been instructed. The radar was in operation and set on the ¼ mile range. The screens of the GPS and echo sounder had been dimmed to aid night vision.
- 1.1.10 The skipper went to the after deck and chatted with some of the passengers while he cleaned the fish. Some passengers requested that their fish be filleted, which was not usually part of the service but the skipper obliged on this occasion.

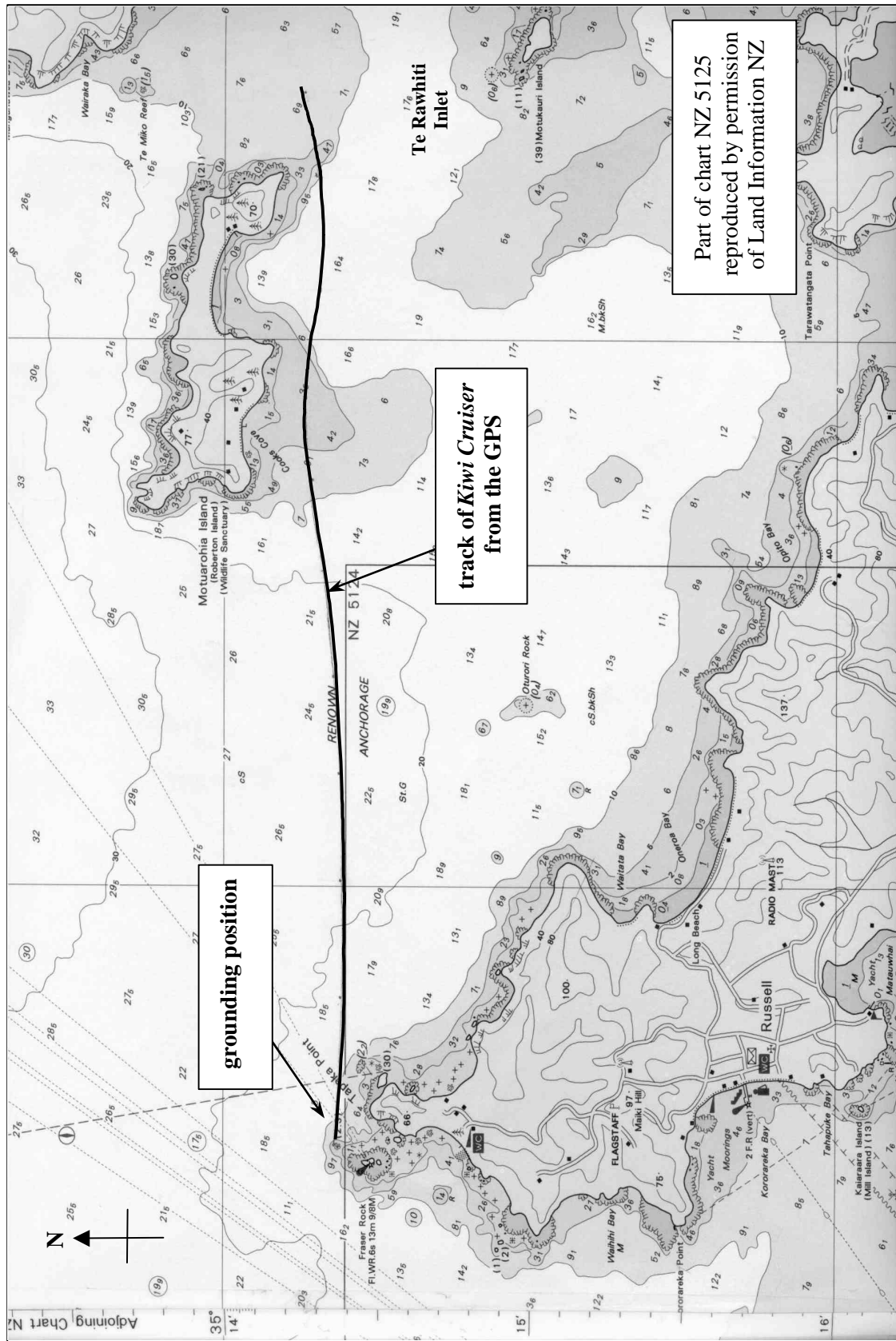


Figure 1
Part of Chart NZ 5125 showing area of accident and track from GPS

- 1.1.11 While on the after deck the skipper recalled visually checking the position of the *Kiwi Cruiser* on numerous occasions. He observed the position of the vessel relative to Fraser Rock light by looking down the port side of the vessel. He could also see the light flashing through the main cabin windows. He occasionally communicated with the trainee over the starboard side through the open window, but felt it was not necessary to adjust the course the trainee was steering.
- 1.1.12 On the flying bridge the trainee kept Fraser Rock light on the port bow. He recalled the echo from the land appearing on the radar screen but felt the vessel was on a safe course. He was under the impression that the light was situated at the extremity of any danger.
- 1.1.13 At about 1945 the *Kiwi Cruiser* ran aground at about 6 knots on the rocks just north-east of Fraser Rock.
- 1.1.14 The skipper immediately went up to the flying bridge and put the engine to neutral. Realising that the vessel was badly holed and taking water he turned on the bilge pump and transmitted a mayday call over channel 16 on the very high frequency (VHF) radio; he also contacted the owner by mobile telephone. The *Kiwi Cruiser* was taking water fast and listing to port.
- 1.1.15 The mayday call was received by the Bay of Islands marine radio association at 1947. Other vessels in the vicinity responded to the call. The closest vessel was at Russell, about 2 miles away, and was dispatched to assist.
- 1.1.16 The skipper stopped the engine and instructed the hostess and one of the passengers to hand out the lifejackets, which were stowed under the bunks in the main cabin. He and the trainee then went to the foredeck to launch the rigid life raft. There were not enough adult lifejackets for everyone on board, so some passengers chose to wear child lifejackets. They also used some of the lifebuoys from the vessel. Some passengers had problems donning their lifejackets as they had not been instructed how to wear them.
- 1.1.17 The skipper and trainee managed to launch the raft over the starboard side, by which time the *Kiwi Cruiser* was listing heavily to port and water was entering the vessel over the bulwarks aft and rapidly filling the cabin. While launching the raft the skipper cut his foot and the trainee cut his knee.
- 1.1.18 Meanwhile, some passengers had entered the water and others were still on the starboard side of the vessel. The skipper instructed all the passengers and hostess to enter the water and stay together holding on to the life raft. In the distance the skipper could see the lights of an approaching vessel, so he and the trainee remained on board awaiting its arrival.
- 1.1.19 The rescue vessel arrived at the scene at about 1955 and about 4 of the passengers were able to board it from the water. The skipper of the rescue vessel was concerned that his vessel may also ground so he towed the life raft and the remaining passengers clear of the *Kiwi Cruiser* before they were also able to board his vessel. Once all the passengers were safely aboard the rescue vessel, the skipper and trainee entered the water and swam the short distance to it.
- 1.1.20 At 2004 everybody was safely aboard the rescue vessel and a head count was made. When everyone was accounted for they returned to Paihia Wharf. An ambulance met them there and attended to their medical requirements.
- 1.1.21 The owner went to Tapeka Point early the next morning but the *Kiwi Cruiser* had slipped off the rocks and sunk. Later that day the owner returned with diving equipment and located the *Kiwi Cruiser* on the seabed. He found a “football size” hole in the port bow.
- 1.1.22 During the dive the skipper recovered personal equipment and, at the request of the Commission, the GPS receiver. The track of the *Kiwi Cruiser* was later downloaded from the GPS. The track shown on Figure 1 was derived from the downloaded data.

1.2 Personnel information

- 1.2.1 Under existing legislation the *Kiwi Cruiser* was required to carry a qualified skipper only, but the owner chose to crew the vessel with a trainee deckhand and a hostess as well.
- 1.2.2 The owner of the *Kiwi Cruiser* had owned and operated the vessel as a charter launch for about 9 of the previous 12 years. He had sold the boat about 3 years before the accident and re-purchased it in December 1999. He held a Commercial Launch Master Certificate (CLM) and had extensive maritime experience. Over the years he had trained numerous deckhands on the *Kiwi Cruiser*, including the skipper at the time of the accident.
- 1.2.3 The skipper was a 24 year old Dutch national who had worked as deckhand for the owner of the *Kiwi Cruiser* for about 3 months before returning to Holland in April 1999. In August 1999 he returned to New Zealand and was again employed by the owner of the *Kiwi Cruiser*, initially as deckhand. He obtained a CLM in November 1999 and had been skipper of the *Kiwi Cruiser* since.
- 1.2.4 The skipper had previously gained some maritime experience in Holland and Australia before being employed in New Zealand. Since being promoted he had been skipper of the *Kiwi Cruiser* almost continuously and had completed numerous trips in the area where the accident occurred.
- 1.2.5 The trainee was also a Dutch national and was the skipper's cousin. The skipper had arranged employment for him with the owner of the *Kiwi Cruiser*. He had been in New Zealand about 5 days and had been trainee on one day trip prior to the accident trip. He had no maritime qualifications and little maritime experience. He had seen the chart for the area during his previous trip but had not referred to it during the accident trip; neither had the skipper.
- 1.2.6 The hostess was on a back-packing holiday and was helping on a no-pay basis. She was making her first trip on the *Kiwi Cruiser*.

1.3 Vessel information

- 1.3.1 The *Kiwi Cruiser* was built in 1967 to a standard design. The vessel was of timber construction and it had a length of 14.69 m and a gross tonnage of 12 t.
- 1.3.2 The *Kiwi Cruiser* had a safe ship management certificate that was issued by Nortel Limited on 21 January 2000, the date of the last inspection by the safe ship management company. The certificate expired on 21 January 2004.
- 1.3.3 About a week before the accident the starboard engine had been removed from the vessel for servicing. The owner stated that all the auxiliary equipment could be run from the port engine. Neither the owner nor skipper had informed Nortel Limited that the engine had been removed from the vessel. The manager of Nortel Limited later stated that he thought it would have made no difference to the validity of the safe ship management certificate. The *Kiwi Cruiser* had a service speed of about 6 knots on one engine.
- 1.3.4 Rule Part 21, Safe Ship Management Systems, Clause 21.13, described the entry to and conditions to be met in order for ships to remain in a safe ship management system (SSMS). Paragraph 21.13(19) stated:

The owner of a ship to which this section applies must ensure that if a ship undergoes major modification, major repair, changes its operating limits temporarily or permanently, or increases its passenger carrying capacity, the ship is not operated until the owner has obtained:

- (a) a new certificate issued by a surveyor stating the particulars referred to in rule 21.13(2)(a)(i) to (vii) inclusive; and
- (b) a new New Zealand Safe Ship Management Certificate issued under rule 21.13(11) stating that the safety management of that ship complies with the requirements of the *New Zealand Safe Ship Management Code*.

1.3.5 Clause 21.11 of Rule Part 20, Definitions, stated:

“**Major alteration**” and “**major repair**” mean the repair or alteration of a ship, or the replacement or removal or addition of any part of a ship, that is likely

- (a) to significantly affect the structural integrity, tonnage, freeboard, cargo or passenger capacity, crew or passenger accommodation, conditions of assignment of load line, watertight subdivision, stability, structural fire protection, or safety equipment of the ship; or
- (b) to result in significant changes to the propulsion machinery, auxiliary machinery, or method of propulsion of the ship.

1.3.6 Navigation and communication equipment included:

- one magnetic compass
- one Furuno 24 mile radar
- one Lowrance global GPS
- one Jefferson echo sounder
- one Codan VHF radio.

1.3.7 Under existing legislation the *Kiwi Cruiser* was required to carry buoyant apparatus for 120% of the total number of passengers and crew the vessel was certified to carry. This equipment had to include at least 2 lifebuoys. The remainder could be made up of life rafts, lifebuoys, buoyant apparatus or lifejackets.

The lifesaving equipment aboard the *Kiwi Cruiser* included:

- 8 adult lifejackets
- child lifejackets (number unknown)
- one 16-person rigid life raft
- 6 lifebuoys
- one emergency position indicating radio beacon (EPIRB)
- 2 smoke floats
- 2 parachute flares
- one line-throwing apparatus

The lifejackets, rigid life raft and lifebuoys together provided life saving equipment for 28 passengers and 3 crew.

1.3.8 The Maritime Safety Authority conducted a flag state inspection of the *Kiwi Cruiser* on 31 March 1999 and found 2 minor deficiencies.

1.4 Radar training

1.4.1 On 22 October 1999 Maritime Rule Part 32, Ships Personnel-Qualifications, came into force. Under this rule the Inshore Launch Master Certificate (ILM) replaced the CLM. Rule Part 32 was introduced to update maritime qualifications and acknowledge changes in technology and training techniques.

1.4.2 The syllabus for CLM included the following with regard to radar training:

- 16.3 Know the correct procedure for using radar with particular reference to:
 - (a) Obtaining a satisfactory display.
 - (b) Using range rings or parallel indexing techniques to ensure safe passing distances off navigational hazards.
 - (c) Describing the effect of sea clutter and the dangers of incorrect setting of the anti clutter control.

This syllabus was typically covered in about 2 hours of tutorial.

1.4.3 The syllabus for ILM required the candidate to obtain a Restricted Radar Observer Certificate. This entailed attendance at a 4 day course and an examination with a 70% pass mark.

1.4.4 The skipper of the *Kiwi Cruiser* had commenced his studies before the introduction of Rule Part 32 so he had to complete the syllabus for CLM. He had not completed a Restricted Radar Observer Certificate. When asked after the accident why the radar was on the ¼ mile range he replied, “we have always got it on a ¼ mile range”. He felt that this was a suitable range to navigate with. When asked about parallel indexing² he stated that he had been taught the theory but had never used it in practice.

2. Analysis

2.1 The *Kiwi Cruiser* was operating on the port engine only at the time of the grounding, which reduced the cruising speed of the vessel by about 2 knots. As the vessel had sunk it was not possible to ascertain the configuration of the propulsion system and associated machinery to determine whether safety was compromised by the removal of the starboard engine. Although the removal of the engine did not contribute to the grounding it would have been wise for the owner to discuss the situation with the safe ship management company first.

2.2 The *Kiwi Cruiser* was issued with a safe ship management certificate signifying that it was fit for purpose based on it having 2 engines. Under the definitions in Rule Part 20, the removal of one engine should have been notified to Nortel Limited. For the owner to remove one engine without informing Nortel Limited, and for Nortel Limited to be comfortable with this, suggested that both the safe ship management company and the owner had misconstrued the intent of the New Zealand SSMS.

2.3 When the passengers boarded the *Kiwi Cruiser* they were not given a safety briefing or shown where the lifesaving equipment was stowed. Even though the trip was supposed to be routine, relatively short and in sheltered waters it would have been wise to acquaint the passengers with the stowage and use of the basic safety equipment as was stipulated in the safe ship management manual.

2.4 A passenger safety briefing should form part of any safety regime designed for a passenger-carrying operation. The safe ship management manual aboard the *Kiwi Cruiser* stipulated that a

² A quick and simple method of using a radar to maintain a predetermined distance off a navigational feature.

briefing was to be given, but the skipper did not routinely give one. This further indicated that the safety system was in need of review.

- 2.5 The *Kiwi Cruiser* was required to carry enough buoyancy aids for 120% of 31 persons, which could have been made up from any combination of lifejackets, lifebuoys, life rafts and buoyancy apparatus. The owner had supplied 8 adult lifejackets and an unknown number of child lifejackets as part of this requirement, which meant that not all persons had a lifejacket when they had to abandon the vessel.
- 2.6 The grounding and subsequent abandoning of the *Kiwi Cruiser* occurred relatively close to help and in good weather and sea conditions. If the accident had occurred further out in the vessel's allowable limits and in poor weather, it is questionable whether those passengers and crew not wearing lifejackets would have fared as well as they did.
- 2.7 An appropriate lifejacket will support a person in the water without he or she having to expend energy to stay afloat. Wearers are able to use their hands for other tasks, or to band together in the huddle position, which is important when in the water for extended periods, particularly in cold water.
- 2.8 Maritime Rule Part 40A was due to come into force later in the year 2000. Under the new rule, Inshore Limit vessels such as the *Kiwi Cruiser* were to be required to have a lifejacket³ for each person on board in addition to other buoyancy equipment. Considering the requirements of the new proposed Rule Part 40A, the Commission has not made a safety recommendation regarding the carriage of lifejackets.
- 2.9 The skipper had only gained his maritime qualification about 4 months before the accident and had limited maritime experience before coming to New Zealand. He had operated the *Kiwi Cruiser* on most days since becoming skipper but the trainee had only previously made one day trip. The skipper was still gaining confidence and local knowledge. The trainee and hostess had virtually no experience or local knowledge.
- 2.10 The owner of the *Kiwi Cruiser* was proactive in training deckhands in the Bay of Islands but it was not a requirement for the *Kiwi Cruiser* to carry one. The owner chose to employ a trainee as part of the crew, which made the skipper responsible for his training and supervision.
- 2.11 The prime responsibility of the skipper was the safety of the passengers and the vessel. Before the accident the skipper chose to clean the fish and leave the navigation of the vessel to the trainee, a situation that would normally be reversed with an experienced crew. It may be acceptable for trainees to navigate a vessel when required if they had received sufficient familiarisation and training in the practical use of the navigational equipment.
- 2.12 Due to the navigational hazards off Tapeka Point, it is known locally as a dangerous area. When training the skipper, the owner of the *Kiwi Cruiser* had warned him to be vigilant in that area. On the night of the accident the skipper allowed the inexperienced trainee to navigate the *Kiwi Cruiser* close to this area of known dangers with a minimum of supervision.
- 2.13 The skipper gave the trainee verbal instructions on how to navigate the *Kiwi Cruiser* around Tapeka Point. The trainee was under the impression that Fraser Rock light was situated on the extremity of any dangers and was unaware of the rocks on which the vessel grounded. If the skipper had shown the trainee the chart he could have pointed out the dangers and increased the trainee's situational awareness.

³ Now called personal flotation devices.

- 2.14 The *Kiwi Cruiser* had adequate navigational equipment operating to safely navigate the vessel around Tapeka Point but it was not being used to good effect. The GPS and echo sounder displays had been dimmed to aid night vision and the radar was set on the ¼ mile range. The trainee was instructed to steer a course visually by keeping Fraser Rock light on the port bow and then to take a big loop to the starboard side of the light. Without knowing the actual position of the vessel relative to the light and surrounding dangers, these instructions alone had the potential for the vessel to have grounded on other rocks before reaching Fraser Rock light.
- 2.15 Due to the new moon it was a dark night, making navigating by eye difficult. The trip was the trainee's first in the area at night and the first time he had steered the vessel at night. With the relatively powerful lighthouse flashing every 6 seconds close by, gaining night vision would have been difficult. Monitoring the position of the vessel visually using a single point of reference is difficult at the best of times. Distance is hard to judge at night and without monitoring the navigational aids, simply keeping an object fine on the port bow was not adequate under the circumstances.
- 2.16 The trainee was unlikely to have been able to operate the navigational equipment efficiently himself, but the skipper could have set the radar on a higher range with the range marker set on a safe passing distance off Tapeka Point and explained simple parallel indexing techniques to the trainee. Had he done so, it is likely that the trainee would have successfully navigated the *Kiwi Cruiser* around Tapeka Point.
- 2.17 After clearing Robertson Island the *Kiwi Cruiser* was about 2 miles east of Tapeka Point. With the radar on the ¼ mile range scale there would have been no echoes from the land on the screen until the vessel was about 4 cables from the grounding position. At 6 knots it would take about 4 minutes to cover this distance.
- 2.18 The skipper was monitoring the progress of the *Kiwi Cruiser* by observing Fraser Rock light from the after deck. From this position, while also being engaged in other tasks, the skipper was less likely to be able to monitor the position of the *Kiwi Cruiser* than the trainee was.
- 2.19 The GPS-derived track shown in Figure 1 was typical of the track expected when navigating by eye alone. The initial track headed straight for or slightly to starboard of the light. As the vessel closed on Tapeka Point the vertical angle of the light would have increased, raising the trainee's awareness of how close to it he was. He appears to have responded by altering course away from the light but not far enough to avoid the rocks on which the vessel eventually grounded.
- 2.20 The skipper commenced his CLM before the requirement for a Restricted Radar Observer Certificate was in force. Consequently his knowledge of the efficient use of radar was limited. If he had recently completed the radar course he may have put some of the techniques he would have learnt into practice and avoided the grounding.
- 2.21 The skipper had obtained his CLM about 4 months before the accident but was under the impression that operating the radar on the ¼ mile range was suitable for navigation in the area where the accident occurred. He also had no practical knowledge of parallel indexing, a simple method of navigating by radar, that would probably have averted the grounding, had it been used.
- 2.22 When the vessel grounded it began taking water immediately. The skipper quickly realised the seriousness of the situation, transmitted a mayday call and prepared the passengers to abandon the vessel. The skipper's actions were timely and appropriate. Fortunately the weather conditions at the time of the accident were favourable and assistance was close at hand.

3. Findings

Findings and safety recommendations are listed in order of development and not in order of priority.

- 3.1 The *Kiwi Cruiser* was operating under a SSMS and had a current maritime document at the time of the accident.
- 3.2 One engine had been removed from the *Kiwi Cruiser* for servicing without the knowledge of the safe ship management company. Although this did not contribute to the grounding, it invalidated the vessel's safe ship management certificate.
- 3.3 The skipper held the appropriate qualification for his position.
- 3.4 The *Kiwi Cruiser* struck rocks and sunk off Tapeka Point when the progress of the vessel was not being monitored effectively.
- 3.5 The trainee did not have sufficient knowledge and experience to navigate the *Kiwi Cruiser* unsupervised.
- 3.6 The overall inexperience of the crew and the limited use of the available navigation aids contributed to the grounding.
- 3.7 The passengers and crew successfully abandoned the vessel and were rescued in favourable weather and sea conditions, but would have benefited from a safety briefing detailing the stowage and correct use of the safety equipment.
- 3.8 The *Kiwi Cruiser* was carrying sufficient buoyancy aids as required by the existing regulations but the passengers and crew would have benefited from having a suitable lifejacket for each person.
- 3.9 The circumstances surrounding the removal of one engine and the skipper not giving a passenger safety briefing indicated there were deficiencies in the SSMS for the *Kiwi Cruiser*.

4. Safety Recommendations

- 4.1 On 20 November 2000 it was recommended to the owner of the *Kiwi Cruiser* that he:
 - 4.1.1 Introduce a company policy where the navigation of any vessel is monitored by a person suitably experienced for the circumstances. (089/00)
 - 4.1.2 Take measures to ensure skippers on his company's vessels give embarking passengers a safety briefing. (090/00)
 - 4.1.3 Inform the safe ship management company of matters potentially affecting the validity of the safe ship management certificate. (091/00)
- 4.2 On 20 November 2000 it was recommended to the managing director of Nortel Limited that he:
 - 4.2.1 Change company policy to require clients to inform it of matters potentially affecting the status of safe ship management certificates, as prescribed in Rule Part 20. (092/00)

- 4.3 On 20 November 2000 it was recommended to the director of the Maritime Safety Authority that he:
- 4.3.1 Require Safe Ship Management companies to include in their contracts or agreements with clients, a clear understanding of the operators' responsibility to report "major alterations" or "major repairs" as required by Rule Part 20. (105/00)
- 4.4 On 30 November 2000 the director of the Maritime Safety Authority replied:
- 4.4.1 Recommendation 105/00
- We have considered the Commission's recommendation requiring SSM companies to include in their contracts or arrangements, a clear understanding of the operator's responsibility to report "major alterations" or "major repairs" as required by Rule Part 21.12 (19).
- MSA is of the opinion that we are unable to mandate terms in commercial contractual arrangements between the SSM companies and their clients, nor do we consider it necessary considering the clear requirements of Rule Part 21.
- We do recognise, however, that some operators, and indeed SSM companies, may not fully appreciate all their responsibilities as required by Rule Part 21, and for this reason it is our intention to develop additional advisory circulars that can be read in conjunction with the Rule, which I believe fully cover the sentiment of your recommendation.
- These advisory circulars would address technical issues illustrated by this accident, and provide an expansion of the Rule requirements (including a clear expression of the need to report "major alterations" or "major repairs" to the MSA) for both SSM companies and operators.
- MSA would also note that it is our intention to further define the terms "major alterations" or "major repairs" in the amendments being considered to Rule Part 21.

Approved for publication 22 November 2000

Hon. W P Jeffries
Chief Commissioner