Always someone else

'It will never happen to me on my boat – I'm a good skipper, I drive carefully and always ensure my crew are seated and holding on. Accidents and people going overboard happen to those who don't do it as well as me.'

I'm sure we can all relate to this view; after all, the vast majority of skippers are safe and considerate when helming, and manage their boat well. That said, it doesn't always happen to someone else, as I was to discover!

Earlier this year my school wasw faced with an incident that could so easily have ended in tragedy. In this article we'll look at the incident, the lessons that can be learned, and we'll also look at the related issue of dealing with a man-overboard scenario. For us, one day in April, this became a very real consideration.

It was a Sunday, the second day of a Level 2 course, with three clients on their brand new 5.1m RIB which was fitted with an 80hp outboard. Our instructor had spent a while looking at charts and tides in the classroom, and the students had planned a small passage to take them through Poole Harbour and into Poole Bay. They executed the passage then had some lunch, by which time it was early afternoon, and time was spent discussing and practising 'man-overboard' (MOB) recovery. We've always spent a good amount of time on MOB, both from the point of view of discussing why it occurs and how it can be prevented (prevention is better than cure!), through to the merits of the two recommended directions of approach to the actual physical recovery of the person. After a discussion the students then practised repeatedly both methodologies. After this they moved on to higher-speed runs, and after an initial demo they each took the helm. Towards the end of the session, on a turn to starboard at 20–25 knots, the jockey console broke free from the deck and partially ejected the helm overboard to port, with the instructor being ejected over him to port too – on what is the outside of the turn where the prop is about to appear!

Whether the helm's leg pulled the kill cord or the instructor snagged it on his way past doesn't really matter, as it worked and killed the engine. The helm was dragged back into the boat and the other students restarted it after repositioning the console and putting the throttle to neutral. They then recovered the instructor, whose life jacket had inflated and was OK. Once in the boat the instructor assessed the helm (who was understandably very shaken) and considered the RIB safe to proceed back to the marina at a slow speed.

I was running an instructor course at the marina, so between myself, the instructor from the RIB and the other trainer, we got the students to the classroom, got the helm and instructor some dry clothes and organised some hot drinks. Once everything had settled down we asked the students if they were happy to complete an incident report. As a school we use a version of the MAIB's own incident report form. We discussed the circumstances of the incident and I documented this to the form, read it back to the students and then asked them to sign it. We provided them with a copy of the report.

We offered to sort out recovery of the RIB onto its trailer for the students, and after ensuring they were aware of the need to keep an eye on the helm (their father/father-in-law) they left. At this stage we recovered the RIB, and a cursory examination revealed a major failure had occurred. Our major-incident procedures dictated a requirement to report to the RYA and MAIB anyway; however, we were also concerned that there could be other craft with the same shortcomings but with a potentially more serious outcome. We secured the RIB and ensured items like inflated life jackets were not repacked.

It was a Sunday night, so we emailed the RYA (we would have called the emergency number had there been an injury) and called the MAIB 24-hour hotline. We were contacted within 30 minutes by the MAIB; they took details of the incident and said they would call on Monday with a view to visiting on the Tuesday.

The Marine Accident Investigation Branch (MAIB) is a department of the Department for Transport and is not part of the MCA. They conduct investigations into marine-related incidents in UK waters or involving British flagged vessels, and produce reports from which lessons can be learned to ensure the incident is less likely to reoccur. They have statutory powers and can force you to comply with their requests under Merchant Shipping Law.

The MAIB were with us all day Tuesday, interviewing us, the owners and the dealer who sold the RIB. We tried to be as helpful as possible and provided a classroom, interview/tea facilities etc. We were also on hand to provide some assistance in

respect of terminology and the nature of the training we were doing as, since the MAIB inspectors cover a variety of areas, they are not necessarily RIB experts and were not fully conversant with the contents of a Level 2 course and how what we were doing fitted into things.

Five months later we received the MAIB report in a draft and highly confidential form. We were reminded of our legal obligations not to comment publicly on the contents of the report but were asked for our views. The specifics of the incident can be found in the report (see maib.gov.uk – report on 'Partner 1'); however, what are the lessons we and others can take from the incident?

Man overboard – key tips

• Prevention, as stated elsewhere, is better than cure – manage your boat and crew and drive in a manner appropriate to the conditions. I cannot overstate how critical a man-overboard situation is and, without a quick recovery or assistance from the likes of the RNLI, death is a real possibility. A couple of years ago we responded to an incident where there was a body in the water. A man had gone overboard 150 yards from shore in June on a sunny day – tragically he died. For this reason the RYA/RNLI/coastguard are of the view that, unless you are 100% certain you will affect an immediate recovery, go straight to mayday. The benefit of such a clear-cut piece of advice, if you are ever faced with such an issue, is that you won't need to spend time wondering whether to call – just do it!

• In terms of approach, remember there are two recommended methods. Either straight up into the wind to bring the casualty alongside the bow, or from upwind staying side on to the waves/wind and drifting down alongside the casualty. Each method has its virtues, and it is well worth practising both regularly with the crew you usually rib with. Don't forget your default reaction, when coming alongside the person, must be engine off. If you decide that it is safer to keep the engine on then that is your call, but ensure it is a conscious decision to do so, not because you had forgotten to switch off!

• When alongside, ensure the casualty doesn't drift off. If necessary get a loop under their arms so you can hold on to them. There are a few methods to get people back on board.

• Keeping it simple, they could climb up a ladder if one is fitted. Be careful, though, as if it is rough they may be best to stay clear of the stern in case their head hits a hard object.

• You could pull them over the side. Opinions vary as to whether the casualty should face the RIB or have their back to it. I prefer their back as the legs float up, then pulling their bottom up onto the tube; but, of course, from this position they cannot help themselves into the RIB. In part it depends whether there are one or two of you left in the boat. Another method on a RIB is for them to be on their back in the water with their feet/legs over the tubes – then pull them into the boat.

• Another option is to use a Jacob's Cradle-type net. We use builder's netting, although a fishing net would work equally well. This allows a horizontal recovery, which could be important if they have been in the water a while, so as to prevent the chances of blood rushing away from their heart as you recover them. A line in a U shape can work too.

• In calm conditions you may be able to use the hydraulic trim on the engine to 'jack' them into the RIB. Alternatively, if you have a small dinghy or a life raft then these could be deployed as a stepping stone into the mother ship.

Of course, with a RIB, deflating a tube could make life immeasurably easier.

Firstly, and perhaps most importantly, we feel that we mitigated the impact of the console becoming detached through some sensible operating procedures. We limit high-speed handling to 25 knots irrespective of craft and insist that turns are slow and controlled rather than tight and aggressive. I have always felt that, when the buck stops with us, the extra benefit gained for every extra knot over 25 knots is minimal when compared with the way the risk rises. Keeping speed down means that we stand a good chance of regaining control of an incident before it spirals out of control. In this situation less speed and aggression might have contributed to the lack of injury.

Have a major-incident plan and test it against various scenarios. It is easier to follow a plan than create it when needed.

Report to the authorities as soon as practical. Such an approach evidences that you have nothing to hide, and you can be assured in the incestuous world of boating that everyone will know by the next day anyway, so you will never keep a lid on it even if you wanted to. The advantages of contacting industry bodies/associations were evident here.

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At the time, our instructor did not report the incident to the coastguard as he felt there was no need. We support this decision as it was a sound one at the time; however, going forward we have insisted such incidents are reported. The instructor is massively experienced (ex-marine police, Advanced Instructor and Yachtmaster) but feasibly could have suffered a delayed reaction to going overboard, where the early involvement of the coastguard would have been reassuring and helpful. We now insist instructors carry hand-held VHFs attached to their life jackets, and advise them to consider personal flares (particularly at night).

Advice for commercial operators

Commercial operators, whether RYA centres or not, should plan for the unthinkable and be ready to put that plan into action at a moment's notice. In the heat of the moment, when adrenaline is pumping, it can be difficult to remember what is best practice and what you intended to do. Ensure you document your major-incident plan and keep a copy to hand in offices and on your boats.

Have the relevant phone numbers easily to hand (we have stickers at the helm positions of all boats) and perhaps consider, too, having your incident plan in a flow chart style so it is easy to follow when very shaken up.

Training plays a key part too, and ensure you discuss with skippers/instructors what they should do in the event of an incident, and always ensure that one of the first things they think to do is to call you and get you involved.

In the event of a fatality, remember that the police will probably have to assume worst case and will treat their investigation as a suspicious death until they can conclude otherwise. Irrespective of who is the inspecting body, then, keep your boat and kit away from being tampered with, as it will be evidence to either or both of the police and MAIB.

If there are organisations that you can contact for advice and guidance then do so. For us, the RYA were excellent and, whilst they have a responsibility to investigate too, they are a great source of advice and comfort in ensuring you are doing and saying the right things. My advice to commercial operators is to always report incidents. After all, it is far better that the situation is reviewed and logged than you brush it under the carpet, to be faced with a letter from a solicitor three months later suggesting your failure to report is indicative of a shoddy operation and vindicates the claim his client is making.

Remember, too, that there is a need to ensure you and your staff do not make any public statements or comments to anyone without being absolutely sure of your position. In the case of press statements, make sure that, unless you have extensive experience, you read from a pre-prepared statement rather than trying to ad-lib. Your procedures should state that only the owner of the business can make a statement, and never refer to the names of casualties.

Option 1. Note safe manner of manual lift

A question raised by the inspectors was whether we had made a structural check of the RIB before going afloat. We send all clients a list of required kit and state we will not go afloat in anything we consider unseaworthy, but this does not extend to checking the fitting of the consoles. There is little we could have done in this instance, and we have to rely on the fact that boats won't fall apart; however, without doubt, if you see an issue on a boat that concerns you then you must act.

We learned a lot from this rather stressful episode. We learned that there is a real benefit to having well-documented processes and procedures that have looked at the inherent risks and sought to reduce them to manageable levels. We could not prevent the incident but we strongly feel that, by limiting speed and the tightness of turns, we reduced the effect of it. Our process for

Option 2. Face first

dealing with an incident swung into action well and seemed to work. I'd like to think we came across professionally, which contributed to the investigating agencies' opinion of us and what we had to say. In summary, it's easy to think that the risk assessments you do, and procedures and processes you create as a commercial operator, are a bit OTT sometimes; hopefully in this article I've prompted some people to think that it is time really well spent.

Postscript. And what of the people who actually owned the boat and had such a traumatic first weekend on the water? We're delighted they now have another RIB, and we've spent time with them to ensure they are really enjoying it - they certainly seem to be!

Please note: the RIBs shown in the photos for this article were not involved in this incident.

The use of a Jason's Cradle or similar device

Boarding via cavitation plate over transom

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