



Accident Report

Kea

Person Overboard, North of
Bledisloe Wharf, Auckland

On 21 May 2004



REPORT NO.: 04 3470

VESSEL NAME: KEA

Casualty Details:

Date of Casualty:	21 May 2004
Time of Casualty:	1822 hours New Zealand Standard Time (NZST)
Casualty Type:	Person Overboard
Casualty Location:	Approximately 400 metres north of Bledisloe Wharf, Auckland
Weather Forecast Area:	Colville
Investigator:	Ian Howden



REPORT NO.: 04 3470

VESSEL NAME: *KEA*

Vessel Details:

Vessel Name:	<i>Kea</i>
Vessel Category:	Passenger Ferry
Registered Length (m):	27.06
Tonnage:	341
Official Number:	101597
Port of Registry:	Auckland
Flag:	New Zealand
Owner's Name:	Fullers Group Ltd



SUMMARY

While proceeding from Devonport, the Skipper was alerted that there was a person overboard. The passenger apparently jumped after stating “I’m not feeling well.” The crew was instructed to keep a lookout for the person and made ready, blankets and recovery gear. Both engines were placed in neutral. The engine was then placed in gear and the vessel turned to starboard. The passenger was sighted approximately 300-400m ahead of the vessel. He was brought on board and wrapped in blankets. On being taken ashore, he was handed over to the Police.



KEY EVENTS

- 1.1 At 1815 hours on 21 May 2004, the passenger vessel **Kea** departed from Devonport wharf on a scheduled run across the Waitemata Harbour to Auckland with 47 passengers on board.
- 1.2 At 1822 hours, when **Kea** was approximately 400 metres north of Bledisloe wharf, on a course of 240°C, a passenger jumped overboard.
- 1.3 After being alerted by crew and passengers the Master ordered the crew to attend their respective man overboard stations. A crewmember threw a lifebuoy overboard and the crew then commenced deploying recovery equipment.
- 1.4 The Master put the two engines of **Kea** in neutral. They were then put in gear and the vessel turned to starboard. The Master informed Fullers Duty Manager, on the internal trunk radio system, that he had a man overboard situation. He then placed the vessel on a reciprocal course of 060°C and sighted the passenger, approximately 300 to 400 metres dead ahead.
- 1.5 As **Kea** closed on the passenger, the vessel's structure blocked the Master's vision of him. The ship's engineer communicated with the Master, via the vessel's internal communication system, and advised him of the passenger's position in relation to the vessel.
- 1.6 As the Master positioned **Kea** in a recovery position for man overboard, a crewmember threw a life ring with a light to the passenger. He was then instructed to climb aboard with the assistance of a scramble net that had been deployed by crew.
- 1.7 At approximately 1826 hours, the passenger was back on board **Kea**. He was wrapped in a blanket and treated by crew and passengers.
- 1.8 On arrival in Auckland the passenger was handed over to the Police and medical services.



KEY CONDITIONS

- 2.1 **Kea** is a 341 ton 27.06 metre twin hull passenger vessel owned by Fullers Group Ltd. The vessel conducts regular runs between the Auckland waterfront and Devonport on Auckland's North Shore.
- 2.2 **Kea** is powered by twin 6 cylinder 272 kW Cummins motors. John Deere HRP Sperry Stork Kwant units with Holland Roer HRP25x2 propeller shafts provide propulsion. These provide considerable manoeuvrability and stopping capability.
- 2.3 The Master holds a New Zealand Coastal Master's Certificate of Competency, issued in 20 September 1999. He has extensive commercial experience and had worked for Fullers for approximately five years.
- 2.4 **Kea's** Safe Ship Management (SSM) manual has a man overboard.
- 2.5 The emergency drill form in **Kea's** SSM manual indicates the vessel has regular emergency drills, including man overboard drills. The last man overboard drill was held on 5 May 2004, sixteen days before this incident.
- 2.6 The Master stated that he was able to see the passenger in the water from when first sighted until **Kea** came alongside and his view was blocked by the vessel's superstructure. He was not able to operate the vessel's spotlight from the bridge as he was occupied with operating the controls. *In commenting on the draft report the passenger's associate stated that from his observations it was not possible to see the water for quite a distance in front of the vessel from the wheelhouse, because of its central location. Further, that the Master would need to rely on the crew to see a person in the water ahead of the vessel and not just alongside.*
- 2.7 The Master stated he did not place a PAN PAN call due to the short period required to recover the passenger.
- 2.8 Weather conditions were clear with light winds.
- 2.9 The passenger's associate reported to other passengers and crew that the passenger suffered from bipolar disease and had failed to take prescribed medication. He is reported as saying to the associate that he was not feeling well before jumping overboard.



CONTRIBUTING FACTORS

3.1 The passenger's medical condition.

CAUSE

Human Factor

<input type="checkbox"/> Failure to comply with regulations	<input type="checkbox"/> Drugs & Alcohol	<input type="checkbox"/> Overloading
<input type="checkbox"/> Failure to obtain ships position or course	<input type="checkbox"/> Fatigue	<input checked="" type="checkbox"/> Physiological
<input type="checkbox"/> Improper watchkeeping or lookout	<input type="checkbox"/> Lack of knowledge	<input type="checkbox"/> Ship Handling
<input type="checkbox"/> Misconduct/Negligence	<input type="checkbox"/> Error of judgement	<input type="checkbox"/> Other . . .

Environmental Factor

<input type="checkbox"/> Adverse weather	<input type="checkbox"/> Debris	<input type="checkbox"/> Ice	<input type="checkbox"/> Navigation hazard
<input type="checkbox"/> Adverse current	<input type="checkbox"/> Submerged object	<input type="checkbox"/> Lightning	<input type="checkbox"/> Other . . .

Technical Factor

<input type="checkbox"/> Structural failure	<input type="checkbox"/> Wear & tear	<input type="checkbox"/> Steering failure
<input type="checkbox"/> Mechanical failure	<input type="checkbox"/> Improper welding	<input type="checkbox"/> Inadequate firefighting/lifesaving
<input type="checkbox"/> Electrical failure	<input type="checkbox"/> Inadequate maintenance	<input type="checkbox"/> Insufficient fuel
<input type="checkbox"/> Corrosion	<input type="checkbox"/> Inadequate stability	<input type="checkbox"/> Other . . .

4.1 Passenger jumped overboard.



OPINONS & RECOMMENDATIONS

- 5.1 A man overboard situation, especially at night, is a serious situation that all passenger vessel crews' must be trained to react to immediately.
- 5.2 The crew were able to recover the passenger from the water within a relatively short period and are commended for this.
- 5.3 This incident highlights the importance that all passenger vessels carry out man overboard drills on a regular basis and record them.
- 5.4 It is recommended Maritime Safety Inspectors and SSM company surveyors continue to ensure that all commercial vessels inspected produce evidence of regular man overboard drills.
- 5.5 It is recommended that a crewman be designated to assist the Master on the bridge in emergency situations, to operate the radio and/or bridge spotlight if required.
- 5.6 It is recommended that lighting be improved on the recovery side of the vessel.
- 5.7 It is recommended that a powerful portable spotlight be placed on board **Kea** to enable the crew to locate passengers in man overboard situations.
- 5.8 It is recommended there be adequate blankets on board **Kea** to provide protection from the effects of hypothermia and all crew be briefed on their location.
- 5.9 It is recommended that a lifebuoy with light be kept in the bridge for deployment by the Master as soon as a man overboard situation is raised.
- 5.10 It is recommended a PAN PAN call be made in all man overboard situations to ensure that all available resources are utilized in effecting recovery of persons in the water.

