

Final report MO-2018-204: *Dolphin Seeker*, grounding, 27 October 2018

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# Final Report

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Marine inquiry MO-2018-204  
Dolphin Seeker, grounding  
27 October 2018

Approved for publication: July 2019

# Transport Accident Investigation Commission

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## About the Transport Accident Investigation Commission

The Transport Accident Investigation Commission (Commission) is a standing commission of inquiry and an independent Crown entity responsible for inquiring into maritime, aviation and rail accidents and incidents for New Zealand, and co-ordinating and co-operating with other accident investigation organisations overseas. The principal purpose of its inquiries is to determine the circumstances and causes of occurrences with a view to avoiding similar occurrences in the future. Its purpose is not to ascribe blame to any person or agency or to pursue (or to assist an agency to pursue) criminal, civil or regulatory action against a person or agency. The Commission carries out its purpose by informing members of the transport sector and the public, both domestically and internationally, of the lessons that can be learnt from transport accidents and incidents.

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## Important notes

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### Nature of the final report

This final report has not been prepared for the purpose of supporting any criminal, civil or regulatory action against any person or agency. The Transport Accident Investigation Commission Act 1990 makes this final report inadmissible as evidence in any proceedings with the exception of a Coroner's inquest.

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### Citations and referencing

Information derived from interviews during the Commission's inquiry into the occurrence is not cited in this final report. Documents that would normally be accessible to industry participants only and not discoverable under the Official Information Act 1982 have been referenced as footnotes only. Other documents referred to during the Commission's inquiry that are publicly available are cited.

### Photographs, diagrams, pictures

Unless otherwise specified, photographs, diagrams and pictures included in this final report are provided by, and owned by, the Commission.

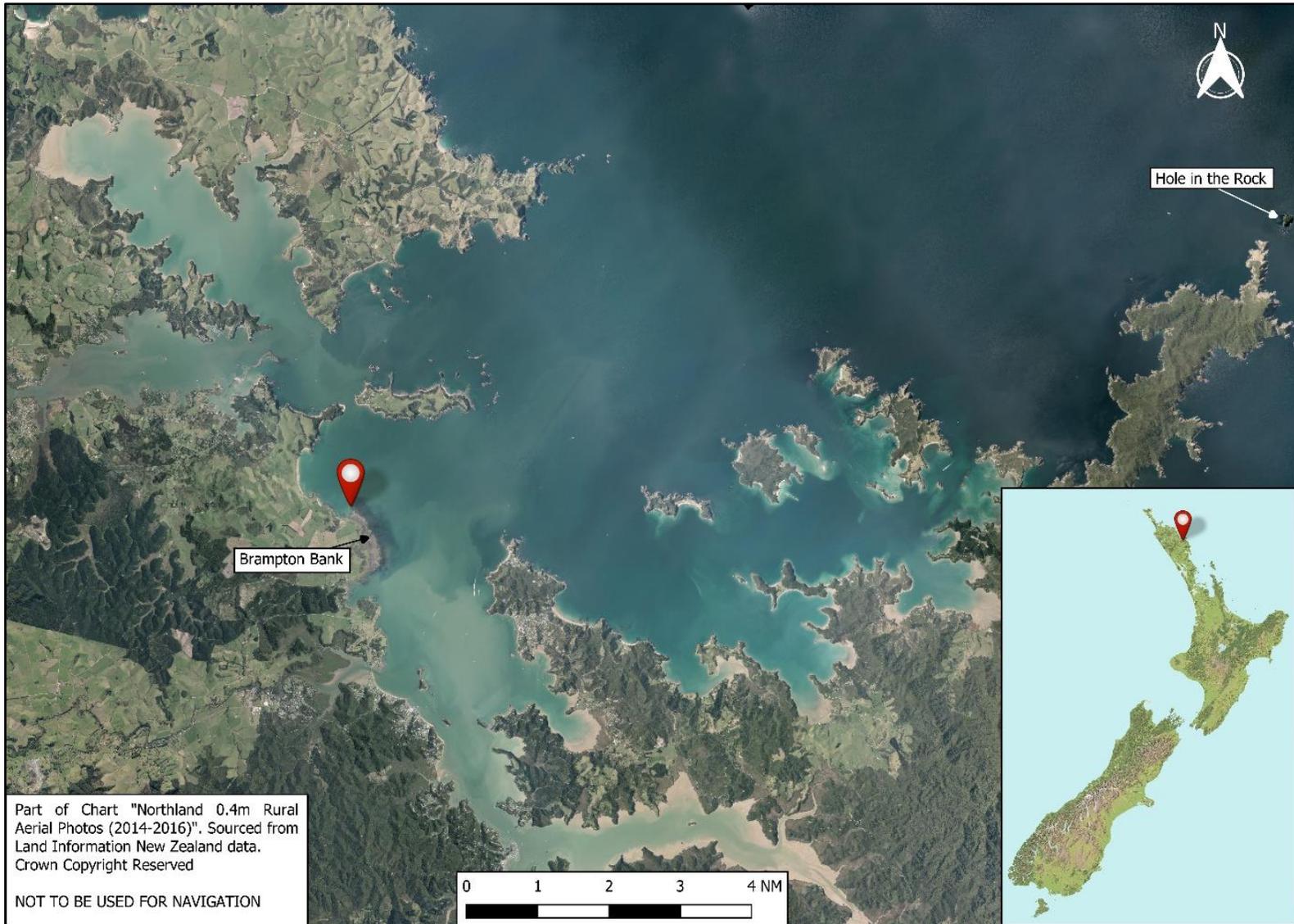
### Verbal probability expressions

The expressions listed in the following table are used in this report to describe the degree of probability (or likelihood) that an event happened or a condition existed in support of a hypothesis.

Terminology (Adopted from the Intergovernmental Panel on Climate Change)	Likelihood of the occurrence/outcome	Equivalent terms
Virtually certain	> 99% probability of occurrence	Almost certain
Very likely	> 90% probability	Highly likely, very probable
Likely	> 66% probability	Probable
About as likely as not	33% to 66% probability	More or less likely
Unlikely	< 33% probability	Improbable
Very unlikely	< 10% probability	Highly unlikely
Exceptionally unlikely	< 1% probability	



*Dolphin Seeker* (image courtesy of Fullers GreatSights)



Location of accident

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## Abbreviation

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AIS	Automatic Identification System
Fullers GreatSights	Fullers GreatSights Limited

## Glossary

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EROAD	a proprietary, GPS-based tracking and monitoring system commonly used to track and monitor land-based vehicles
Knot	a knot is equal to one nautical mile per hour, or about 1.8 kilometres per hour

## Data summary

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### Vehicle particulars

Name:	<i>Dolphin Seeker</i>
Type:	passenger
Limits:	Restricted Limits (inshore)
Length:	23.38 metres
Breadth:	7.80 metres
Built:	2001
Propulsion:	two MTU 378kW single screw
Service speed:	18 knots
Owner/Operator:	Fullers GreatSights Limited
Port of registry:	Bay of Islands
Minimum crew:	two

**Date and time** 27 October 2018 at approximately 1414<sup>1</sup>

**Location** Bay of Islands

**Persons involved** skipper and five crew, and 47 passengers

**Injuries** none reported

**Damage** minor damage to the vessel's hull, extensive damage to both propellers

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<sup>1</sup> Times in this report are New Zealand Daylight Saving Time (Co-ordinated Universal Time + 13 hours), and are expressed in the 24-hour mode.



## 1. Executive summary

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- 1.1. During the afternoon of 27 October 2018, the restricted-limits passenger catamaran *Dolphin Seeker* was on its second dolphin-watching tourist trip of the day in the Bay of Islands, with six crew and 47 passengers on board.
- 1.2. The skipper had located a pod of dolphins near the Brampton Bank area and was manoeuvring the *Dolphin Seeker* to stay with the pod, at the same time as giving a commentary over the public address system, when the vessel ran aground on rocks at slow speed.
- 1.3. Nobody was injured, but the vessel sustained significant damage to both propellers and minor damage to its hull. The passengers were transferred to another company vessel. The *Dolphin Seeker* was re-floated on the rising tide and towed back to its berth.
- 1.4. The Transport Accident Investigation Commission (Commission) **found** that the grounding occurred because the skipper did not notice that the vessel had moved into shallow waters while focusing on giving a passenger commentary at the same time as manoeuvring the vessel to maintain proximity to the pod of dolphins.
- 1.5. The Commission also found that the skipper was effectively working alone in a high-risk situation. There were few or no defences in place to prevent the one-person errors that resulted in the grounding, such as fully utilising the features of the vessel's electronic navigation equipment.
- 1.6. The Commission identified a **safety issue** that the operator's safety management system did not fully address the risk of vessel groundings and collisions where its skippers were in effect working alone in the wheelhouse.
- 1.7. The operator took **safety actions** to address this safety issue. Therefore no new recommendations were required.
- 1.8. A **key lesson** arising from this inquiry is that when skippers are operating vessels alone in high-risk situations, there should be adequate measures in place to minimise the risk of one-person errors resulting in maritime accidents and incidents.

## 2. Conduct of the inquiry

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- 2.1. On 27 October 2018 the Rescue Coordination Centre New Zealand notified the Transport Accident Investigation Commission that the *Dolphin Seeker* had run aground in the Bay of Islands.
- 2.2. On 27 October 2018 the Commission opened an inquiry under section 13(1)b of the Transport Accident Investigation Commission Act 1990, and appointed an investigator in charge.
- 2.3. On 28 October 2018, three investigators were deployed to the Bay of Islands to conduct a site investigation.
- 2.4. The investigators interviewed: the operator's general manager and operations manager, the vessel's skipper, a vessel crew member, and the operator's training skipper. The investigators also gathered evidence from the vessel and company offices, including photographs, documents and electronic data.
- 2.5. On 22 May 2019 the Commission approved the draft report for circulation to interested persons. A joint submission was received by three of the interested persons.
- 2.6. On 24 July 2019 the Commission approved the final report for publication.

## 3. Factual information

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### 3.1. Background

- 3.1.1. Fullers Bay of Islands Limited trading as Fullers GreatSights is a subsidiary company of InterCity Group (NZ) Limited. Fullers GreatSights operates 10 passenger vessels and a coach service, providing mainly tourist trips in and around the Bay of Islands, New Zealand.
- 3.1.2. The *Dolphin Seeker* was one of the vessels operated by Fullers GreatSights. On the day of the accident the *Dolphin Seeker* was delivering one of Fullers GreatSights' tourism products, the 'Hole in the Rock Dolphin Cruise'. The cruise was offered twice per day, the first departing Paihia at 0900, and the second at 1330.
- 3.1.3. Passengers embarked at Paihia, then the vessel made the short trip to Russell to pick up other passengers before beginning the cruise through the Bay of Islands towards the Hole in the Rock.<sup>2</sup> There were several tourist features along the way, where the skipper slowed the vessel and delivered commentary related to the points of interest (see Figure 1).
- 3.1.4. During the cruise the crew would keep a look-out for dolphins. If a pod of dolphins were spotted, the skipper could deviate from the planned track to intercept and follow the pod, giving commentary over the public address system.

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<sup>2</sup> A renowned feature of Piery Island in the outer Bay of Islands; there is a hole through the middle of the island large enough for tourist vessels to pass through.



Figure 1  
Fullers GreatSights' tourist map of the Bay of Islands, showing locations of interest

### 3.2. Narrative

- 3.2.1. On the morning of 27 October 2018, the *Dolphin Seeker* was at its overnight berth in Ōpua (see Figure 2). The skipper and crew went on board and prepared the vessel for the day.
- 3.2.2. At about 0805 the *Dolphin Seeker* departed its berth in Ōpua for Paihia, where it boarded 100 passengers. The vessel then departed Paihia for Russell, where it boarded another 30 passengers. The *Dolphin Seeker* then departed Russell at about 0920 for the morning 'Hole in the Rock Dolphin Cruise'. The trip was completed without incident. During the trip the skipper had a radio call from another vessel, informing them that dolphins were in the region of Brampton Bank.

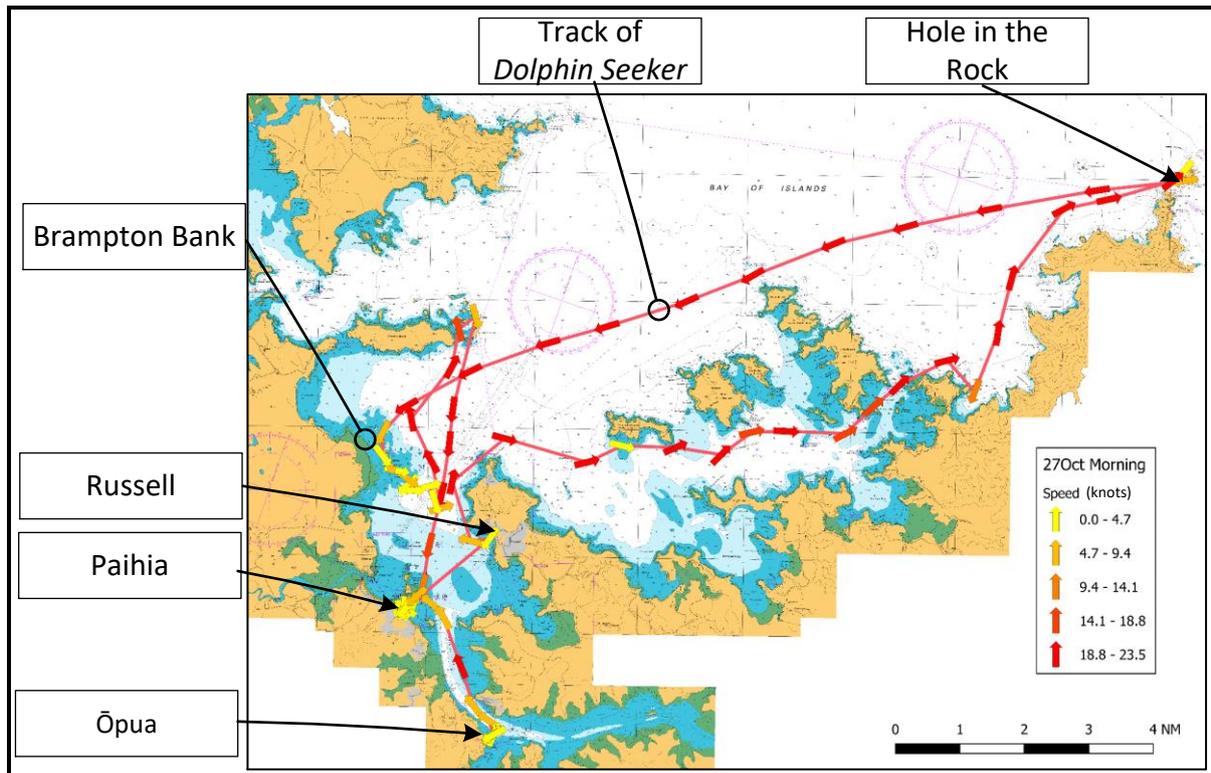
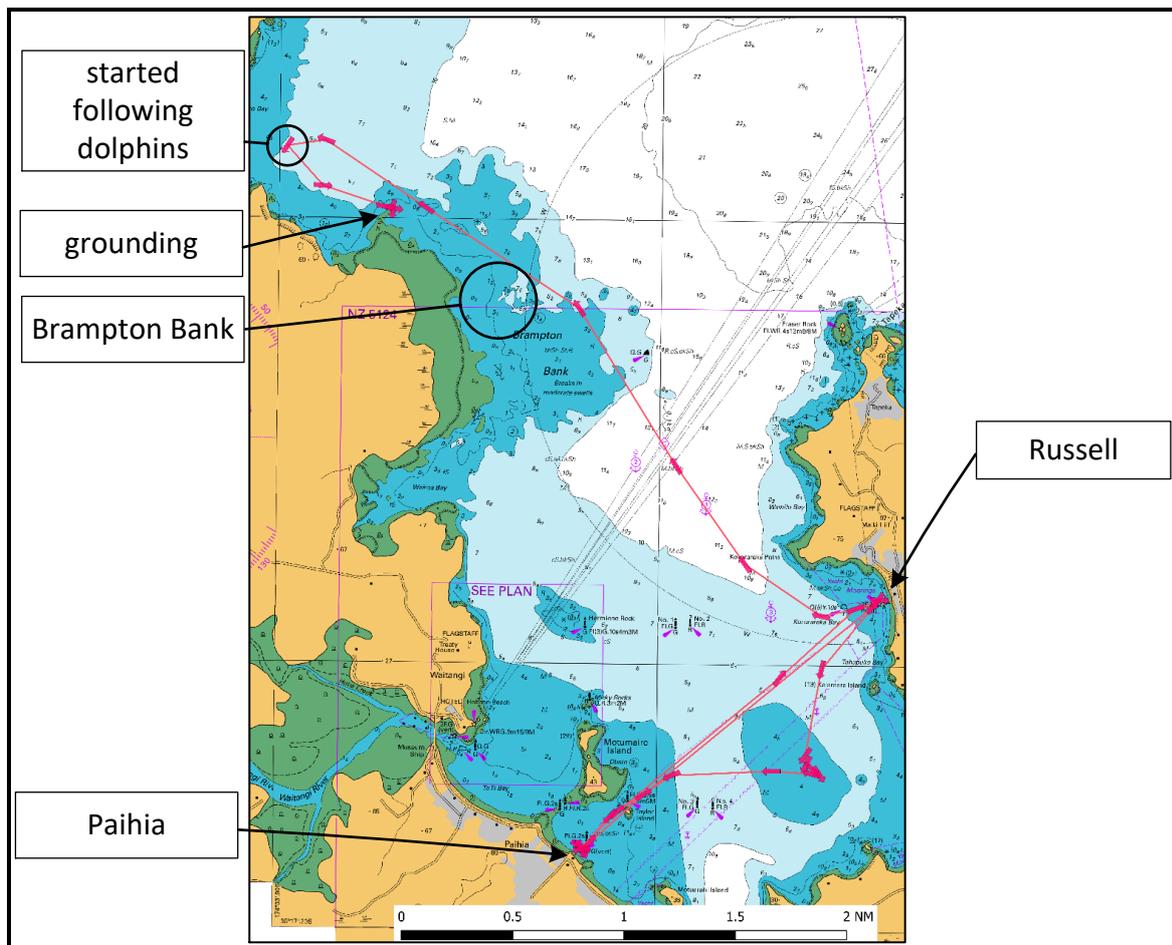


Figure 2  
Excerpt from chart of the Bay of Islands showing the morning voyage of the *Dolphin Seeker*

- 3.2.3. The skipper navigated the *Dolphin Seeker* to Brampton Bank, where they slowed the vessel to enable the passengers to watch dolphins at about 1105. After the passengers had spent some time dolphin watching, the *Dolphin Seeker* returned to Paihia and then Russell to disembark passengers. The *Dolphin Seeker* was alongside back in Paihia by 1250.
- 3.2.4. The reported weather during the afternoon was small waves and a gentle breeze.
- 3.2.5. Passengers embarked in Paihia for the afternoon voyage at about 1315. The *Dolphin Seeker* then went to Russell, where more passengers boarded.



**Figure 3**  
 Excerpt of chart of the Bay of Islands showing the afternoon voyage of the *Dolphin Seeker*

- 3.2.6. The *Dolphin Seeker* departed Russell for its afternoon voyage at about 1346, with 47 passengers on board. The skipper took the vessel directly to the area near Bampton Bank where they had found the dolphins on the morning trip (see Figure 3). A pod of dolphins was located at about 1400.
- 3.2.7. The skipper, who was alone in the wheelhouse, slowed the vessel and began following the pod of dolphins at a low speed of up to about 5 knots at times. At the same time the skipper began delivering the tourist commentary about the dolphins over the public address system.
- 3.2.8. Having been following the dolphins for about 15 minutes, the *Dolphin Seeker* entered an area of shallow water and ran aground on rocks at low speed. The skipper was not able to manoeuvre the vessel off the rocks. The crew made an internal inspection of the hulls and found no evidence that the vessel was taking on water.
- 3.2.9. The skipper contacted Fullers GreatSights' management and notified them of the grounding. Because there were other company vessels in the vicinity and the *Dolphin Seeker* appeared to be resting stably on the rocks, the skipper did not make a radio distress call. They agreed to transfer the passengers to another Fullers GreatSights vessel of a similar size to the *Dolphin Seeker*, the *Te Maki*.
- 3.2.10. The *Te Maki* and a smaller company vessel the *Tutunui* were standing by, ready to assist the *Dolphin Seeker*, by about 1430. The *Tutunui* was used to transfer all the passengers to the *Te Maki*. The transfer operation was complete and the passengers disembarked at the wharf in Paihia by 1540, one hour and 40 minutes after the vessel ran aground. There were no reports of passenger or crew injury.

- 3.2.11. The time of the grounding was about two hours before low water. The incoming tide lifted the *Dolphin Seeker* off the rocks at about 1830, whereupon it was towed back to its berth in Ōpua.
- 3.2.12. An underwater inspection revealed that the grounding had caused minor damage to the hulls, but both propellers were significantly damaged.

### 3.3. The *Dolphin Seeker*

- 3.3.1. The *Dolphin Seeker* was a 23.38-metre catamaran constructed of aluminium. The vessel had been built in 2001.
- 3.3.2. The *Dolphin Seeker's* operating limit was Restricted Limits (inshore)<sup>3</sup> in the Northland, Auckland and Great Barrier Island areas.
- 3.3.3. The minimum safe crewing certificate issued by Maritime New Zealand allowed the *Dolphin Seeker* to carry up to 230 passengers. The minimum number of crew members required on board was dependent on how many passengers there were. One of the crew members had to hold an Inshore Launch Master certificate or higher, and one of the crew members had to hold a Marine Engineer Class 6 certificate or higher. The same crew member could hold both certificates. There were six crew members on board during the voyage in which the vessel grounded.
- 3.3.4. Paper charts were carried on board. The vessel was equipped with the following electronic navigation and monitoring systems:
- SIMRAD NSS12 evo2 series incorporating a chart plotter with AIS, depth sounder and radar
  - MTU<sup>4</sup> engine displays
  - two very-high-frequency radios
  - an EROAD<sup>5</sup> unit
  - autopilot.

### 3.4. The safety management system

- 3.4.1. Fullers GreatSights was subject to Maritime Rules Part 19, Maritime Transport Operator – Certification and Responsibilities. Under this rule Fullers GreatSights operated under a Maritime Operator Safety System.
- 3.4.2. Underpinning the safety system is an operator's Maritime Transport Operator Plan, which must be audited and approved by Maritime New Zealand.
- 3.4.3. Once a plan has been approved, Maritime New Zealand issues the operator with a Maritime Transport Operator Certificate. Each vessel in an operator's fleet is issued with a certificate of survey by a Maritime New Zealand authorised surveyor.
- 3.4.4. The Maritime Transport Operator Plan contained all the various policies, guidelines and requirements of the *Dolphin Seeker*.

### 3.5. Navigation

- 3.5.1. The skipper was solely responsible for the *Dolphin Seeker's* navigational watch, that is to say the skipper was routinely alone in the wheelhouse during the voyage. The skipper was also responsible for delivering the tourist commentary as necessary. At the discretion of the

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<sup>3</sup> Restricted Limits (inshore) means within five nautical miles of the coast in certain areas.

<sup>4</sup> MTU is a manufacturer of commercial internal combustion engines

<sup>5</sup> A proprietary, GPS-based tracking and monitoring system commonly used to track and monitor land-based vehicles.

skipper, other crew would occasionally deliver the tourist commentary instead of the skipper, usually for the purpose of training the crew.

3.5.2. The *Dolphin Seeker's* standing orders stated:

LOOK-OUT Every Skipper must at all times maintain a proper look out by sight and hearing as well as by all available means appropriate in the prevailing circumstances and conditions, so as to make full appraisal of the situation and the risk of collision.

3.5.3. The *Dolphin Seeker's* safe navigation policy stated:

At certain times the need to provide commentary could distract the Skipper from the safe navigation of the vessel. At such times the commentary is to be suspended until conditions are such that it is safe for the commentary to resume.

3.5.4. The operator prohibited skippers delivering tourist commentary at certain times as the risk to navigation was considered too high. Those times included when its vessels transited the Hole in the Rock.

### 3.6. Electronic navigation aids

3.6.1. In 2014 Maritime New Zealand had introduced SeaCert, a new certification framework for seafarers. As part of transitioning older qualifications to the new system Maritime New Zealand had run training workshops to refresh and update the knowledge of those holding the older qualifications. The workshops had included training for electronic navigation aids.

3.6.2. The skipper had attended one of the workshops, following which the company had decided to improve the use of electronic navigation aids on its vessels. Fullers GreatSights had adopted a standardised electronic chart navigation system across its fleet and engaged an external provider to provide additional training for its skippers on its use. The skipper of the *Dolphin Seeker* had received this additional training.

3.6.3. The *Dolphin Seeker's* safe navigation policy stated:

Electronic navigational aids such as GPS, Chart Plotter, Radar and AIS [automatic identification system], are to be used to assist with the safe navigation of the vessel; however there is to be no over reliance on these aids in lieu of maintaining an efficient visual lookout and reference to the proper navigational charts for the area.

### 3.7. The skipper

3.7.1. The skipper had been issued with a Commercial Launch Master certificate in 1998 and a Marine Engineer Class 5 certificate in 2008. Both the Commercial Launch Master and the Marine Engineer Class 5 certificates were higher qualifications than those required by the minimum safe crewing certificate.

3.7.2. The skipper had started working at Fullers GreatSights in 2000 and had been involved in all areas of sea-going operations.

3.7.3. Maritime New Zealand had issued the skipper with a Pilotage Exemption Certificate for the Bay of Islands in 2011, which the skipper required to pilot Fullers GreatSights' largest passenger vessel. A Pilotage Exemption Certificate confirms that the skipper has a thorough navigational knowledge of the local area and has met the requirements for piloting vessels larger than 500 gross tonnes in designated pilotage areas; they are exempt from the requirement to use an independent marine pilot. The Pilotage Exemption Certificate had expired in 2016, and had not been renewed due to the large vessel being retired from the fleet.

## 4. Analysis

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### 4.1. General

- 4.1.1. The *Dolphin Seeker* grounded on rocks at low speed and in benign weather conditions. Although nobody was injured and the watertight integrity of the vessel remained intact, any grounding of a passenger vessel is of concern. It is an indication that the safety system has not necessarily worked. System failures increase the likelihood of repeat accidents, potentially with serious consequences.
- 4.1.2. There is no suggestion that mechanical or equipment failure contributed to the grounding. It is very likely that the skipper became distracted by the simultaneous tasks of following the pod of dolphins and giving the passenger commentary over the public address system, to the detriment of monitoring the progress of the vessel in relation to navigation dangers.
- 4.1.3. The following analysis considers the circumstances leading up to the grounding, and the safety issue that the operator's safety management system did not fully address the risk of vessel groundings and collisions where its skippers were in effect working alone in the wheelhouse.
- 4.1.4. The operator has taken a number of safety actions to address this safety issue. Consequently, there was no need for the Commission to make a recommendation.

### 4.2. What happened

- 4.2.1. The skipper had ample experience driving the *Dolphin Seeker* and was familiar with the format of the trips and the general routes that were covered. When the *Dolphin Seeker* neared the pod of dolphins, the skipper followed the usual routine of maintaining proximity with but keeping clear of the pod to avoid disturbing the dolphins. This task involved frequent manoeuvring of the vessel by engaging and disengaging the engines from time to time. In itself the task was not onerous.
- 4.2.2. The second simultaneous task for the skipper was to give the commentary over the public address system, again not in itself an onerous task.
- 4.2.3. However, the dolphins were in an area close inshore and in the shallows. The skipper appears to have become fully engaged with keeping the *Dolphin Seeker* close to the pod and delivering the commentary, to the detriment of monitoring the vessel's proximity to navigation hazards.
- 4.2.4. In human factors terms the skipper lost situational awareness, and did not realise that the vessel was navigating close to rocks until it ran aground on them. Once a person loses situational awareness their ability to realise that fact diminishes with time, unless they are prompted by someone or by some form of alarm. There was nobody else in the wheelhouse to prompt the skipper. The potential for the electronic navigation system to have alerted the skipper is discussed in the following section.
- 4.2.5. The operator had identified the risk of skippers becoming distracted by giving commentary, but had only really identified the risk in certain situations, such as transiting the Hole in the Rock. The nature of the trips meant that skippers were expected to take their vessels off the routes between known tourist points of interest in order to fulfil a key feature of the trips, watching dolphins. Within the Bay of Islands the operator applied few restrictions on where the vessels could go. Therefore, it was foreseeable that its vessels could and would from time to time navigate close to navigational dangers in order to connect with and follow pods of dolphins.
- 4.2.6. The operator has partially addressed this risk by prohibiting all skippers within its fleet from delivering significant commentary while navigating vessels, thus allowing skippers to concentrate solely on manoeuvring their vessels and staying clear of navigational hazards and other vessels, and also required a second crew member to assist in the wheelhouse in those cases.

### 4.3. Electronic navigation aids

- 4.3.1. The skipper of the *Dolphin Seeker* lost situational awareness and put the vessel into shallow water on a collision course with the rocks. That error was not identified or rectified before the vessel grounded.
- 4.3.2. Human error is inevitable, regardless of an individual's experience and expertise, so a primary aim of safety management is to put defences in place to 'trap' and rectify those errors before they contribute to an accident. Electronic navigation aids can be a good way to improve navigation safety.
- 4.3.3. The operator's initiative to standardise the electronic aids on all vessels in its fleet was a positive action. It meant skippers transferring between vessels would already be familiar with the navigation equipment.
- 4.3.4. The skipper was competent in using the electronic navigation aids on the *Dolphin Seeker*, and they were switched on and available for immediate use. However, the skipper did not routinely use them to full effect and neither did some of the operator's other skippers.
- 4.3.5. One reason for some skippers not routinely using the electronic aids was that most operations were tourism based and only occurred in good weather. The skippers were fully familiar with the Bay of Islands area and they usually navigated visually. Adequate risk mitigation appeared to be in place, and the Maritime Transport Operator Plan requirement appeared to be satisfied, because the electronic navigation aids were available immediately should they be required for any reason.
- 4.3.6. However, a key component of using electronic navigation aids effectively is that the users must be fully current and practised in their use so that they can seamlessly switch back and forth between visual and electronic navigation. That ability depends on their routine and frequent use of the equipment, and the equipment being set up for the conditions at the time.
- 4.3.7. The Commission has raised the issue of ineffective or improper use of electronic navigation aids in two other recent inquiries.<sup>6</sup> In one case the electronic navigation aids were not configured correctly for immediate use. In both cases the alarms were either not set or silenced, or were noticed by the crew and not acted on. Although both these cases involved large ocean-going ships, the proper and effective use of electronic navigation aids is equally applicable to smaller, restricted-limit vessels.
- 4.3.8. There were at least two available features of electronic navigation equipment that could have been used to improve navigation safety, and either would likely have prevented this grounding:
- the chart plotter could have been used to effectively 'geo-fence' hazards such as the rocks. In geo-fencing, certain geographic areas are defined in the chart plotter and set up so that an alarm is given when a vessel moves into that area. The equipment onboard the *Dolphin Seeker* could have been used to set a proximity alarm around a way point located on particular hazards such as the reef. Due to the repetitive nature of the *Dolphin Seeker*'s mission, and the common equipment across the fleet, it would be achievable to geo-fence most navigational hazards within the Bay of Islands
  - the depth sounder could have had an alarm set to alert the skipper when the vessel moved into shallow water.
- 4.3.9. Since this grounding the operator has required all vessels in its fleet to set the depth sounder to alarm if the depth of water under the keel reduces to a pre-set value.

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<sup>6</sup> Inquiry MO-2016-204 *Molly Manx* (grounding) and inquiry MO-2017-201 *L'Austral* (collision with rock).

## 5. Findings

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- 5.1. The *Dolphin Seeker* ran aground on rocks because the skipper became focused on giving a passenger commentary at the same time as manoeuvring the vessel to maintain proximity to a pod of dolphins, and did not notice the vessel had moved into shallow waters.
- 5.2. The skipper was effectively working alone in a high-risk situation, with little or no defences in place to prevent the one-person errors that resulted in the grounding.
- 5.3. There were features of the various electronic navigation aids on board the *Dolphin Seeker* that, if utilised, could have prevented this grounding.
- 5.4. The operator has taken a number of safety actions to minimise the risk of skippers becoming distracted from the core task of navigation safety.

## 6. Safety issue

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- 6.1. The operator's safety management system did not fully address the risk of vessel groundings and collisions where its skippers were in effect working alone in the wheelhouse.

## 7. Safety actions

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### General

- 7.1. The Commission classifies safety actions by two types:
- (a) safety actions taken by the regulator or an operator to address safety issues identified by the Commission during an inquiry that would otherwise result in the Commission issuing a recommendation
  - (b) safety actions taken by the regulator or an operator to address other safety issues that would not normally result in the Commission issuing a recommendation.

### Safety actions addressing safety issues identified during an inquiry

- 7.2. Safety actions taken by the operator post-incident are outlined below:
- internal investigation was carried out, which included individual interviews with all involved and group debriefs
  - a hazard review was carried out around skippers giving commentary and maintaining a navigational watch
  - implemented compulsory use of depth alarms where fitted
  - changes to policies and procedures across the company's Maritime Transport Operator Plan
  - management oversight of conduct out on the water has been increased with the use of electronic tools within the EROAD suite of products
  - in March 2019 Maritime New Zealand carried out a Maritime Operator Safety System audit. The Maritime New Zealand auditor commented that the crew's "reaction to emergency procedures was of a very good standard".

### Safety actions addressing other safety issues

- 7.3. None identified.

## 8. Recommendations

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### General

- 8.1. The Commission may issue, or give notice of, recommendations to any person or organisation that it considers the most appropriate to address the identified safety issues, depending on whether these safety issues are applicable to a single operator only or to the wider transport sector.
- 8.2. In the interests of transport safety it is important that these recommendations are implemented without delay to help prevent similar accidents or incidents occurring in the future.

### Recommendations

- 8.3. No new recommendations were issued.

## 9. Key lesson

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- 9.1. When skippers are operating vessels alone in high-risk situations, there should be adequate measures in place to minimise the risk of one-person errors resulting in maritime accidents and incidents.









**Recent Marine Occurrence Reports published by  
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MO-2017-204	Passenger vessel <i>Seabourn Encore</i> . breakaway from wharf and collision with bulk cement carrier at Timaru, 12 February 2017
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MO-2017-205	Multipurpose container vessel <i>Kokopo Chief</i> , cargo hold fire, 23 September 2017
MO-2017-202	Passenger vessel <i>L'Austral</i> , grounding, Milford Sound, Fiordland, 9 February 2017
MO-2016-206	Capsize and foundering of the charter fishing vessel <i>Francie</i> , with the loss of eight lives, Kaipara Harbour bar, 26 November 2016
MO-2016-202	Passenger ship, <i>Azamara Quest</i> , contact with Wheki Rock, Tory Channel, 27 January 2016
MO-2017-201	Passenger vessel <i>L'Austral</i> contact with rock Snares Islands, 9 January 2017
MO-2016-201	Restricted-limits passenger vessel the <i>PeeJay V</i> , Fire and sinking , 18 January 2016
MO-2016-204	Bulk carrier, <i>Molly Manx</i> , grounding, Otago Harbour, 19 August 2016
MO-2016-205	Fatal fall from height on bulk carrier, <i>New Legend Pearl</i> , 3 November 2016
MO-2015-201	Passenger ferry <i>Kea</i> , collision with Victoria Wharf, Devonport, 17 February 2015
Interim Report MO-2017-203	Burst nitrogen cylinder causing fatality on board the passenger cruise ship <i>Emerald Princess</i> , 9 February 2017
MO-2012-203	Fire on board <i>Amaltal Columbia</i> , 12 September 2012
MO-2016-203	Bulk log carrier Mount Hikurangi, Crew fatality, during cargo securing operation, 27 February 2016
MO-2014-203	Fatal injury, Purse seine fishing vessel, <i>Captain M. J. Souza</i> , 24 August 2014
MO-2015-202	Containership <i>Madinah</i> , loss of person overboard, Lyttelton Harbour entrance, 2 July 2015
MO-2016-202	Urgent recommendation: Cruise ship <i>Azamara Quest</i> , contact with Wheki Rock, Tory Channel, 27 January 2016
MO-2011-202	Roll-on-roll-off passenger ferry <i>Monte Stello</i> , contact with rock, Tory Channel, Marlborough Sounds, 4 May 2011
MO-2014-201	<i>Dream Weaver</i> , flooding due to structural failure of the hull, Hauraki Gulf, 23 February 2014
MO-2010-206	Coastal container ship <i>Spirit of Resolution</i> , grounding on Manukau Bar, Auckland, 18 September 2010

Price \$13.00

ISSN 1173-5597 (Print)  
ISSN 1179-9072 (Online)