

## CAYMAN ISLANDS SHIPPING REGISTRY

Maritime Authority of the Cayman Islands

### FLYER TO THE LARGE YACHT INDUSTRY

Fatal accident during bridge transit.

A large motor yacht (453 GT, 38.8m Length) was leaving the Sydney Superyacht Marina for a "lunchtime cruise" of Sydney Harbour to be followed by a short voyage to Broken Bay, the next Bay north of Sydney. On arrival in Broken Bay, the yacht intended to cruise around and anchor for two days. Three passengers were on board.

Shortly after leaving the marina it was necessary for the yacht to transit a disused swing bridge at Glebe Island. When passing through the bridge, the yacht passed close to the eastern buttress of the bridge requiring the crew to manually "fend off" by placing fenders between the yacht's hull and the eastern bridge buttress.



Eastern Buttress of the Swing Bridge

While placing one of the yacht's fenders, a crew member was apparently struck by a fixed fender attached to the bridge structure and pulled over the side of the yacht. The crew member was caught between the bridge structure and the hull of the yacht as it passed through the bridge and sustained severe crushing injuries. Once clear of the yacht's hull, the crew member fell to the water. The crewmember was retrieved from the water by a small boat that was in the vicinity of the Glebe Island Bridge at the time of the accident. When the crew member was retrieved there were no apparent signs of life and the crew member was pronounced dead shortly after.



Note the lifebuoy in white cover behind door.

The accident was witnessed by a number of members of the yacht's crew. The yacht alerted the emergency services by calling the Australian general emergency services number on a mobile telephone by dialling "Triple Zero". (This is the equivalent emergency telephone number to "999" in the United Kingdom, or "911" in the United States".) The harbour authorities and other vessels in the area were alerted to the accident by a VHF radio call originating from another craft whose crew had also witnessed the accident.

Location on deck where the crew member went overboard.



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#### **Safety Issues**

Although the investigation into the circumstances surrounding this accident is still in its early stages, a number of notable safety considerations have been identified. The contribution, if any, of these factors will be evaluated as part of the investigation into this accident. These issues are included in this flyer for the sole purpose of raising awareness of their possible consequences in emergency situations.

## Passage Planning

Proper passage planning is an essential exercise in identifying risk and putting suitable mitigation measures in place. Even when the exact track for part of the voyage is not known in advance (e.g. a general "harbour cruise"), potential hazards should be identified and criteria such as minimum distance from shore, minimum under keel clearance, etc determined. Potential hazards and "no go" areas should be identified on navigational charts to be used for the intended voyage.

The passage plan should be approved by the master and understood by all crew members who may be responsible for the navigation of the vessel during the voyage.

## • Crew Briefings and "Toolbox Talks"

Whenever an activity is to be carried out on board, it is essential that all crew members involved are aware of the what is to be done and the part that they and others will play in carrying out the activity. This principle applies equally to both "one off" and "routine" activities as there is sometimes a temptation to be less vigilant during "routine" tasks.. During the pre-activity briefing any additional hazards or risks that are expected to be encountered can be identified, discussed and understood by all who will be taking part.

#### • Deployment of Life Saving Appliances

Life saving appliances, such as lifebuoys, should be readily availably and highly visible to all crew members in an emergency. When an emergency situation occurs, crew members are often under extreme stress and the location of suitable life saving appliances should be immediately obvious. The use of white cosmetic lifebuoy covers to reduce their visual impact is never recommended, but if fitted, such covers should always be removed as part of the standard "pre departure activities" prior to any vessel leaving the relative safety of the dock.

### • Communication in distress situation.

Although mobile telephones provide an easy way to contact shore based emergency services, they should only be used for marine incidents after all attempts to raise the appropriate responders by VHF radio (or other GMDSS methods) have been expended or exhausted.

Calling by mobile telephone means:

The call is between the vessel and a single person at the emergency response switchboard. No other vessels in the area are made aware of the developing situation on board when the call is made. Such vessels are best placed to offer immediate, and often lifesaving, assistance to a vessel in distress.

The operator taking the call, who probably will have little maritime knowledge or understanding, may be hundreds of miles from the location of the incident and also have no local knowledge to aid

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in gaining "situational awareness" with regard to the emergency situation on board and the appropriate response.

Generally, shore based emergency switchboard operators are trained to keep the caller "on the line" until the appropriate shore based emergency service arrives at the scene. Keeping such lines of communication open is entirely appropriate for typical shore based emergencies; however the person making such a call from a vessel may have other important and immediate functions to perform so as to prevent the escalation of the reported incident.

Distress calling by VHF radio has none of the above disadvantages and will ensure the quickest and most appropriate response to an emergency situation on board.

#### Note

This document, containing urgent safety information, has been produced for marine safety purposes only, on the basis of information available to date. The sole objective of the investigation of any accident conducted under the Cayman Islands Merchant Shipping Law (2012 Revision) is the prevention of future accidents through the ascertainment of its causes and circumstances.

It is not the purpose of an investigation to determine liability nor to apportion blame.

An investigation into this accident is being carried out by the Australian Transport Safety Bureau (ATSB) and the Maritime Authority of the Cayman Islands (MACI). A full report will be published on completion of the investigation. The report will be available from www.cishipping.com and www.atsb.gov.au.

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