Notorious bar claims fisherman

Inside page 2
The capsize happened at the approach to port after six days at sea trawling. The skipper advised the ship’s owner that he would steam up to outside the bar first, to assess the conditions, and would cross at about 10am if they were favourable. However, the vessel arrived at the bar around 7am, and set out to cross at about 7.30am – just half an hour before the forecast low water.

Those aboard prepared for the bar crossing, with the skipper and one crew in the wheelhouse and the other keeping lookout at the stern of the boat, but none put on a lifejacket. The lookout warned the skipper about four big swells, which passed beneath the stern without incident.

Then a bigger wave built and the lookout counted it in. “Four, three, two, one.” The wave broke on the stern and as the vessel was lifted, he knew something was wrong. A man watching from the shore said there were initially no big waves as the vessel approached the bar, but then he saw a wave stand up behind the vessel, making it broach and roll onto its side. He expected the vessel to right itself, but it did not. As he phoned 111, he saw all three on board climb onto the upturned hull. He estimated that it was less than a minute before a wave washed them back into the water.

The two crew grabbed onto a lifebuoy ring and were eventually swept onto the beach, where they were helped ashore. The skipper could be seen floating in the water, but conditions were considered too dangerous for a rescue to be attempted by swimming to him from the rocks.

It was only when someone swam out from the beach, clear of the rocks, that the skipper considered too dangerous for a rescue to be attempted by swimming to him from the rocks. They were eventually swept onto the beach, where conditions were too rough for a rescue to be attempted by swimming to him from the rocks. The two crew grabbed onto a lifebuoy ring and were eventually swept onto the beach, where they were helped ashore. The skipper could be seen floating in the water, but conditions were considered too dangerous for a rescue to be attempted by swimming to him from the rocks.

The skipper advised the ship’s owner he 15m wooden vessel was returning to its home port. The skipper advised the ship’s owner that he would steam up to outside the bar first, to assess the conditions, and would cross at about 10am if they were favourable. However, the vessel arrived at the bar around 7am, and set out to cross at about 7.30am – just half an hour before the forecast low water.

Those aboard prepared for the bar crossing, with the skipper and one crew in the wheelhouse and the other keeping lookout at the stern of the boat, but none put on a lifejacket. The lookout warned the skipper about four big swells, which passed beneath the stern without incident.

Then a bigger wave built and the lookout counted it in. “Four, three, two, one.” The wave broke on the stern and as the vessel was lifted, he knew something was wrong. A man watching from the shore said there were initially no big waves as the vessel approached the bar, but then he saw a wave stand up behind the vessel, making it broach and roll onto its side. He expected the vessel to right itself, but it did not. As he phoned 111, he saw all three on board climb onto the upturned hull. He estimated that it was less than a minute before a wave washed them back into the water.

The two crew grabbed onto a lifebuoy ring and were eventually swept onto the beach, where they were helped ashore. The skipper could be seen floating in the water, but conditions were considered too dangerous for a rescue to be attempted by swimming to him from the rocks. It was only when someone swam out from the beach, clear of the rocks, that the skipper considered too dangerous for a rescue to be attempted by swimming to him from the rocks. They were eventually swept onto the beach, where conditions were too rough for a rescue to be attempted by swimming to him from the rocks. The two crew grabbed onto a lifebuoy ring and were eventually swept onto the beach, where they were helped ashore. The skipper could be seen floating in the water, but conditions were considered too dangerous for a rescue to be attempted by swimming to him from the rocks.

It was only when someone swam out from the beach, clear of the rocks, that the skipper considered too dangerous for a rescue to be attempted by swimming to him from the rocks. They were eventually swept onto the beach, where conditions were too rough for a rescue to be attempted by swimming to him from the rocks. The two crew grabbed onto a lifebuoy ring and were eventually swept onto the beach, where they were helped ashore. The skipper could be seen floating in the water, but conditions were considered too dangerous for a rescue to be attempted by swimming to him from the rocks. It was only when someone swam out from the beach, clear of the rocks, that the skipper considered too dangerous for a rescue to be attempted by swimming to him from the rocks. They were eventually swept onto the beach, where conditions were too rough for a rescue to be attempted by swimming to him from the rocks. The two crew grabbed onto a lifebuoy ring and were eventually swept onto the beach, where they were helped ashore. The skipper could be seen floating in the water, but conditions were considered too dangerous for a rescue to be attempted by swimming to him from the rocks.

The crossing was not in line with the “National code of practice for bar crossings”, and the fatality could probably have been avoided had the skipper waited a little longer and crossed the bar shortly before high water, as recommended, rather than shortly before low water.

As the vessel crossed the bar, the weather and sea conditions were changing. The sea, previously relatively calm, built up quickly with larger and more difficult waves. Once committed to the crossing, the vessel appeared to have either struck the sea bed or bar, or had its stability affected by its proximity to them.

It is not unusual for conditions at a bar to change within minutes. Moderate seas can turn rough too quickly for a vessel that’s committed to its course to change direction and abort a crossing. This can put a vessel in grave danger at times of heightened risk, such as low tide.

Vessels crossing a bar can be affected by the tide’s height, the water depth over the bar, the number of bars that have formed, the set of the sea, aeration of the water by waves, the height and direction of the swell, how the vessel is positioned, and the vessel’s stability.

Fresh water flowing out of a river at a fast rate can also create a layer on top of the sea water and, having less buoyancy than the salt water, impair a vessel’s handling ability because it has to push harder into the additional current, particularly when inbound.

Some experts considered the vessel’s load had probably shifted, either before or when the large following wave lifted the vessel and bottomed it on a shoal of the bar. This load shift may have contributed to the vessel’s loss of stability and intensified its roll.

No one on board was wearing a lifejacket as the vessel attempted the crossing, and the lifejackets became inaccessible following the capsize. The two crew managed to cling to...
a lifebuoy ring, which floated free during the capsize. They eventually made it to shore.

While he was only in the sea for a few minutes before being recovered, the skipper did not survive. But the support provided by a lifejacket may have been all he needed to ensure his survival.

In his findings, the coroner emphasised that even if fishermen do not routinely wear lifejackets, they should be worn at times of danger, and especially when crossing a river bar that has been known to claim lives in the past. He said that the ability of the skipper to exit the wheelhouse in the event of a capsize need not be reduced by wearing a lifejacket if the door is latched open and other precautions taken to ensure clear access. Inflatable lifejackets are not bulky and are relatively comfortable to wear.

- Before his death, the skipper had recently consumed cannabis, with a medical expert saying it was likely that cannabis had been consumed during the trip. As well as producing a sense of euphoria and relaxation, cannabis impairs thinking and coordination and reduces reaction times. The coroner concluded that while steering the vessel over the bar, at a hazardous time for himself and his crew, the skipper had been adversely affected by cannabis.

- MNZ’s investigation concluded that the capsize was probably caused by a combination of the timing of the crossing, the wave’s size and its impact on the vessel, the catch shifting and the vessel losing stability as it rolled through 90 degrees.

- Had the skipper waited a few hours for a higher tide, the vessel been loaded or configured in a different way, the skipper been wearing a lifejacket or not smoked cannabis, this tragedy may not have occurred.

Although he was known as a cautious and competent seafarer with many years of experience in crossing the river bar, the skipper’s error or errors of judgment on this day proved fatal.
Worker sustains head injury in wake surge

A man employed by a maritime construction company sustained a serious head injury when his head was caught between a bollard on the barge he was working on and a wharf piling.

The barge was alongside the berthing piles on the wharf’s outer face. The worker, kneeling on the barge deck, reached out to take a mooring line passed to him by a workmate from around the back of a pile.

As he reached for the line, the wake of a passing vessel slammed the barge against the berthing pile with an upward motion. The man was struck by the top edge of the mooring bollard on the barge and the face of the berthing pile.

As the man stood up, holding his head, his colleague noticed he was bleeding and helped him into a sitting position. He was taken by ambulance to hospital, where an MRI scan showed he had sustained a fracture to his skull and required surgery.

LOOKOUT! POINTS

- The staff working on the barge were experienced in the berthing procedure. They had been operating in this way to secure floating plant to a wharf for the previous 26 years.

A moment’s complacency had put the worker at risk. At the time of berthing he had to kneel on the deck to reach the mooring line being passed to him around the back of the berthing pile. He leaned against the pile as he reached for the line and, because of the position of his body, was unable to avoid being struck by the bollard when the barge unexpectedly and violently surged upwards.

The man admitted that his loss of focus had contributed to the accident. When berthing or departing, you must keep your body well clear of any pinch points. This includes all moving plant in any location. Use a boat hook to handle mooring lines, if required.

- Personal protective equipment (PPE) must be worn on barges at all times, including hard hats. When this incident occurred, appropriate PPE was being used – safety boots, high-viz vests and hard hats – but the worker had removed his hard hat and put it on the deck beside him. Had he been wearing his hard hat as required, he may have avoided injury.

- There should be a designated person to keep a lookout for wave and wake action that could affect the motion of the barge and put people’s safety at risk.

- No enforcement action was taken over the incident, in recognition of the company’s previous good safety record. The company reported the accident to MNZ as required and took proactive measures to prevent similar incidents in future. Operational procedures were revised, including staff briefings and training drills for securing floating plant.

Other actions involved hazard identification and task analysis when securing floating plant, avoiding potential pinch points between fixed structures and floating plant, and using a boat hook when passing lines around piles to avoid the need to reach out. The foreman is now required to keep a safety watch during the procedure, and to alert staff about the wake of other vessels or wave action that could make floating plant react unexpectedly.

- Maritime officers investigating the incident said the workers on the barge had responded to the medical emergency in a professional manner, and their up-to-date first aid training was evident in their care of their workmate.
Swimmer injured by unguarded propeller

A woman was seriously injured when she was struck by a vessel’s propeller while swimming with dolphins. The female tourist was one of 20 passengers on a catamaran built for dolphin watching and swimming. The passengers were given a safety briefing for the vessel shortly after its 8am departure from the wharf.

When the vessel encountered dolphins, there was another safety briefing before swimming. During this briefing, passengers were advised not to enter the water until told to do so by a crew member. They were instructed to sit on the first steps at the stern transom and then ‘sit, slip and slide’ into the water. No advice was given to avoid swimming near the propellers.

The swimmers returned to the vessel from their first swim without mishap. As the vessel approached dolphins at a new location, the crew instructed the passengers intending to swim to gather at the port and starboard aft quarters, and to wait for instructions to enter the water over the sterns of both hulls.

One passenger interviewed later said people were excited and the crew encouraged swimmers to get into the water quickly to make the most of their time with the mammals. The passenger described the situation as ‘frenetic’.

The catamaran used for dolphin watching and swimming did not have propeller guards.
Believing she’d been given the go-ahead, a woman seated on a step on the port aft section of the transom dropped down into the water. However, the master was still positioning the vessel and had the engines in reverse. The port hull slowly reversed over the woman, bringing her into contact with the port propeller.

As he soon as he noticed that the woman was no longer sitting on the swim platform ready to enter the water, the master put the engines into neutral. He noticed a series of impacts through the controls, most likely caused by a propeller striking the woman. The master cut the engines immediately and went to the roof of the bridge. Seeing the woman emerge, screaming, at the surface of the water, he jumped in to assist her.

The woman, whose right leg had sustained a deep cut, was helped back on board by the master and another crew member. She said later that she had felt the propeller hit her shoulder and she remembered clawing her way to the surface, fighting against the force of water that was pulling her down. At the time, she believed she was going to lose her leg or bleed to death.

A medical professional on board gave first aid, while the master radioed for an ambulance to meet the vessel at the shore. The injured woman was treated in hospital for a deep laceration to her calf, and for multiple linear abrasions and bruising to her right arm.
Practicable steps that could have been taken to address the risks include:

- procedures to prevent passengers getting onto the swim platform and into the water while the vessel was moving.
- identifying the hazard of unguarded propellers in the vessel’s SSM manual and having measures to manage it. These include:
  - posting a diagram on board the vessel to show danger areas for swimmers
  - possibly installing a safer drive system (such as jets)
  - creating an area forward of the stern where swimmers could get in and out of the water safely
  - using guards and barriers and ensuring that entry to the water was only from the swim platform and not from outboard of the sponsons
  - using the vessel’s horn or other clear signal to indicate to passengers when it was safe to enter the water
  - auditing the crew to ensure the procedures were being followed.

Had some or all of these measures been taken, there would have been a greatly reduced risk of any person getting into the water while the vessel was moving and coming into contact with the propellers.

The master breached the HSE Act as he failed as an employee to take all practicable steps to ensure that no action or inaction by him while at work caused harm to any other person.

Restraints to prevent people coming into contact with moving machine parts or to prevent them from getting into the water at the wrong time must be used as intended. The injured woman said a restraint rail and partition boards to control swimmers’ entry to the water were present but not in use. The master should have ensured these physical barriers were used to prevent swimmers accessing the swim platforms and entering the water while the vessel was manoeuvring. The operator said the guards weren’t in place, to give swimmers faster access to the water. But it said safety procedures had since been improved and passengers were no longer allowed to be on the swim platforms while the vessel was reversing.

As well as safety briefings provided to passengers, all other instructions and signals involving the safety of people on board a vessel should be clear and unambiguous.

Practicable steps that could be taken include a requirement to give a clear signal (such as sounding the horn or a whistle) to indicate when a swimming vessel has stopped moving and it is safe to enter the water.

The master and operator were both convicted and fined under the HSE Act.

MNZ is concerned about the number of recent injuries caused by propeller strike. The lessons from this and similar accidents should be heeded and incorporated into operational procedures for vessels involved in swimming operations.
An experienced sailor had to swim to shore after falling from the stern of a 30 foot yacht with twilight approaching.

Departing in the morning in convoy with another yacht, the crew of three enjoyed a reasonable day’s sailing as they tacked into moderate headwinds.

During a squall, all hands were on deck to deal with an overriding turn on a winch. They then started up the engine and motor-sailed so they would reach their destination before nightfall.

The skipper and one of the crew went below deck to warm up and rest, leaving the third crew member on watch with the motor running and steering on auto-pilot.

As the lone sailor relieved himself off the stern, a sudden movement of the yacht upset his footing and he fell overboard. With the noise of the engine drowning out his cries for help, he watched the yacht sail away into the distance in the late afternoon. The crew were still resting below decks, unaware of his plight, and the winter twilight was rapidly descending.

Once in the water, the man had to quickly decide whether to conserve energy by staying where he was and hope for rescue, or swim to the shore some kilometres away. Although a strong swimmer, he was lightly dressed and aware of the light fading. He knew his chances of being seen were diminishing and it could be some time before his mates noticed he was missing. He made the choice to head for land.

He struck out through the choppy sea (aware of the risks of hypothermia and drowning) and, after swimming several miles, landed ashore on an island. He then walked the length of the island around the rocks before plunging into the sea again, making for the mainland. When he came ashore, he marked out an ‘SOS’ signal in the sand.

Meanwhile, on board the yacht, the skipper emerged from the cabin after a short rest and noticed a fish on a lure they were towing. As he went about hauling it in, he wondered where his crew mate was, thinking he might be on the fore deck or in the head.

Before long, the skipper shouted out to the other crew below decks to find out whether the third crew member was in the head. Finding that he wasn’t there, the skipper immediately turned the yacht around, called the Police and alerted the yacht they were motoring in convoy with.

Coastguard launched three rescue boats from different locations to begin searching for the man, and a fishing launch was also diverted to assist. A rescue helicopter was also deployed by the Rescue Coordination Centre New Zealand and its crew searched the sea in the area where the man had gone overboard.

At the same time as the helicopter crew decided to return to base for night vision equipment, they noticed a man on the beach with SOS scrawled in the sand beside him.

The exhausted but grateful man was airlifted to hospital and treated for mild hypothermia before being reunited with his crew mates the next day.
The wearing of a well-fitting lifejacket or personal flotation device (PFD), preferably with a crotch strap, allows freedom of movement when sailing or fishing, but also provides potentially life saving flotation in the event of falling or being thrown overboard by a sudden movement of the yacht.

MNZ recommends wearing a lifejacket at all times when above decks, especially in situations of heightened risk, such as in poor weather or when sailing short-handed.

When short-handed on a vessel, the lifejacket should be fitted with an attachment for a safety lanyard or a harness worn under the lifejacket with jack-lines and/or other attachment points at suitable locations around the yacht, such as at the mast.

While this incident had a successful outcome, it could easily have become a tragedy. Many resources were deployed to respond to the search and rescue of the man overboard. The rescue could have been effected more quickly and using fewer resources if the sailor had some way of calling for help.

MNZ recommends having two ways to call for emergency help on board your boat, with at least one carried on your person. Having a distress beacon (an EPIRB or a PLB) on board is a reliable way to signal for help.

Other methods of maintaining contact should be considered, such as a fixed VHF radio or fully charged waterproof handheld VHF, with contact frequencies kept handy. A mobile phone loaded with emergency contact numbers and sealed inside a waterproof bag or container is a useful back-up – if there is reception.

It’s also advisable for boaties to have a waterproof way of a calling for help on their person – a PLB in the pocket of wet weather gear or fastened to a belt will greatly increase chances of rescue should someone go overboard without being seen.

Experienced boaties can succumb to momentary lapses in judgment and land themselves in a predicament just as easily as the inexperienced. As an experienced sailor, the man had relieved himself off the stern of a boat many times before. A momentary loss of balance caused by a wave or unexpected vessel movement can easily result in a person falling overboard.

There have been a number of cases in recent years in which experienced mariners urinating off the side of a vessel have fallen overboard and drowned, especially at night. Be careful where and how you go.

Appropriate protection, such as rails or wires fitted across the open transom, would allow a sailor to lean through the rails when the need arose without risk of falling overboard. Using the toilet or a bucket are other options.

Although in this case the skipper called for help as soon as he realised something was amiss, all people on board every boat need to be prepared and know what to do in the event of an emergency.

A crew briefing should be conducted before any passage to ensure that someone else can handle the vessel in the case of the skipper becoming incapacitated or falling overboard. Instructions should be given on how to use the radio, start the engine, find the safety equipment and general procedures should the unexpected happen. Man overboard drills can help prepare people for real emergencies.

When leaving sheltered New Zealand harbours, the coast should be treated as ‘offshore’ with respect to preparation, as the areas are usually remote and exposed. Trip reporting to a coastal radio station or at least advising someone ashore of intentions is essential.

Protective clothing appropriate to the weather conditions and water temperature should be worn, as this makes for more comfortable sailing and offers protection from the cold if you unexpectedly end up in the water.

Navigation should be recorded and positions plotted on charts, so that if someone goes overboard, the last position can be provided for search and rescue purposes. A basic GPS chart-plotter can be an invaluable addition to your boat’s safety equipment, as it can be set to record the yacht’s track continuously.
Speeding cruiser snags family runabout

An 65-ton ocean-going motor cruiser on a world trip dragged a small runabout for 30m, after it took a shortcut through a cluster of anchored vessels and picked up the runabout’s anchor line. The family fishing from the runabout, including 10-year-old twins, was seriously endangered, and people on board neighbouring craft were traumatised by the incident.

The 17m motor vessel was headed up harbour towards the entrance to a marina when people fishing from a group of anchored vessels noticed it steaming towards them. As it approached, it sounded its horn, while witnesses grew increasingly alarmed as it closed on their vessels without altering course or slowing down.

The motor vessel appeared to be steering on a collision course with several craft, but changed its course at the last minute, passing between two boats closely anchored together and missing one of them by less than a metre.

As it passed, the motor vessel picked up the anchor rope of the 4.5m runabout, and the jolt almost threw a child overboard. The runabout was towed for about 30m at a speed up to 10 knots, before its skipper managed to cut the anchor rope.

The motor vessel continued without slowing down or stopping and berthed at the marina, where its skipper was later interviewed by Maritime Police and MNZ. The skipper said because of the narrow channel, he’d had no option other than to pass through the vessels to access the marina entrance, even though they were not anchored in the marina channel.

He had not realised the vessels he passed were anchored or that they had fishing lines in the water. He also claimed to have been travelling at a speed of no more than 3 knots and was not aware of the bylaws and rules for passing speeds and distances from other vessels and the shore.

The skipper was charged under Section 65 of the Maritime Transport Act 1994 with operating a ship in a way that caused unnecessary danger or risk to other people. He pleaded guilty and was fined $1,000 and ordered to pay reparations of $2,000 to the family.

The skipper of this motor vessel was travelling too fast and was not aware of the maritime rules and bylaws for safe navigation in New Zealand waters.

Maritime rules place a number of obligations on skippers, including the requirement to maintain a proper lookout at all times, keep a safe distance from other vessels and proceed at a safe speed.

This close-quarters situation was avoidable and put the safety of a large number of people needlessly at risk. The towed vessel was in danger of being pulled under the water, endangering the lives of the four people on board. It was also a terrifying encounter for those on board the neighbouring craft, who were sure they would be hit. With fishing lines in the water and anchors down, they could not quickly move out of the way. The children on board the runabout were traumatised by the incident.

The skipper deliberately took a course through a concentration of anchored vessels when it was clearly dangerous to do so. His vessel could easily have passed well away from the vessels by taking a longer route to the marina. Other large vessels using the harbour that morning had managed to give the anchored boats a wide berth.

The skipper was travelling too fast and had not made himself aware of the maritime rules and bylaws for safe navigation in New Zealand waters. All vessels operating in close proximity to each other must follow all relevant maritime rules and bylaws to avoid causing any danger to members of the public.

Skippers of overseas vessels who operate in New Zealand waters are required to educate themselves about, and follow, the maritime rules and bylaws for safe navigation.

This incident could easily have resulted in serious harm, but would have been avoided completely if sensible navigational practices had been followed. The successful prosecution sends a clear message that behaviour by either recreational or commercial skippers that poses a danger or risk of harm at sea will not be tolerated.

For more information about safe navigation, see ‘Rules of the road’ in MNZ’s “Safe Boating Essential Guide”. This is available on the MNZ website, maritimenz.govt.nz or by emailing epublications@maritimenz.govt.nz
A man on a PWC (personal water craft) was seriously injured when he was struck by a powerboat following close behind.

The victim, an experienced PWC operator, had just finished rebuilding his machine in readiness for competition in the freestyle PWC season. He’d taken it to the river to go through a series of engine tests.

The powerboat, a 5.5m aluminium fishing vessel, had been purchased just the previous week and its two new owners were taking it on its first outing. The skipper had no formal boating education and was unfamiliar with the section of river.

The vessels launched from the boat ramp within a short time of each other. About 900m south of the ramp the PWC rider had finished his tests and decided to turn back towards the boat ramp. He slowed virtually to a standstill, then applied the throttle and spun the ski on its axis to the left, unaware that the other vessel was approaching from behind at a speed in excess of 20 knots and was about to overtake him.

When the powerboat collided with the PWC, the rider was thrown backwards through the air and landed in the water. He remembered later that after his lifejacket brought him to the surface, he realised he’d been hit by a boat. The pain was beyond anything he’d known and he believed he was going to die.

The powerboat, significantly damaged in the collision, was used to transport the injured man back to the boat ramp. An ambulance met them there and transferred him to hospital, where he spent a week being treated for internal injuries, which included nine fractured ribs and sternum, a collapsed lung and lacerated spleen and liver.

While his physical recovery took a long time, he and his family also suffered serious psychological effects. He kept replaying the event in his mind and was unable to move forward with his life. As a result, his business and financial situation were also set back.

This accident was a straightforward case of travelling too fast and too close to another vessel, and could easily have resulted in a fatality. It was entirely preventable and would have been avoided had some fundamental maritime rules been followed.

Not only was the powerboat skipper unfamiliar with his new vessel, he didn’t know the local speed restrictions and maritime rules of the road. A lack of experience and boating skills is no excuse for non-compliance with the rules of the road on the water.

The section of river where the incident occurred was designated for PWC users. At the time of the collision, the skipper was trying to pass the PWC while travelling at between 20 and 25 knots, which is well in excess of the 5 knot speed restriction required by navigation safety regulations, and by safe practice. Restricted speed zones are put in place where there is a greater risk of accident due to the close proximity of other water users or navigational hazards.

It is likely that even if the PWC rider hadn’t made the u-turn, the other vessel was travelling so close behind him that it would have hit him anyway.

It is always vitally important to be aware of other water users. Skippers are required to keep a lookout at all times for other vessels and people in the water.

The skipper was convicted under the Maritime Transport Act 1994 of operating his boat dangerously, and fined $2,000 and ordered to pay $750 reparation to the victim. The maximum penalty under the act is a $10,000 fine and one year in prison.
Men drown checking craypots

Two experienced boaties drowned after their small fishing boat became flooded at sea and they ended up in the water. When the men’s bodies were found, one was not wearing a lifejacket and the other man’s lifejacket had not inflated and was found to be unserviceable.

The men had set off in the morning to uplift crayfish pots. Several hours later, a boatie out picking up pots noticed a partially submerged boat in the water about 200m from shore. There had been no distress signal in the area.

He motored across to the boat, which was floating with its bow out of the water and the stern submerged. Unable to find anyone in the water, he motored towards the shoreline and carried out a search there before returning to the boat ramp and reporting the incident.

A short while later, searchers in an inflatable boat found the partially submerged fishing boat and established that no-one was trapped underneath it. Soon afterwards, a search helicopter located one man’s body on the shoreline, about 300m from where the boat had first been seen. The man was wearing an inflatable lifejacket, but it was not inflated.

The search continued the following day, until a helicopter sighted the second man’s body in the water. He was not wearing a lifejacket.

When the 16 foot (about 5m) fibreglass boat was recovered from the water and inspected, the 60 horsepower motor was in gear, with the throttle in the full forward position. The anchor was still on board and the davit used for lifting crayfish pots was in the lifting position, but the lifting rope was missing.

There were no witnesses to the incident and no obvious damage to the vessel, making it difficult to determine exactly what had caused the vessel to flood.

The engine was in gear with the throttle in the full forward position and there was a swell up to 2m running from the south at the time.

Incidents at sea usually happen very quickly, particularly in small boats, and there may not be time to put on a lifejacket. A lifejacket’s buoyancy also makes it extremely difficult to put on once you are in the water.

The man who was found about 200m from shore.

The lifejacket belonged to the man. On initial inspection, it may have appeared to be in good working order, but the empty gas cylinder meant that once in the water it would not inflate automatically or by pulling the manual inflation toggle. It could only have been inflated if the wearer had used the inflation tube to ‘blow up’ the lifejacket. When someone is plunged into cold water, it can be difficult to find the inflation tube and blow enough air into the lifejacket to inflate it.

The lifejacket had probably been inflated previously, intentionally or by accident, and then been deflated and repacked without the cylinder being recharged.

It is vitally important to maintain all lifejackets in an operational condition. Ensure that you are familiar with the operation and servicing of your lifejacket. It will not be apparent that a lifejacket has been inflated and repacked unless the cylinder is checked. Cylinders can also leak gas slowly over time, and a lifejacket may become unserviceable even if it hasn’t been inflated. Ask an approved service agent to check that the cylinder is still full and to generally assess the condition of your lifejacket.

The lifejacket may become waterlogged and their boots filled with water, weighing them down.

Witnesses confirmed that one of the men, a retired commercial fisherman, was known to not wear a lifejacket because he thought those he kept on board were too bulky and would get in the way while fishing. He may have thought he would have time to put on a lifejacket if he needed to, or would be able to put on a lifejacket once in the water.

The other man was wearing an inflatable lifejacket when he was found on the beach, but it was not inflated. The gas cylinder that provides the gas to inflate the lifejacket was found to be empty, and the oral inflation tube had not been used.

The lifejacket belonged to the man. On initial inspection, it may have appeared to be in good working order, but the empty gas cylinder meant that once in the water it would not inflate automatically or by pulling the manual inflation toggle. It could only have been inflated if the wearer had used the inflation tube to ‘blow up’ the lifejacket. When someone is plunged into cold water, it can be difficult to find the inflation tube and blow enough air into the lifejacket to inflate it.

The lifejacket had probably been inflated previously, intentionally or by accident, and then been deflated and repacked without the cylinder being recharged.

It is vitally important to maintain all lifejackets in an operational condition. Ensure that you are familiar with the operation and servicing of your lifejacket. It will not be apparent that a lifejacket has been inflated and repacked unless the cylinder is checked. Cylinders can also leak gas slowly over time, and a lifejacket may become unserviceable even if it hasn’t been inflated. Ask an approved service agent to check that the cylinder is still full and to generally assess the condition of your lifejacket.

The man who was found about 200m from shore.

The other man was wearing an inflatable lifejacket when he was found on the beach, but it was not inflated. The gas cylinder that provides the gas to inflate the lifejacket was found to be empty, and the oral inflation tube had not been used.

The search continued the following day, until a helicopter sighted the second man’s body in the water. He was not wearing a lifejacket.

When the 16 foot (about 5m) fibreglass boat was recovered from the water and inspected, the 60 horsepower motor was in gear, with the throttle in the full forward position. The anchor was still on board and the davit used for lifting crayfish pots was in the lifting position, but the lifting rope was missing.

There were no witnesses to the incident and no obvious damage to the vessel, making it difficult to determine exactly what had caused the vessel to flood.

The engine was in gear with the throttle in the full forward position and there was a swell up to 2m running from the south at the time.

Incidents at sea usually happen very quickly, particularly in small boats, and there may not be time to put on a lifejacket. A lifejacket’s buoyancy also makes it extremely difficult to put on once you are in the water.

The lifejacket belonged to the man. On initial inspection, it may have appeared to be in good working order, but the empty gas cylinder meant that once in the water it would not inflate automatically or by pulling the manual inflation toggle. It could only have been inflated if the wearer had used the inflation tube to ‘blow up’ the lifejacket. When someone is plunged into cold water, it can be difficult to find the inflation tube and blow enough air into the lifejacket to inflate it.

The lifejacket had probably been inflated previously, intentionally or by accident, and then been deflated and repacked without the cylinder being recharged.

It is vitally important to maintain all lifejackets in an operational condition. Ensure that you are familiar with the operation and servicing of your lifejacket. It will not be apparent that a lifejacket has been inflated and repacked unless the cylinder is checked. Cylinders can also leak gas slowly over time, and a lifejacket may become unserviceable even if it hasn’t been inflated. Ask an approved service agent to check that the cylinder is still full and to generally assess the condition of your lifejacket.

The lifejacket may become waterlogged and their boots filled with water, weighing them down.

Witnesses confirmed that one of the men, a retired commercial fisherman, was known to not wear a lifejacket because he thought those he kept on board were too bulky and would get in the way while fishing. He may have thought he would have time to put on a lifejacket if he needed to, or would be able to put on a lifejacket once in the water.

The other man was wearing an inflatable lifejacket when he was found on the beach, but it was not inflated. The gas cylinder that provides the gas to inflate the lifejacket was found to be empty, and the oral inflation tube had not been used.

The search continued the following day, until a helicopter sighted the second man’s body in the water. He was not wearing a lifejacket.

When the 16 foot (about 5m) fibreglass boat was recovered from the water and inspected, the 60 horsepower motor was in gear, with the throttle in the full forward position. The anchor was still on board and the davit used for lifting crayfish pots was in the lifting position, but the lifting rope was missing.

There were no witnesses to the incident and no obvious damage to the vessel, making it difficult to determine exactly what had caused the vessel to flood.

The engine was in gear with the throttle in the full forward position and there was a swell up to 2m running from the south at the time.

Incidents at sea usually happen very quickly, particularly in small boats, and there may not be time to put on a lifejacket. A lifejacket’s buoyancy also makes it extremely difficult to put on once you are in the water.

The lifejacket belonged to the man. On initial inspection, it may have appeared to be in good working order, but the empty gas cylinder meant that once in the water it would not inflate automatically or by pulling the manual inflation toggle. It could only have been inflated if the wearer had used the inflation tube to ‘blow up’ the lifejacket. When someone is plunged into cold water, it can be difficult to find the inflation tube and blow enough air into the lifejacket to inflate it.

The lifejacket had probably been inflated previously, intentionally or by accident, and then been deflated and repacked without the cylinder being recharged.

It is vitally important to maintain all lifejackets in an operational condition. Ensure that you are familiar with the operation and servicing of your lifejacket. It will not be apparent that a lifejacket has been inflated and repacked unless the cylinder is checked. Cylinders can also leak gas slowly over time, and a lifejacket may become unserviceable even if it hasn’t been inflated. Ask an approved service agent to check that the cylinder is still full and to generally assess the condition of your lifejacket.

The lifejacket may become waterlogged and their boots filled with water, weighing them down.

Witnesses confirmed that one of the men, a retired commercial fisherman, was known to not wear a lifejacket because he thought those he kept on board were too bulky and would get in the way while fishing. He may have thought he would have time to put on a lifejacket if he needed to, or would be able to put on a lifejacket once in the water.
Yachts collide after give-way failure

A fleet of yachts in a race leaving the harbour on a port tack encountered a cruising catamaran approaching on starboard tack. One of the racing yachts failed to give way as required and collided with the non-racing catamaran.

The racing yacht’s skipper on port tack held his course on a racing line rather than giving way, because he judged that the approaching catamaran would pass across just ahead of him, clearing by a few metres.

The catamaran was on a starboard tack when its skipper noticed two yachts in the distance, both on a port tack, sailing towards his vessel. He thought they might be on a collision path with him but, as the stand-on vessel, he maintained course.

Finally, as they bore down on him without altering course, creating a close quarters situation, the skipper dipped slightly to port to avoid colliding with the first vessel, watching out to make sure it didn’t change course to starboard.

The skipper said if he had turned to starboard at that point, his vessel would have stalled by going into the wind, exposing the side of his vessel to impact from the other yacht. There was also a risk of fouling the tow line of the dinghy he was trailing 15m astern.

After just passing astern of the first boat, the catamaran skipper noticed that the second yacht had made no attempt to alter course. The racing yacht hit his vessel’s port pontoon, shearing off the nose cone, and then carried on to the main hull, coming to a stop at the port-side cross member.

Vessels involved in racing need to be aware that the water space is shared with other boaties and abide by the rules of the road even if it means sacrificing a racing position.

All vessels need to be aware of, and meet, their responsibilities under the rules for the prevention of collisions at sea. Maritime rules require all vessels to keep a proper look out by sight and hearing in order to fully assess their situation and the risk of collision.

When two sailing vessels are approaching one another with the risk of colliding, the vessel with the wind on the port side must keep out of the way of the leeward vessel. A vessel with the wind on the port side that sees a vessel to windward but can’t tell whether it has the wind on the port or starboard side must keep out of its way.

The collision rules require that if one of the vessels is keeping out of the way, the other must hold its course and speed. As soon as it becomes apparent to the stand-on vessel that the vessel required to give way is not doing so, it may take action to avoid collision by manoeuvring itself out of the way.

If the stand-on vessel is so close that collision can’t be avoided by the give-way vessel’s actions alone, it must take whatever action will best avoid collision.

Vessel skippers need to make their intentions clear by making early and bold moves to avoid the risk of collision. As the give-way vessel in this situation, the racing yacht’s skipper should have taken early and decisive action to avoid the collision.

The catamaran could not tell whether the yacht was moving out of its path and did not have confidence that the vessels would not intersect. He opted to take action himself, in keeping with the collision rules, by veering away and then turning back.

Unfortunately, this resulted in a collision that could have been avoided, had the give-way vessel clearly indicated, early on, that it was keeping out of the catamaran’s way.