

# Incident Somerton Yacht Club

## Saturday 1st February 2020, 1800 CDT

Death by medical episode and while on scene the deceased's wife also had a medical episode and was treated and taken to hospital.

### 1.1 History.

Extract SYC Incident report:- *In the minutes leading into the start of the second set of club heat races, (sailor 1) was seen by a group of close by yachts to fall backwards into the water from his yacht and remain floating face down on his side in the water.*

*As all yachts were in relative proximity, one of the yachts, skippered by (sailor 2), was able to make it to (sailor 1) very quickly (within 10-20 seconds) at which time (sailor 2) turned him over.*

*(sailor 1) was shortly after lifted into another close yacht, skippered by (Sailor 3) with crew (sailor 4). No vital signs of life could be detected for (sailor 1). (sailor 4) immediately commenced administering CPR with support from (sailor 3), (sailor 2) (in water adjacent to yacht) and (sailor 5) (also in water adjacent to Yacht, having left the yacht he was sailing on).*

*Simultaneous with above the start boat skipper (which was not too far from the event) radioed through to the Bridge for an ambulance to be called. Rescue boat 2, which had just returned from dropping a sea sick crew member at beach and was stationed off the opposite end of the starting line, responded to the incident and arrived shortly after (probably within 120-240 seconds) .....*

Extract from outcome SYC incident report: - *Despite the urgency displayed by all, the commendable efforts of everyone involved, and the contribution of many, (sailor 1) was never revived.*

*(Sailor 1's wife) was able to be with (sailor 1) throughout most of the time he was onshore, the family were respectfully supported throughout.*

*After a period of time (sailor 1's wife) was brought up to Clubrooms as it was cool on the beach. She was provided with additional blankets and water/coffee. (a SYC volunteer) ensured (sailor 1's wife) and the family were supported throughout.*

*After a short while (sailor 1's wife) began to feel unwell indicating that she had lost some feeling in her legs. She was also shaking and showing signs in her face of something not being right. (2 SYC volunteers) called over the paramedics who were still nearby. (sailor 1's wife) was subsequently taken to hospital with her sons as well as one son's partner, to Flinders Medical Centre. Indications from the paramedics were that she was showing signs of having experienced a stroke.*

*Later in the afternoon, (SYC Committee member and his wife) visited Flinders Emergency and it was confirmed that (sailor 1's wife) did experience a stroke. (SYC Committee member and his wife) were able to visit (sailor 1's wife) briefly.*

### **1.2 Injuries to persons.**

The sailor in the water suffered a medical event, and from the available information there appears to have been no physical injury sustained.

Later the wife of the sailor involved suffered a stroke while at the club.

### **1.3 Damage to vessel.**

Not applicable, the unmanned vessel was latter taken to shore.

### **1.4 Other damage.**

None

### **1.5 Personnel information:**

N/a

### **1.6 Vessel information:**

N/a

### **1.7 Meteorological information:**

Weather was considered uncomfortable due to persistent rain for much of the day. Conditions were considered suitable for sailing being 13-15 knots with a swell of around 1m.

### **1.8 Aids to navigation.**

N/a

### **1.9 Communications.**

Extract SYC Risk Assessment Action Plan (Incident Comments):- *The 2 person requirement proved critical and worked very well enabling all relevant contacts to be made (emergency services, SLSC, Sea Rescue, wife) as well as maintain comms with the rescue boats. All services and apparatus were in place at required moments throughout the rescue.*

*> Emergency phone numbers need to be reviewed at the start of each season and all members required to update their records. A new print copy of all contacts should be readily available in the bridge from the start of each season. SYC only had the land line number for Somerton SLSC which was not being answered resulting in one person running to the SLSC.*

*> Personnel used their own phones due to familiarity. The club mobile was not used for this reason and also as it's used downstairs. It was noted that 2x phones are required in the bridge, 1 per person. This enables one caller to be online with emergency services whilst the other is performing other duties. (i.e. calling SLAC, Sea Rescue etc).*

*> Emergency contact number should include both mobile and land line where possible.*

> Phone lists and emergency procedures should be laminated to enable them to be taken out into the weather and water when required outside the bridge.

> An emergency call order with numbers should be produced as clear signage within the bridge. (i.e. laminated on the wall and also at the desks) Note: SYC do have a board with numbers on it but it was considered that it could be more clearly defined.

> A GPS co-ordinate was required to direct Sea Rescue. SYC didn't have that detail available and contacting the rescue boat with a GPS not practical at the time. This has now been resolved with a GPS point from shore for the front of club recorded.

> Separation of bar POS service and mobile phone could be considered.

> Comms is difficult when a boat is under full power. Bridge was communicating with the committee boat to understand what was happening when the rescue boat was operating at pace.

Note: When contacting emergency services '000' it was found that the emergency call received was making recommendations that did not appear fit for the circumstance. (i.e. not moving Sailor 1 and sailing him into the beach which was not feasible whilst administering CPR on the stern of a Tasar.) Bridge personnel had to communicate back to the rescue boats based on what they could see happening on the water which was emotionally stressful (i.e. allowing the transfer to rescue boat to occur).

#### **1.10 Race information.**

The incident occurred after the boat had finished the race.

#### **1.11 GPS recorders.**

None

#### **1.12 Post contact information.**

N/a.

#### **1.13 Medical and pathological information.**

None

#### **1.14 Fire or Flooding**

N/a

#### **1.15 Survival aspects.**

N/a

#### **1.16 Research.**

No research was carried out for this report its content is totally dependent on information supplied by the SYC

**1.17 Organizational and management information.**

From the documentation supplied, the SYC is to be commended for their professionalism and attention to forward planning and detail.

**1.18 Additional information.**

N/a

**1.19 Useful or effective investigation techniques.**

No research was carried out for this report its content is totally dependent on information supplied by the SYC

**2. Analysis**

It is the opinion of the Australian Sailing South Australian Safety Committee that these incidents are without scenarios that would have prevented either incident from occurring. Unforeseen medical events are a human factor.

**3. Conclusions**

The root cause of these incidents is unforeseen medical events which is a human factor and is extremely hard to mitigate risk of, or from. The handling of these events is however an area that can be planned for and have a bearing on the outcome. The SYC and all who attended did what they could to save life and to look after the those attending including the wife of the deceased who also suffered an event at the scene, which was noticed and given prompt attention by medical personnel.

Communication plays a role in all incidents and accidents. While with these incidents it is not believed or implied that changes or improvements would have changed the outcome. It is the legacy of these events that we can adapt to change and or improve our policies and procedures, which may have an effect on the outcome of future incidents or accidents.

**4. Safety recommendations**

An all too common theme in incident and accident reports is that communications seems to be an area that can always be improved. We recommend to all clubs a review of their communications systems and procedures, then undertake a desk top scenario to see how it plays out in a simulated event.

In particular, where there are other marine based authorities in close range to a club (such as Surf Life Saving and Seas Rescue etc). We recommend that regular proactive engagement at the beginning of each sailing season, including scenario testing take place to ensure that each authorities operational requirements for assistance are known and understood, and that communication flow with them in an actual event can be as efficient and effective as possible.

Moreover, clubs should consider providing training in the adequate retrieval techniques for persons in the water. This will vary from club to club on the basis of the type of racing conducted and the size and style of support vessel in place.

Clubs should review the availability of portable defibrillators and or oxygen equipment. Location of this equipment as part of their safety protocol should be considered if not already part of a club's emergency equipment

**\*Note:**

**Extracts taken from SYC reports have been edited for spelling errors and the identities of individuals have been altered to protect their privacy.**

**Appendices**

Incident Report SYC

Timeline of Events SYC

Risk Management Plan (incident Comments)