70th Bunbury and Return Ocean Race Independent Investigation and Report

The Bunbury and Return Ocean Race is an annual race in the Offshore Racing Western Australia Calendar, under the organisation of Royal Freshwater Bay Yacht Club. The 2018 event was the 70th anniversary of the Race.

The 16-strong fleet of yachts started racing on the evening of Friday 23 February from Fremantle Harbour bound for a turning mark inside Bunbury Harbour and then were to continue racing back to Fremantle, with the fleet expected to finish the following day.

Just before 23:45 on 23 February, the competing yacht Finistere suffered a major structural failure causing her to capsize and the six crew entered the water. Four of the crew were successfully rescued, however two, Mr Rob Thomas and Mr Paul Owens, tragically died.

In the aftermath of this tragedy, Royal Freshwater Bay Yacht Club commissioned an independent investigation and report into its conduct of the race, including management, administration and emergency response procedures.

The cause of the yacht’s capsize is the subject of a separate investigation and report by the Department of Transport. Both reports will be submitted to the coronial investigator for presentation to the State Coroner’s office.

This document comprises two parts and is encouraged to be read as such;

1. The RFBYC commissioned independent report into its conduct of the race.

2. The Club’s response to the recommendations made by the report.

Royal Freshwater Bay Yacht Club expresses its sincere condolences to the families of the deceased sailors and to the many people affected by this incident. We are committed to learning from this tragic event and sharing these learnings with other yacht clubs throughout Australia.

Any questions about the report or the Royal Freshwater Bay Yacht Club’s response should be directed to:

Paul Bayliss  
Chief Executive Officer  
ceo@rfbyc.asn.au

Gary McNally  
Commodore
INDEPENDENT REVIEW

OF THE

70TH BUNBURY AND RETURN OCEAN RACE

23 - 24 FEBRUARY 2018

COMMISSIONED BY

ROYAL FRESHWATER BAY YACHT CLUB
# TABLE OF CONTENTS

**CHAPTER ONE** ......................................................................................................................... 1  
Introduction .................................................................................................................................. 1  
The scope of the Review ............................................................................................................. 1  
The information gathered for the Review ................................................................................ 3  

**CHAPTER TWO** ......................................................................................................................... 5  
Roles and responsibilities ............................................................................................................ 5  
Royal Freshwater Bay Yacht Club ................................................................................................. 5  
Ocean Racing Western Australia .................................................................................................. 5  
The Race Committee ..................................................................................................................... 6  
The Notice of Race ........................................................................................................................ 7  
The Racing Rules of Sailing and other prescriptions ..................................................................... 7  
The pre-race weather briefing ....................................................................................................... 9  
Pre-race administration ................................................................................................................ 9  
Yellow Brick Tracker .................................................................................................................... 10  
Radio communications and position reports ............................................................................. 10  
Royal Freshwater Bay Yacht Club’s radio room and its volunteers ........................................... 10  
Arrangements between the Race Officer and the radio room ...................................................... 11  
Arrangements within the Race Committee for the start ................................................................ 12  
The decision with regard to weather ............................................................................................ 12  

**CHAPTER THREE** ...................................................................................................................... 15  
The yacht *Finistere* ...................................................................................................................... 15  

**CHAPTER FOUR** ......................................................................................................................... 17  
Events during the race ................................................................................................................. 17  
The start of the race ..................................................................................................................... 17  
Events prior to the capsize .......................................................................................................... 17  
The capsize as experienced by the crew on deck ......................................................................... 19  
The capsize as experienced by the crew below deck ................................................................... 19  
The plight of the crew following the capsize ............................................................................... 20  
The distress signals sent by the crew ......................................................................................... 22  
*Fourth Dimension’s* response to the man overboard/Automatic Identification System distress signal ............................................................................................................................... 24  
The search and rescue operation ................................................................................................. 25  
The search following the rescue .................................................................................................. 28
Events at race control during the incident ................................................................. 29
The radio room records of the incident ..................................................................... 33
The failure to notify next of kin .................................................................................. 34
The decision not to abandon the race ....................................................................... 35
Royal Freshwater Bay Yacht Club’s handling of the aftermath ................................. 36

CHAPTER FIVE ............................................................................................................. 39

Issues and recommendations ..................................................................................... 39
Issues raised by the facts ............................................................................................. 39
Key facts and conclusions ........................................................................................... 39
Ocean Racing Western Australia’s system of race control ......................................... 41
Royal Freshwater Bay Yacht Club’s race control structure ....................................... 41
The Race Officer’s absence from the radio room ....................................................... 42
Whether the race was in the right category ............................................................... 43
Untimely or inaccurate crew lists ................................................................................ 44
Australian Maritime Safety Authority having the wrong telephone number .......... 45
The decision to start the race ...................................................................................... 45
The radio room ........................................................................................................... 46
The role of nearby yachts during an Australian Maritime Safety Authority sea and rescue ..... 48
The time taken for Huckleberry to reach Finistere .................................................. 49
Notification of next of kin .......................................................................................... 50
The decision not to abandon the race ........................................................................ 53
The comparative benefits of Automatic Identification System beacons and Personal Locator Beacons ........................................................................................................ 54
The Yellow Brick Tracker ........................................................................................... 58
Problems with local sailing culture regarding safety ............................................... 59
Sprayhoods on lifejackets ............................................................................................ 60
The wearing of lifejackets generally ......................................................................... 61
Personal Locator Beacons ........................................................................................... 62
Crew training ............................................................................................................... 63
Safety briefings ............................................................................................................. 65
Post-race declarations ................................................................................................ 66
Incident management and the media ......................................................................... 67
Royal Freshwater Bay Yacht Club’s Ocean Risk Management Plan .......................... 68
Submissions not adopted ............................................................................................ 68

CHAPTER SIX .............................................................................................................. 71

Conclusions and recommendations ............................................................................. 71
Summary of recommendations ........................................................................................................... 72
Recommendation one .......................................................................................................................... 72
Recommendation two .......................................................................................................................... 72
Recommendation three ......................................................................................................................... 72
Recommendation four ........................................................................................................................... 72
Recommendation five ........................................................................................................................... 72
Recommendation six ............................................................................................................................ 72
Recommendation seven ......................................................................................................................... 73
Recommendation eight .......................................................................................................................... 73
Recommendation nine ........................................................................................................................... 73
Recommendation ten ............................................................................................................................. 74
Recommendation eleven ....................................................................................................................... 74
Recommendation twelve ....................................................................................................................... 74
Recommendation thirteen ..................................................................................................................... 75
Recommendation fourteen .................................................................................................................... 75
Recommendation fifteen ....................................................................................................................... 75
Recommendation sixteen ....................................................................................................................... 75
Recommendation seventeen ............................................................................................................... 75
Recommendation eighteen ................................................................................................................... 76
Recommendation nineteen ................................................................................................................... 76
Recommendation twenty ....................................................................................................................... 76
Finally .................................................................................................................................................. 76

APPENDIX 1
Terms of Reference for the Review
Powers and restrictions

APPENDIX 2
Members of the Panel
Panel biographies
Hon John McKechnie, QC
Hon Peter Blaxell
Mr Manfred Speicher Esq

APPENDIX 3
2018 Bunbury and Return Ocean Race course

APPENDIX 4
Suggested template for appointing Race Control Committee
APPENDIX 5
Suggested template for recording decisions to race

APPENDIX 6
Yellow Brick Tracker screen shots

APPENDIX 6.1
APPENDIX 6.2
APPENDIX 6.3
APPENDIX 6.4
APPENDIX 6.5

APPENDIX 7
Suggested template for post-race declaration

APPENDIX 8
Summary of submissions not adopted
CHAPTER ONE

Introduction

[1] Royal Freshwater Bay Yacht Club (RFBYC) has conducted ocean yachting races off the WA coast for many years. One such race was its platinum jubilee 70th Annual Bunbury and Return Ocean Race (2018 BROR) which started in Fremantle harbour on the evening of 23 February 2018. Those who were present to witness the start, could never have imagined that less than seven hours later, a participating yacht would have capsized and two of its crew would be either missing or dead.

[2] The yacht to suffer that fate was *Finistere* (F108), a Davidson 50 with a long history of ocean racing which started the race with six crew including its owner/skipper, Mr Rob Thomas. *Finistere* was fitted with a lifting keel and because that keel snapped off shortly before 23:45 hours, the yacht capsized 11 miles west of Mandurah throwing all the crew into the sea. Unfortunately, the circumstances then faced by the crew were not good for their survival and despite a relatively swift search and rescue operation, two lives (including that of the skipper) were lost.

[3] As happens with all unexpected deaths, the cause or causes of this tragedy are subject to investigation by the State's Coroner, who is being assisted in that task by the WA Police Force and the State's Department of Transport. Given that *Finistere*’s keel detaching is a major focus of the investigation, it can be expected that the Coroner will ultimately determine the reason why that occurred.

[4] In the meantime, RFBYC as the organising authority for the 2018 BROR decided that it should arrange for a Review of its own conduct of the race. The Terms of Reference for this Review are Appendix 1 and the Panel members who have performed it are named in Appendix 2. The Panel members participated in the Review on the basis that they would operate independently of RFBYC and that their report would be made available to all interested parties. RFBYC readily agreed to this and Commodore Dean McAullay said he "would not have it any other way".

The scope of the Review

[5] As can be seen from the Terms of Reference, the Review focuses on all aspects of RFBYC’s role in conducting the 2018 BROR including management, administration and emergency response procedures. The Panel is also asked to examine 'the application of the Australian Sailing
Safety and Sea Survival Course (AS SSSC) content to the experiences of the surviving crew of *Finistere*.

[6] The Panel, if it thinks fit, may recommend changes to any rules, documentation, processes or procedures that might further mitigate risk, as well as to emergency management procedures. Any other recommendations that the Panel may wish to make must be limited to 'matters relating to the conduct of the race'.

[7] Importantly, the Terms of Reference specify that the Panel should not enquire into the causes of *Finistere*’s capsize or of the subsequent loss of life 'except to the extent whether the conduct of the race contributed in some way'. The reasons for this significant exclusion from the Terms of Reference are clear:

- The issue as to why the keel dropped off is a matter for the Coroner and it would be improper for the Review to overlap with, or impose findings that might conflict with that statutory investigation.

- The same considerations apply to issues concerning other possible causes for the loss of life and these are all matters for the Coroner.

- The determination of these issues will require expert evidence and the Panel does not have the relevant expertise, nor is it in a position to access such evidence.

[8] It is understood that at the time of this report, the coronial investigation is making good progress towards discovering the reasons why *Finistere*’s keel detached.

[9] Accordingly, it can be expected that in due course, the sailing community (and in particular the owners of yachts with lifting keels) will be fully informed on the causes of this tragic event and will have the opportunity to learn from it.

[10] Another aspect of the tragedy that falls outside the scope of the Review is the overall efficiency of the search and rescue operation after Australian Maritime Safety Authority (AMSA) assumed control. As a matter of law, AMSA was responsible for all search and rescue activities from the moment it received (via satellite in Canberra) the first distress signal from a *Finistere* crew member’s Personal Locater Beacon (PLB). From that point on, the role of race control was limited to assisting AMSA with search and rescue in any way it could and it is only in that role that RFBYC’s conduct falls within this Review.

[11] Nevertheless, the Panel has considered all safety issues surrounding the capsize of *Finistere*, the subsequent search and rescue operation and the
experiences of the surviving crew members. In essence, the Panel has looked at what can be done to minimise the risks of such an event ever occurring again, as well as the lessons to be learned from all that happened.

[12] Many of those lessons are repeat lessons which were learned in the past but have since been forgotten. If there is any theme to this report, it is that the necessary requirements for safety can never be a second priority to other aspects of sailing such as comfort and enjoyment. The sailing community and particularly the racing fraternity, must be constantly vigilant to ensure that basic safety measures (even if boring or inconvenient) are always observed.

The information gathered for the Review

[13] The Review has been carried out without the need for formal hearings or the taking of evidence because all of the necessary information has been acquired by other means.

[14] The first step was to obtain a full record of all documentary evidence and Commodore McAullay was the main link between the Panel and RFBYC in this regard. He promptly responded to all requests for documents (which were assembled by the Chief Executive Officer, Mr Paul Bayliss) and the Panel is satisfied that RFBYC has made a full disclosure of all relevant materials.

[15] At the initiative of RFBYC, Mr Ian Clarke (an appropriately skilled former Commodore of the club who had no involvement in the 2018 BROR) interviewed most of the witnesses who had relevant information which they were willing to provide to the Panel. The transcripts of those interviews were an invaluable resource for the Review and the Panel records its appreciation to Mr Clarke for his work.

[16] Some witnesses voluntarily forwarded copies of their statements to police and/or additional written statements they had prepared for the purposes of the Review. When gaps in the available information were identified, all requests to witnesses for interviews (or further interviews) by the Panel were met and the Panel records its great appreciation for their cooperation.

[17] The Panel also arranged for a circular 'Call for Submissions' to be emailed to all persons likely to have an interest in the Review (including race participants, involved volunteers, deceased’s next of kin and various yachting clubs or organisations). The circular invited submissions to be sent to a dedicated email address accessible only to the Panel, which
submissions would be treated confidentially upon request. All the submissions received in response, have been taken into account during the Review, and the Panel thanks the authors for their contributions (some of which were very insightful).

The Panel also thanks YBTracking Ltd in the United Kingdom for providing a replay of its satellite coverage of the 2018 BROR. It is often said that a picture is worth a thousand words, but a moving picture is worth many more. The YBT replay proved to be a valuable resource which greatly assisted the Panel’s understanding of the events following *Finistere’s* capsize.

A number of people were traumatised by the incident or its aftermath, and some of them are still emotionally affected. When the Panel has sought information from any of those people, it has tried to do so in a way that does not aggravate their condition. When it was known that an individual was in a fragile state, the decision was made to not ask any questions at all.

Not all readers of this report will be sailors, so an effort has been made to explain rules, race procedures and the relevant events in ways which everyone will understand. For those already familiar with any of these matters, the Panel asks for their tolerance to what might seem needless explanations.
CHAPTER TWO

Roles and responsibilities

[21] This chapter will explain the organisational structure, pre-race preparations and the rules (relevant to the Review) which applied to the 2018 BROR.

Royal Freshwater Bay Yacht Club

[22] RFBYC was established in 1896 and is an incorporated association with a constitution and rules (this report will refer to certain aspects of the constitution in due course). The club is a major enterprise at the forefront of all forms of yacht racing in WA.

[23] It has a mature governance and administration with its affairs managed by the General Committee. There are sub-committees including the Yachting Committee. There are specialist committees including the Offshore Committee which reports to the Yachting Committee.

[24] The rules of RFBYC require the Offshore Committee ‘to organise and control all offshore races as the organising authority, in accordance with Racing rules of Sailing of the International Sailing Federation and the Australian Yachting Federation Prescriptions thereto' (which rules and prescriptions are colloquially known in Australia as the Blue Book).

[25] RFBYC has administrative staff under the direction of its CEO, Mr Bayliss. Ms Susan Ghent is a staff member whose duties include those of Offshore Racing Administrator.

Ocean Racing Western Australia

[26] Ocean Racing Western Australia (ORWA) is a committee of Yachting WA comprising representatives of ‘organising authority’ clubs and of some other clubs which assist in running particular ocean races. ORWA itself is not an organising authority entitled to conduct races, but is best described as the umbrella under which all offshore and ocean race activities in WA are coordinated.

[27] The Blue Book (RRS 89.1) requires that all yacht races be conducted by an organising authority. In WA, the only organising authority clubs for ocean races are: Fremantle Sailing Club (FSC), Hillarys Yacht Club, Royal Perth Yacht Club, RFBYC and South of Perth Yacht Club.

[28] Another member of the ORWA committee is its Ocean Racing WA Race Officer, Mr Trevor Milton, who is an accredited national race officer and
a very experienced race manager. Mr Milton leads a team of race officials who regularly act as race control for most ocean races in WA.

[29] In this regard and over the last several years, ORWA has gradually introduced a system which ensures consistency in the way races are run. All organising authority clubs are offered (and most accept) the use of Mr Milton’s race control team for their ocean races. Each club remains responsible for its own pre-race preparation but between the start of each race and the finish of the last yacht, it is Mr Milton’s team (sometimes supplemented by host club volunteers) which has control.

[30] Under this system, Mr Milton has acted as RFBYC’s race officer for at least the last five annual BRORs. However, unlike most other organising authority clubs, RFBYC has not fully relinquished its independence. It has its own longstanding and very experienced team of radio room volunteers who undertake radio control of the BRORs under Mr Milton’s supervision.

[31] As a further measure to improve consistency, ORWA has arranged for all organising authorities to use the same Notice of Race and the same Sailing Instructions for each ocean race. These appear in an ORWA Handbook (‘the Yellow Book’) issued at the beginning of each season along with a racing schedule and individual notices, showing the course and other details for each race. It is then left to each club to issue any later supplementary race instructions which may be peculiar to its own individual race.

[32] ORWA is to be commended for these very sensible and flexible arrangements which have improved the quality of ocean race control in WA.

The Race Committee

[33] The Blue Book (RRS 89.2) requires an organising authority to appoint a Race Committee to conduct each race. The supplementary sailing instructions (SSIs) for the 2018 BROR nominated the Race Committee to be:

- Rear Commodore Sail, Luke Paterson
- Mr Trevor Milton (also named as Principal Race Officer)
- Mr Kim Laurence (also named as Race Officer Start)
- Mr John Milne
- Mr John Anderson (also named as Protest Mediator)
The Panel has not seen any documents from RFBYC as the organising authority to the Race Committee such as an instrument of delegation. The Panel assumes there isn't one. Nor does there appear to be any formal delegation from the Race Committee to the Race Officer.

The term Principal Race Officer is a misnomer. There was only one race and the Panel is of the view that Mr Milton was the Race Officer.

The Notice of Race

RFBYC, with the assistance of Koombana Bay Sailing Club, was the organising authority for the 2018 BROR. The first warning signal was scheduled between 17:30 hours and 18:30 hours on 23 February 2018. The race was over a distance of 170 nautical miles and was classified as Category 3 with further conditions:

- All yachts must carry a tracking device supplied by the organising authority;
- All crew must carry PLBs registered with AMSA and the organising authority; and
- Crew lists must be submitted to the organising authority on entry in the approved format as an excel file.

Because this was an event of special significance, the organising authority obtained permission from the Fremantle Harbour Master to conduct the start within the inner harbour. After crossing the start line, the course took yachts to the Western South Passage Transit beacon to port and then directly to a gate off Bunbury returning leaving the Western South Passage Transit beacon to starboard, Hall Bank to starboard and to the South Mole finish line. The course is Appendix 3.

The Racing Rules of Sailing and other prescriptions

As already noted, the Notice of Race and Sailing Instructions for the 2018 BROR were issued in the Yellow Book along with important safety information. The Notice of Race specified the safety standards required of yachts participating in the 2018 BROR by naming it as a Category 3 race. This meant that each yacht had to comply with the minimum standards for Category 3 races as set out in the Australian Sailing Special Regulations 2017-2020 - Part 1 for Racing Boats (which form part of the Blue Book).

In this regard, the Blue Book's minimum required safety standards vary according to the category of each particular race. Special Regulation 2.01 lists eight different categories which start with Category 0 (for transoceanic races) and progress through the remaining categories for races
of gradually decreasing risk down to Category 7 (which is for short races during daylight in sheltered waters). The safety requirements for Category 7 races are the least onerous, whereas those for Category 0 are the most stringent. In between, graduated standards apply.

The Notice of Race’s naming of the 2018 BROR as a Category 3 race meant it was considered to be one which SR 2.01.4 defines as:

... offshore races across open water, most of which is relatively protected or close to shorelines.

Notwithstanding that categorisation, it was recognised that the Category 3 safety requirements were not quite enough because the Notice of Race (and SSIs) also required that:

All crew must carry PLB’s registered with AMSA and OA.

PLBs are GPS capable 406 MHz personal locator beacons which are ordinarily required to be carried by crew in Category 1 or Category 2 races. Accordingly, the safety standards for yachts in the 2018 BROR went part of the way towards meeting those for Category 2 races, which are defined as:

... offshore races of extended duration along or not far removed from shorelines or in large unprotected bays or lakes where a high degree of self-sufficiency is required of the yacht.

The wisdom of the choice of Category 3 over Category 2 will be discussed later in this report. For the present, it is important to note the Category 3 requirements for the 2018 BROR included:

- SR 2.04: At least two crew members, including the skipper, to have completed a previous Category 3 race or an equivalent passage (all of Finistere’s crew qualified in this respect).
- SR 5.01.1: Each crew member to have a lifejacket which met certain specifications.
- SR 5.01.1(e): It is strongly recommended that lifejackets be fitted with a splashguard/sprayhood (the relevance of this recommendation will be dealt with later in this report).
- SR 1.01.1(g): A lifejacket shall be worn by each member of the crew when on deck between the hours of sunset and sunrise. (This requirement is highly relevant to the circumstances under review).
- SR 1.01.1 (h): It is strongly recommended that a lifejacket be worn by each member of the crew at times such as but not limited to: (i) when
alone on deck (ii) when the true wind speed is 25 knots or above (iii) when visibility is less than one mile.

The pre-race weather briefing

[44] The SSIs for the race provided for a race and weather briefing at RFBYC on 22 February 2018 at 19:00 hours, 24 hours before the start. At least the skipper and the navigator from each yacht were required to attend.

[45] There is an issue as to the extent of the weather briefing and how comprehensive it was. The Panel notes that there are many apps available providing accurate weather forecasting and from its interviews, concludes that most yachts relied on their own weather information.

Pre-race administration

[46] Ms Ghent, the Offshore Racing Administrator at RFBYC also represents the club on the ORWA Committee.

[47] The Panel was provided with the Clarke interview of Ms Ghent and copies of relevant documents she had created. The Panel also interviewed her and was impressed with her efficiency both prior to, during the race and her actions on the night.

[48] One of Ms Ghent's important duties was to gather information from the competitors and enter it on an excel spreadsheet including names of crew, contact details of next of kin and PLB numbers which she then forwarded to AMSA. She was able to complete this task in a timely fashion despite some competitors failing to meet the deadline for supply of this information.

[49] Ms Ghent also provided Mandurah Volunteer Marine Rescue and Water Police in North Fremantle with a list of participating yachts, contact numbers, details of radio schedules and all other information that might assist in the event of an emergency.

[50] One error in the information compiled by Ms Ghent was that the telephone number nominated for race control had been disconnected. RFBYC owns a number of mobile phones and the particular number allocated to the radio room for the 2018 BROR had not been renewed. This error was discovered at about 14:30 hours on 23 February 2018. A message was immediately sent to all skippers, competitors, social media and placed on the website advising that the race control phone number had changed.

[51] However, late that night when AMSA received the first PLB distress signal, it tried to contact the radio room on the old number (at about 23:50 hours
on 23 February 2018). When it could not get through, it instead phoned Ms Ghent direct on another mobile number that had been provided, which resulted in all lines of communications being restored.

**Yellow Brick Tracker**

[52] It was a requirement for the race that each yacht carry a tracking device attached to a rear stanchion. The Yellow Brick Tracker (YBT) is a commercial product now commonly used in yacht races to enable spectators with computer screens to follow the progress of a race such as the BROR.

[53] Charges are levied by YBT according to the frequency of reports. For the 2018 BROR, the YBT system was programmed to record each yacht’s position, speed and course every five minutes and to update a triple batch of this data on the live screen every 15 minutes.

[54] Although YBT is not designed or used for search and rescue operations, obviously it is capable of giving valuable information in that regard.

**Radio communications and position reports**

[55] The SSIs required all race communications be conducted on VHF channel 82. The reason for this was that a repeater tower inland from Mandurah provided full VHF coverage of the course on that channel. All yachts were to conduct a pre-race radio check on that channel prior to the start and also maintain a continuous dual watch on VHF channels 82 and 16, except at scheduled reporting times.

[56] RFBYC race control was to call for position reports at six hourly intervals commencing at 23:15 hours on 23 February 2018. The SSIs also informed yachts that race control would continuously monitor VHF channel 82 and that Coast Radio Perth at the Water Police Coordination Centre in North Fremantle would be monitoring VHF channel 16. RFBYC race control in fact maintained a dual watch on both of VHF channels 82 and 16.

**Royal Freshwater Bay Yacht Club's radio room and its volunteers**

[57] The clubhouse at RFBYC has a dedicated radio room fully equipped for VHF and HF radio communications. The adjacent radio tower is topped by an HF antenna and a VHF whip aerial. The latter is 32.5 metres above sea level.

[58] In view of the difficulties experienced with some VHF communications during the *Finistere* incident, the radio room and its equipment have since been checked by an expert and found to be working perfectly. Line of sight communications on VHF channel 16 provide the coverage which can
reasonably be expected and extend to approximately the south end of Garden Island. With the benefit of the repeater tower at Turner Hill (approximately half way to Bunbury), the duplex VHF channel 82 provided radio coverage over the whole of the BROR course.

[59] An issue has been raised as to why the radio room could hear VHF channel 16 transmissions from Water Police vessels on the night but not those from adjacent yachts. Enquiries have revealed the reason for this anomaly is that Water Police have their own dedicated repeater tower at Canning Mills which results in a wider coverage of VHF channel 16 transmissions from their own craft than from other boats. Water Police also use an encrypted UHF channel for their own communications.

[60] RFBYC has run the BROR for 70 years and as a result, has a long standing and very experienced team who volunteer for radio room duties during each event. For the 2018 BROR, a total of nine volunteers were rostered in pairs for six hours at a time commencing at 18:00 hours on 23 February 2018 (radio communications prior to that time were conducted from the start in Fremantle harbour).

[61] A day or two prior to the race, Mr John Milne and Mr Ron Fletcher checked all equipment in the radio room and ensured it was performing as it should. They also decided that, contrary to past practice, they would set up the radios so there would be a continuous dual watch on VHF channels 82(R) and 16.

Arrangements between the Race Officer and the radio room

[62] With most offshore races, the ORWA race control team led by Mr Milton operates from the radio room at FSC. Nearly all organising authority clubs agree to this arrangement because the FSC location is closer to the sea and provides better VHF radio coverage for races.

[63] With RFBYC, the arrangement has been different because it has always had its own race control team. For a number of years prior to ORWA introducing a new system, race control for the BROR was based at a private property on the coast between Mandurah and Bunbury. This was instigated by Mr Fletcher and Mr Milne under the name ‘Southern Race Control’ so there would be better VHF coverage of the whole course.

[64] Later, when it became apparent that the repeater tower at Turner Hill enabled full radio coverage of the course on VHF channel 82, the Southern Race Control was disbanded and race control for the BROR returned to the RFBYC clubhouse.
Throughout this period, there has always been a degree of physical separation between Mr Milton as Race Officer and the race control team (whether based south of Mandurah or at the RFBYC clubhouse). This does not appear to have caused difficulties in coordinating activities during each race because all monitored the same VHF channels and tracker system and communications regularly flowed between them by radio or mobile phone. Also, Mr Milton was always in the position to communicate directly with participating yachts.

Nevertheless, it has led to the unusual circumstance of a Race Officer supervising a race team distant from him.

**Arrangements within the Race Committee for the start**

The Race Officer, Mr Milton, has employment which regularly takes him into remote regions of WA and he was so situated during the week leading up to the 2018 BROR. Because of heavy and unexpected rains which had closed roads in the area where he was located, he realised he could have trouble returning to Perth in time for the start and might possibly miss the race altogether.

For this reason, the Race Committee appointed Mr Lawrence as Race Officer Start on the understanding that he would also become Race Officer if Mr Milton was not available.

As it turned out, Mr Milton was able to get back to Perth in time to attend the start of the race. Mr Lawrence nevertheless conducted the start.

**The decision with regard to weather**

The BROR was scheduled to last two days with all yachts sailing overnight on 23 and 24 February 2018. On the afternoon of 23 February 2018, the forecasts predicted that yachts heading south would face headwinds of 25 to 30 knots which would gradually swing east and abate overnight through to Sunday, when there would be little or no breeze. There would also be a moderate swell from the south to south west.

The actual winds between 15:30 hours and 16:00 hours on 23 February 2018 were 25 knots with occasional gusts to 30 knots at Fish Rocks and gusting 25 to 30 knots at Rottnest.

At about 15:00 hours, Mr Milton initiated a round of telephone calls amongst members of the Race Committee to discuss the weather forecasts and whether or not the race should be postponed. He did this after receiving calls from some competitors enquiring whether the race would be going ahead.
Mr Laurence, an experienced offshore sailor, consulted with an experienced skipper participating in the race. During these discussions, the factors considered included study of weather charts and predictions from a number of reputable internet sites; the probability of lessening winds during the race; the competency of various skippers and crews; the fact that the race was Category 3 with the addition of PLBs; and that the conditions were certainly sailable. No-one expressed a view that the race should be postponed or abandoned and the decision was made that it should start at the designated time.

It is relevant to note that the Panel is unaware of any participating skipper or crew member who in retrospect, thinks the race should have been abandoned or postponed. All witnesses who experienced the actual conditions and were specifically asked that question, agreed with the Race Committee’s decision. The Panel considers that the decision was the correct one.
CHAPTER THREE

The yacht *Finistere*

[75] *Finistere* is a Davidson 50 yacht built in 1990 by Mr Peter Milner to a New Zealand design. It has an overall length of 15.4 metres, a beam of 4.28 metres and a draft of 3.75 metres. It is a regular ocean going cruiser-racer said to do its best in medium to heavy conditions and has competed in three Sydney to Hobart Yacht Races (1994, 2008 and 2012).

[76] It has had three owners and was purchased by Mr Rob Thomas in 2002. Before then, the original fixed keel had been replaced with a lifting keel capable of reducing the draft to 2.6 metres. This keel had an oregon core with embedded carbon fibre struts attached to a lead bulb and was encased in a carbon fibre skin. It was built to engineering drawings and specifications prepared by Bakewell White Yacht Design in New Zealand.

[77] When *Finistere* was returning to Fremantle from the 2008 Sydney to Hobart Race, it had to call into Albany for repairs to the keel's carbon fibre skin which had delaminated. The keel could not be removed from the hull without destroying it, so it was completely rebuilt as per the original drawings and specifications. The keel was later modified by installation of a hydraulic lift. In view of what happened on 23 February 2018, it is pertinent to note Mr Justin van Didden’s statement that after leaving FSC that day:

> ... the keel was lowered into position. Mike Walker was doing this below deck. Mike reported that it was not going down and needed ‘a couple of bumps’ from wave action to help get into final position. (This was not an unusual thing to happen – but in light of the keel breaking I feel this needs to be noted). On the way to Fremantle main harbor, Mike advised that the keel was successfully lowered and bolted in place.

[78] When in the lowered position, bolts were inserted to keep the keel in place.

[79] Although *Finistere* was capable of carrying a larger crew, the crew for the 2018 BROR was the following:

- Mr Rob Thomas (skipper)
- Dr Helga Weaving
- Mr Kim Strickland
- Mr Mike Walker
- Mr Paul Owens
- Mr Justin van Didden

[80] All were experienced ocean racers.
CHAPTER FOUR

Events during the race

The start of the race

[81] The start line was laid inside Fremantle harbour and the race commenced at 17:30 hours on 23 February 2018.

[82] Although 18 yachts had entered the race (with 12 entrants in Division 1 IRC; four entrants in Division 2 IRC; 13 entrants in Division 1 YAH and five in Division 2 YAH), two yachts had withdrawn before the start.

[83] *Finistere* had entered in Division 1 IRC and YAH. Division 2 included two yachts, *Huckleberry* (R131) and *Fourth Dimension* (F40), which were to play vital roles in the search and rescue operation early the following morning.

[84] Observation of footage taken of the start and thereafter showed that at least half of all sailors (most of whom were visible above deck) had already donned their lifejackets despite the fact there was no Blue Book requirement they do so. On some yachts, all sailors who were visible, were wearing lifejackets.

[85] The Panel has learned that on at least one of the participating yachts, it was standard practice to require all crew to don their lifejackets before leaving the pen and be worn at all times while on deck during the race regardless of conditions or time of day. The skipper of that yacht said that when crew come on-board from other boats, “they can be a bit reluctant” to comply with this protocol. This suggests there may be a cultural problem amongst some members of the WA yacht racing fraternity concerning the wearing of lifejackets, which is an issue dealt with later in this report.

Events prior to the capsize

[86] The first leg of the race took the fleet on a reach out to the Western South Passage, with Transit Beacon to be left to port. The yachts then headed south into the wind on a more or less straight line course which took them outside Garden Island, past Mandurah and down to the rounding mark off Bunbury.

[87] After rounding the Transit Beacon, yachts had to harden up on a port tack and most were able to sail fairly close to the rhumb line. The descriptions of various skippers and crew of weather conditions over the next few hours are that they were as expected, with winds of 25 to 30 knots hard
on the nose and seas which were sometimes lumpy. None of the yachts appear to have had trouble coping with the conditions and in the words of one experienced skipper “it was not boat breaking weather”.

[88] On-board *Finistere*, the crew were similarly untroubled by the conditions. According to Mr Strickland, after reefing the mainsail, “*Finistere* was sailing quite comfortably without too much load”. Mr Walker confirmed that “the boat was handling the conditions well, although a few times we were a bit overpowered. Around 20:00 or 21:00 we reefed the main and this made the sailing easier”.

[89] Mr Strickland was aware of the Blue Book requirement that all crew on deck wear a lifejacket between sunset and sunrise. Accordingly:

> At around sunset I went below deck to obtain a PFD and harness. At the time I asked all on deck if they wanted me to pass them a PFD and harness. My recollection is that the majority said they would help themselves the next time they went below deck. I recall Helga (Weaving) had her own on around that time and Justin (Van Didden) put his on around that time. I put mine on and sat on the port rail for the next hour or two. To the best of my knowledge when we capsized only Justin and Helga were wearing their PFDs as I was below deck and had taken mine off. I don’t recall seeing anyone else with a PFD on.

[90] Mr van Didden and Dr Weaving confirm they were both wearing lifejackets after sunset. They were also both carrying PLBs which in an emergency, must be manually activated to transmit a signal via satellite to AMSA. In addition, Dr Weaving was carrying a newly purchased MOB/Automatic Identification System (AIS) beacon which automatically activated when her lifejacket inflated (her PLB and AIS beacons were both fitted inside her lifejacket).

[91] With regard to the other crew members, it is relevant to note that Mr Walker, Mr Strickland and Mr Owens went off watch and were below deck from about 20:30 hours (Mr Walker was also the navigator and for much of the time, was at the navigation table). At the time of the capsize, all three were due to come back on watch, were putting on gear and were about to don their lifejackets.

[92] Mr Thomas, Dr Weaving and Mr van Didden were on watch and remained in the cockpit throughout the period until *Finistere* capsized.

[93] The first position reports for all yachts had been scheduled for 23:15 hours and these were duly transmitted without incident.

[94] The YBT device on each yacht was recording its position, speed and course every five minutes and then relaying that data to the internet (in batches of three) every 15 minutes via satellite.
The last such batch of YBT data from *Finistere* was received at 23:30 hours when it was about 11 miles west of Mandurah. This data showed that over the previous half hour, *Finistere*’s speed had dropped from 6.2 knots to 5.1 knots and its heading had gradually changed from 180 degrees to 186 degrees. *Finistere*’s position at 23:30 hours relative to other nearby yachts is shown in the screenshot from the YBT tracker displayed in Appendix 6.1.

The next batch of YBT data from *Finistere* was due at 23:45 hours but this was not transmitted. Clearly, the capsize had happened by then and the evidence overall suggests that it occurred very close to 23:45 hours and perhaps, only a minute or two beforehand.

**The capsize as experienced by the crew on deck**

At the time of the capsize, Mr van Didden was at the helm, Mr Thomas and Dr Weaving were both sitting on the port side of the cockpit. Mr Thomas was the only one on deck not wearing a lifejacket.

According to Mr van Didden, when a gust hit the boat, Mr Thomas commenced to ease out the mainsheet. *Finistere* started to lean and continued to go horizontal. The mainsail and mast then hit the water and Mr Thomas fell from the high side of the boat into the sea.

Dr Weaving has given a more detailed description:

Justin was at the helm, all of us upstairs had our wet weather gear, trousers and jackets on. Justin had a life jacket on, he was at the helm. Rob was on the main, had his wet weather gear but no lifejacket. I was sitting next to him port side high, clipped on, lifejacket with devices on and my tether clip to the port jack line. The first thing we noticed was Rob slide from the port side, topside to go over to the starboard and went under the starboard rail. Justin and I said "Man overboard". I came down because Justin was at the helm. I was the only other person on deck. I came down on my tether. The other three were down below, I could see them getting ready, putting their gear on to come up as we were about to swap crew over. The boat kept coming on up and I thought we were going for a knockdown. We all jumped over the side and the boat came over. It went quickly. I knew it was the keel because nothing else takes a boat like that. Justin was pushed out the back, the other two got pushed under but they were pushed out. The suction and a rush of water pulled me back in to the cockpit bulge.

**The capsize as experienced by the crew below deck**

Mr Walker describes:

... a loudish bang like we had hit the water hard. Then the boat fell on its starboard side. I didn’t think it was a problem at the time and I was waiting for the boat to right itself. Stuff started to fall everywhere. I believe Kim and Paul headed out of the cabin at this time, and it was then that I realized that the boat was continuing to roll over. The boat was completely upside down and water was pouring in...
through the open hatch. A torch must have been on in the cockpit and I could see
the way out. I grabbed a life jacket and made my way through the water now
pouring into the companion way. As I entered the upside down cockpit I saw Helga
and shouted to her to get out. I kept moving towards the back of the boat, and I
realized that the water had inflated the life jacket so I let go of it. Helga and I were
in an air pocket under the upturned boat and I swam down underwater and
towards the stern (where) I surfaced ...

[101] Mr Strickland gives the following account:

At about 11.45pm I had my boots, long johns and dry shirt on and was standing
opposite the navigation table talking to Paul who was also getting ready to go on
watch. I still hadn’t put my wet weather jacket or PFD on and noted Paul had not
yet put his PFD on, but had his long johns and jacket on ...

We then just heard a loud crack like timber snapping. We both looked at each
other and I remember asking what that noise was. We both looked down at the
timber decking thinking that something was wrong there and immediately
Finistere tipped over flat onto her starboard side. This would have taken less than
10 seconds. We knew that this was not a knockdown because the conditions were
not that bad. There were items flying around everywhere and we knew we were in
serious trouble.

I remember Paul saying we are going over and I recall yelling let’s get out.
I made immediately for the cabin stairway ‘up’ to the cockpit which was now
90 degrees to normal. I remember Helga being at the exit to the stairway and
having to tell her to get out of the way so we could get out of the cabin. I then got
out into the flooding cockpit followed by Paul and then Mike. At this stage Finistere
was starting to invert. Paul and I then swam down and under the port guard rails
and Mike somehow went out the back ...

The time it took me to get out of the cabin then cockpit and then out and under
Finistere was definitely less than one minute. It happened amazingly quickly.
Finistere continued to invert and I believe went from upright and sailing to upside
down in probably less than one minute.

The plight of the crew following the capsize

[102] Immediately after the capsize, Dr Weaving was trapped (wearing her
inflated lifejacket) within an air pocket in the upside down cockpit. The
other five were outside the hull trying to cling to it while it pitched up and
down in the waves and at the same time trying to remain above water.

[103] Those outside faced a very difficult task because (surprisingly) there were
no trailing ropes for them to grasp and no real hand holds anywhere
within reach on the very slippery hull. Also, all but Mr van Didden were
not wearing lifejackets.

[104] Mr Strickland and Mr van Didden were able to manually activate their PLB
distress beacons. Although Mr van Didden had the benefit of a lifejacket,
he was hampered in holding on to the hull by using one arm to hold his
PLB skywards in the hope of sending a better signal. His PLB did not have a wrist lanyard.

Mr Owens was the only one of the five who seemed to have a reasonable grip on the hull. He was located on the port side of the upside down hull a few metres away from the others who were clustered around the stern. None of the survivors are able to say how Mr Owens managed to hang on. All that they could observe was that he appeared to be standing on something (perhaps a lifeline?).

However, Mr Owens was in obvious difficulties because every time the hull dipped with the waves, he was immersed in water. The others could see that these repeated immersions were taking their toll and repeatedly urged Mr Owens to join them at the stern, but he did not respond and remained in the same position.

Although the four crew at the stern were more sheltered from the waves, they were also in a desperate situation. Mr van Didden swam around the side of the hull looking for Dr Weaving and after returning to the stern, was able to release the dan buoy (an upright floating flag pole attached to the yacht by a thin line). Although the dan buoy provided limited assistance, the four crew at the stern still faced great difficulties (as best described by Mr Strickland):

*It was hard for us all to hold on. As the stern of the yacht pitched under the waves we had to hold on and were constantly dragged under or forced to let go. It would then resurface after the wave passed over. We were holding our breath each time. I remember thinking around that time that I maybe had another 30 minutes before I would have succumbed to fatigue and/or hypothermia. I remember discussing this with the other guys and I knew we could not last for a long time, even though the water was reasonably warm.*

Mr Thomas was the first amongst those at the stern to show serious signs of succumbing. Mr Strickland tried to assist; and Mr Walker for some time attempted to keep Mr Thomas afloat by hugging him with one arm while at the same time trying to hold on to the hull. However, a big wave intervened and Mr Thomas (who by that time was seemingly unconscious) was washed away. The others were horrified that this had happened, but as Mr Strickland has said:

*We couldn’t do anything. We couldn’t search for Rob as it was too hard to see under the water. I could only hold on to the yacht and wait to be saved. I didn’t have long left in me myself … unfortunately we had lost Rob and the rest of us outside the yacht were struggling and didn’t know how long we could hang on. I recall shaking quite a lot and having cramps in both lower legs and both feet, so I assumed hypothermia was setting in.*
Meanwhile inside the hull, Dr Weaving was surviving in a gradually diminishing air pocket formed by a bulge in the cockpit floor where a life raft would normally be stored. Soon after the capsize, she had calmly assessed her situation and thought “this isn’t good but it could be a lot worse”.

In this regard, she was not in darkness because the strobe light on her lifejacket was flashing and she also had a floating torch. She thought her lifejacket too buoyant so deflated it a little and found her boots to be too heavy so kicked them off. Dr Weaving also knew that she was still tethered to the port lifeline and after deflating and orally refloating her lifejacket, realised she would be able to pull herself down and get out from under the hull when she wanted to. She then decided to stay where she was and thought to herself “if Tony Bullimore could do this for five days I can do this for a few hours”.

Dr Weaving also made her situation known to the rest of the crew by yelling, banging the hull and blowing her whistle. At least some of the crew at the stern heard those signals.

**The distress signals sent by the crew**

There were a total of four distress signals transmitted following the capsize and these came from Dr Weaving’s MOB/AIS beacon and PLB, and the PLBs carried by Mr Strickland and Mr van Didden. Dr Weaving’s PLB signal was only transmitted when she came out from under the hull, so it played no part in the search and rescue response.

The first distress signal came from Dr Weaving’s MOB/AIS beacon which was automatically activated when her lifejacket inflated as she fell into the water. Importantly, this happened while the capsize was still in progress and before Dr Weaving was sucked back into the cockpit and under the hull. This meant that when the beacon was activated, it was open to the sky but only for a very short period.

This short exposure was sufficient for the beacon to connect with a GPS satellite to obtain its position and then briefly transmit that position as a VHF distress signal. An AIS beacon is essentially a man overboard (MOB) device and the VHF signal it sends from water level, can only be received by a vessel with compatible equipment (usually the vessel the person has fallen from) which is within line of sight range. This range is usually a radius of four to five miles.

When a vessel receives an MOB/AIS VHF distress signal, it comes in the form of an audible alarm from its plotter, as well as a visual symbol displayed on the electronic chart showing where the beacon is located. A
small window also appears on the plotter screen indicating the beacon’s distance and bearing from the vessel.

[116] When a vessel responds to such an alarm and moves towards the person in distress, the beacon is continually transmitting its location, which causes the data on distance and bearing to be constantly recalibrated. In this way, the vessel is guided to the precise point of rescue.

[117] However, this did not happen with Dr Weaving’s AIS signal because when she was sucked back into the cockpit, her beacon’s satellite connection and VHF transmissions were blocked by the upturned hull. Consequently, the only transmission which went the full four or five mile radius was the one transmitted momentarily while she was outside the hull.

[118] The only vessel within range and with compatible equipment able to receive the signal was Fourth Dimension. Accordingly, the AIS signal was heard and seen on-board Fourth Dimension simultaneously with the capsize. The information displayed on its plotter gave a distance and bearing to the beacon, the number of the beacon, as well as an error message to the effect that it was a lost signal. Thereafter and for the reasons already indicated, the position of the beacon on Fourth Dimension’s plotter screen remained static and never changed.

[119] Unfortunately, and because the satellite connection was too brief, the position transmitted to Fourth Dimension was inaccurate. In this regard, it is well known that initial GPS positions received by satellite are sometimes unreliable and that it can take a number of minutes to achieve accuracy. In the present instance, the evidence before the Panel establishes that the position displayed on Fourth Dimension’s screen was more than two miles east-north-east of Finistere’s actual position (this inaccuracy understandably caused some confusion during the search and rescue operation).

[120] The second distress signal was manually activated by Mr Strickland on his PLB “within a couple of minutes of getting out of Finistere”. Unlike AIS signals, all PLB distress signals are relayed by satellite directly to AMSA in Canberra which has statutory authority to initiate a search and rescue operation. AMSA did not immediately initiate an emergency response to Mr Strickland’s signal because it wanted to make sure that his PLB activation was not accidental.

[121] Accordingly, AMSA immediately commenced telephone inquiries and in this regard, it had Mr Strickland’s beacon registration and contact details as well as the data sheet received from RFBYC showing he was then on-board Finistere.
Minutes later and while still making enquiries, AMSA received another distress signal, this time from Mr van Didden’s PLB. Yet again, AMSA had Mr van Didden’s beacon registration details and RFBYC’s data sheet showing that he too was also on-board Finistere.

Knowing there were now two distress signals from the same yacht, AMSA immediately initiated a search and rescue response and did so via the WA Water Police based in North Fremantle.

Fortunately, a Department of Fire and Emergency Services rescue helicopter was in training near Mandurah and it was immediately dispatched to find Finistere.

Fourth Dimension’s response to the man overboard/Automatic Identification System distress signal

Fourth Dimension is skippered by Ms Lyn Powell and Mr Ian Whitehead jointly and at the time the AIS distress signal was received, Mr Whitehead was on the helm and Ms Powell was down below asleep in a bunk. Ms Powell was woken by the alarm and could hear it from where she was but because of general noise outside, it was not audible in the cockpit.

Ms Powell immediately got up, checked the plotter screen and realised the alarm was an MOB signal. Her first thought was that the signal had come from one of her crew (because Fourth Dimension had MOB/AIS beacons fitted to lifejackets) so she shouted to Mr Whitehead, did a headcount and realised all crew members were there.

The data on the plotter screen showed that the MOB/AIS beacon was directly behind in Fourth Dimension’s wake and only a short distance away, so Ms Powell’s next thought was that the signal may have come from another MOB/AIS beacon attached to the yacht’s dan buoy. She then checked the dan buoy at the stern which took time because she had to get past Mr Whitehead on the helm to access a rear locker and he had to untether and retether. This check confirmed that the dan buoy and beacon were still in position. Ms Powell then peeled open her own lifejacket to check that its beacon had not fallen out.

By this time, another crew member had been put on the helm and the two skippers were discussing (and were very perplexed by) the alarm signal. They could not determine what vessel it had come from because the data on the plotter screen provided only a meaningless nine digit number for the beacon and did not identify the person or yacht it belonged to. Even though it was a dark night, they knew there were no yachts or lights in the vicinity of the signal’s plotter position. They checked
the most recently reported positions of other yachts and none of these correlated with the signal. Mr Whitehead then tried to connect with the YBT system on his mobile phone but was unsuccessful.

While the skippers were still debating what to do about the signal Fourth Dimension received a radio call from race control (on VHF channel 82) asking that it “do a visual on Finistere”. Race control made this call because it had been informed by AMSA of the second PLB distress signal and knew Fourth Dimension was the closest boat and were only about two miles to the east of where Finistere should be.

Fourth Dimension made the requested visual check and reported back that Finistere was nowhere to be seen. It also informed race control of the AIS distress signal and of the position of that signal. At about the same time, the Water Police became active on VHF channel 82 and Fourth Dimension also supplied them with details of the AIS signal. Water Police then said that this signal “is not on our records” to which Fourth Dimension responded “no it’s an AIS not a PLB”, “of course it’s not going to go off with you, it’s going to go off with us”, and made sure they “understood the difference”.

Fourth Dimension decided that it should investigate the plotter position of the MOB/AIS beacon and after informing race control of this decision at 00:17 hours, it made a 180 degree turn (at 00:25 hours) and headed back north. By then, it was approximately four miles south of the beacon’s plotter position. By the time it had covered about two thirds of the distance back, news came over the radio that Finistere had been found and Fourth Dimension decided to divert to the correct position.

In retrospect, it is clear that the inaccurate position as transmitted by the AIS beacon introduced an element of confusion into the search and rescue operation. It not only caused the closest boat, Fourth Dimension, to head off in the wrong direction but also presented Water Police with two conflicting positions for Finistere. Therefore, it is very fortunate that the rescue of the survivors was achieved remarkably swiftly in all the circumstances.

The search and rescue operation

AMSA received Mr Strickland’s PLB signal at approximately 23:50 hours on 23 February 2018 and initiated the search and rescue operation when it received the second signal from Mr van Didden’s PLB not long after. In accordance with usual practice, it delegated the conduct of that operation to the appropriate State authority, WA Water Police.
Water Police were well equipped to conduct the operation as they have skilled operators (both on water and on radio at its North Fremantle base) as well as a variety of rescue craft. Water Police also have access to and are in the position to instruct the numerous volunteer sea rescue operations based up and down the coast. They have access to fixed wing search aircraft and helicopter services.

One of the first steps taken by Water Police was to arrange for a helicopter search in the vicinity of the positions of the two PLB signals. For the survivors in the water, it seemed an eternity before the helicopter appeared when in fact, it had arrived well before 00:28 hours when Huckleberry reported it to be overhead. The survivors at the stern believed that the helicopter could not see them and the following statement from one of them is consistent with what they all have to say:

*It flew over or nearby at least 10 times but because the hull was painted with black antifouling paint I believe it couldn’t see us with a black ocean as a contrast. The searchlight was hitting the ocean around us but the helicopter never stopped or slowed when it was near or over us. Many times it flew straight over us and we shone torches at it, but it never even slowed. It was very demoralizing to see rescue potentially so close but with no sign they ever saw us. The majority of the time it was a very long way away from us so I suspect it never saw us, despite what the media reports say.*

However, the survivors were mistaken in these perceptions because the helicopter had in fact seen Finistere’s hull and radioed the position to the Water Police. The helicopter reported that it had a spotlight on the hull and could see lights in the water. Furthermore, the helicopter’s movements as seen by them are at least partly explained by the fact that it also searched the area (more than two miles away) of the inaccurate AIS position. The helicopter was not equipped with the night winch facilities which would have enabled it to effect a rescue, so Water Police asked race control (at 00:25 hours) if any nearby yacht could assist.

By then, Huckleberry was the closest and Fourth Dimension the second closest yacht to Finistere’s position. At 00:20 hours, race control asked Huckleberry if it “had a visual” on Finistere and it responded in the negative. Race control then asked Huckleberry to divert to the position provided by the Water Police and it did so (at 00:27 hours).

The third closest yacht was Circa, skippered by Mr Bill Henson and although it could not fully hear all transmissions, it heard radio chatter about Fourth Dimension, and an AIS beacon and assumed there was a MOB from that yacht. Circa offered assistance to Fourth Dimension and received the response “yes please”. Circa then turned around (at 00:35 hours) and headed downwind knowing “roughly where to go”. As it went, Circa heard further transmissions and realised that the emergency
involved *Finistere* and not *Fourth Dimension*. It also realised that *Finistere* was at a different location from the AIS beacon and diverted to that other location.

[139] At 00:38 hours, race control reported to Water Police that it had “three yachts on the way”.

[140] *Huckleberry* was the first yacht to reach the position given by Race Control, but for some unknown reason, could find nothing there. Then a *Huckleberry* crew member with good eyes sighted the silhouette of *Finistere*’s upturned rudder against the background of searchlight glow (from the helicopter at a distance) further away to the north-west.

[141] *Huckleberry* then headed towards *Finistere* and as it neared, saw the keel was missing and crew members clinging to the hull. *Huckleberry* had difficulty rescuing the survivors because to the skipper, “it appeared that they were unable to realistically help themselves” and that a close approach risked squashing them against the hull. Mr van Didden was the first to be recovered because he was wearing a lifejacket and was able to make his way to *Huckleberry*. However, after being manhandled over the side, “he was pretty well at the end of his tether” and “was definitely not looking so good”.

[142] It took about half a dozen passes and throwing of ropes to rescue the second survivor, Mr Walker, and eventually, *Huckleberry* also recovered Mr Strickland. *Huckleberry*’s skipper, Mr Phil Sommerville-Ryan gives the following account of his attempts to recover Mr Owens:

> We came in again to try and get Paul (who) was around on the weather side of the boat and I think he had been copping the worst of the waves. We got a rope to him twice and hit him on the head with it once, but got no reaction from him at all. Then what I was going to do was run into the hull. The crew wanted to jump into the water but I vetoed that because there would have been more people in the water ...

> Then the Water Police boat turned up. They had obviously seen our navigation lights and things and we told them on the radio where Paul was. They went straight in and unbeknownst to us at that stage they also got Helga who was underneath. She had pulled herself out. (The Water Police boat) was there less than 5 minutes and then took off and headed back to Mandurah.

[143] Dr Weaving had exited from the cockpit when she heard the engines of the Water Police boat. To do this she “unclipped the tether but held onto it, deflated the lifejacket and pulled myself to the edge and popped out and reinflated my lifejacket”.

[144] Shortly afterwards, Mr Owens was pulled on-board the Water Police boat but was unresponsive. Being a doctor, Dr Weaving offered to assist but
that offer was refused. She witnessed the persistent attempts to resuscitate Mr Owens with CPR and oxygen but these efforts were unsuccessful. In Dr Weaving’s opinion, it was obvious that Mr Owens had drowned. She herself recovered well after a very short stay in Peel Hospital.

The three survivors rescued by Huckleberry were initially severely dehydrated and between them, drank nine litres of water. They recovered well and did not need any hospitalisation.

The search following the rescue

While Huckleberry was carrying out the rescue, Fourth Dimension was instructed by Water Police to simply “stand by”, so it remained in the vicinity of Finistere ready to render assistance and awaited further instructions.

By the time Circa approached, radio traffic had made it clear the rescue was well in-hand but there was one person without a lifejacket who was still ‘missing’. The skipper, Mr Bill Henson, thought the best thing Circa could do would be to search for this missing person at the position given by the AIS beacon, so he headed off in that direction.

Not long afterwards, the same thought occurred to Ms Powell, and her reasoning was that the missing person might have fallen off Finistere prior to the capsize. After obtaining permission from the Water Police to search the other area, Fourth Dimension also went to the same position which was about two miles to the north-east.

The two vessels then unsuccessfully searched that general area for an unknown missing person without a lifejacket whom their skippers believed might still be alive. Circa did so for only a short while because the area was upwind of Finistere and in the skipper’s opinion, too far away for there to be any likelihood that the missing person was there. Circa then searched downwind of Finistere until about 04:00 hours when the battery on its spotlight ran out. Circa resumed its search at dawn, by when the skipper considered that “the odds were low but that there was always a chance to get lucky”. Ultimately, Circa told race control at 08:30 hours that it was retiring from the search.

Fourth Dimension continued to search the area around the AIS signal position until about 03:20 hours and then radioed Water Police to ask what else it could do. In response, Fourth Dimension was instructed to carry out a very wide zigzag search downwind of Finistere. Meanwhile, Water Police had arranged for additional aircraft and vessels to
commence searching a much larger area shortly after dawn. This grid search resulted in Mr Thomas’ body being recovered at about 12:30 hours and Fourth Dimension was then stood down.

**Events at race control during the incident**

[151] Following the start of the 2018 BROR, the Race Officer, Mr Milton, did not go to the RFBYC radio room but instead returned home, where he monitored the race by listening to VHF channel 82 and keeping an eye on the YBT. As previously noted, this arrangement accorded with past practice and as Mr Milton has said:

> Generally, the Bunbury and Return Race is different because you have the radio room at RFBYC to manage it and they talk to me throughout the event. I do not get involved hands on unless there is a problem like we had this year or I take care of the finish. I monitor the boats and make sure there is someone at the finish line to record the finish.

> After the start I went home, and Wildside (a participating yacht) pulled out, and being in the log I didn’t take a note of the time, but it would have been 8.30pm - 9.00pm. They had gear failure, nothing dramatic, and we asked them to call once they got back to the pen ....

> I sat at home and the radio was on but no traffic. I had the tracker/ipad and computer on, and they were all making steady progress, so I was watching TV, then I stayed up for the 11.15pm sched and listened in. If there is something I need to say I will jump in and say it. The guys at the RFBYC radio room were doing their job and it was a pretty normal sched.

[152] The volunteers on duty in the radio room that night were Mr John Milne and Mr Ron Fletcher. They were due to be replaced at midnight by Mr Russell Wellington and Mr David Wedderburn who arrived early so there would be an overlap in the shifts.

[153] They all had long experience in performing the same roles during previous races. They also knew that the Race Officer was readily accessible by phone, lived only 20 minutes away and could attend the radio room at any time on short notice.

[154] The first indication of a problem with Finistere was at 23:50 hours when Mr Milne received a phone call from Ms Ghent. She told him that AMSA had tried to call race control on the disconnected number and then rang her. AMSA had asked her to pass on to race control that a PLB from Finistere had been activated and to request the vessel be contacted to find out if the activation was accidental or an emergency.

[155] Because of the imminent change of shift, it was agreed that Mr Wellington would handle this request and he attempted to call...
Finistere a number of times without success. Mr Milne remained behind while this was happening and at 00:12 hours, he was called again by Ms Ghent who pointed out that Finistere was no longer tracking on the YBT. He informed her of the failure to contact Finistere and she passed this on to AMSA. She was then told by AMSA that there had been a second PLB activation and a search and rescue operation was now underway.

[156] From the commencement of that operation, AMSA (and through it Water Police) had the legal authority and responsibility to make all of the decisions necessary to find Finistere and rescue its crew. Although race control continued to be responsible for running the race, it was not part of the search and rescue operation and had no decision making power in that regard. All that race control could do was to advise and assist AMSA and Water Police in any way it could.

[157] A few minutes after midnight, Mr Milton received a phone call from Mr Milne informing him of the incident involving Finistere. Soon afterwards, Mr Milne rang Mr Milton again to say that a second PLB had been activated and that a helicopter was already on its way.

[158] Mr Milton immediately responded to the situation:

My wife Sue Milton was now awake and taking messages and phone numbers as my mobile phone had started to get busy. I made a couple of calls back on the house phones as we had AMSA and Sea Rescue on the phone plus John or whoever in the radio room trying to get through, so I was taking notes, co-ordinates, e-mail addresses, and who was trying to contact who at what number and what their names were.

[159] One of the early phone calls he made was to Water Police to explain his role as Race Officer and to tell them he was their primary point of contact. He also provided them with pertinent information including confirmation of crew details for Finistere.

[160] While keeping a dual watch on VHF channels 16 and 82 (which had rapidly increasing traffic), he heard the helicopter report (at about 00:25 hours) that it had found Finistere, was shining a spotlight on the hull and could see three people in the water.

[161] As the helicopter was not equipped with a winch facility, Water Police asked race control if there was a vessel nearby which could come to Finistere’s assistance.

[162] Mr Milton was aware that Huckleberry was by then the closest available yacht and he instructed Mr Wellington to ask it to divert to the position
given by the Water Police. Mr Wellington radioed that request at 00:27 hours.

[163] Approximately 10 minutes later, *Huckleberry* was asked to estimate the time it would take to get to the nominated position and it gave an ETA of four minutes. Mr Milton decided that it was time for him to transfer to the radio room and he left home for RFBYC at about 00:45 hours. Before leaving, he had phone conversations with Ms Ghent and instructed her to notify RFBYC’s Commodore and CEO of the situation with *Finistere*. He also asked her to come from her home to RFBYC.

[164] While driving to RFBYC, Mr Milton was unable to monitor the VHF radio traffic and he made a phone call on the way to check what was happening. The gates were shut and being a non-member without a gate access key, he was unable to drive on to the club grounds. By the time he arrived, channels 16 and 82 were becoming very congested, so the radio room ‘stepped back’ its traffic to give Water Police ‘clean air’.

[165] Over the next few hours, Mr Milton had several contacts with Water Police who were initially working on the theory that a *Finistere* crew member may have fallen overboard at the position of the AIS beacon. Mr Milton discussed this theory with them and pointed out that because of *Finistere*’s track as well as the winds and tides, “there is no way anyone falling off the boat is going to be there”. Water Police accepted what he had to say. He also answered questions from the police about crew contacts and descriptions and raised with them a number of times the need to notify next of kin (a subject dealt with below). At the request of Water Police, he also sent them a photograph of Mr Thomas.

[166] Mr Milton offered several times to make additional yachts available for search or recovery. He told Water Police he had “16 assets out there that I can turn around to help” but their response was they already had all the ‘assets’ they needed. These assets included rescue vessels from south-west ports which were temporarily available because of the Rottnest Swim scheduled for that weekend.

[167] Mr Milton also briefed the club’s CEO, Mr Bayliss, when he arrived at RFBYC. Later in the morning and after it became clear there had been two fatalities, he participated in a discussion about whether or not the race should be cancelled (another subject dealt with below).

[168] Throughout the night and into the morning, the radio room was kept exceptionally busy monitoring the very high volume of VHF traffic, in helping to coordinate the yachts assisting with the rescue and subsequent recovery operation and in dealing with innumerable phone calls. One source of frustration was difficulty in hearing VHF channel 16
transmissions from vessels west of Mandurah. This problem was caused by the vessels being out of line of sight with the RFBYC radio tower (which was not an issue with helicopter transmissions or those from the Water Police base in North Fremantle). Nor was there any problem with channel 82 transmissions which were sent and received via the repeater tower inland from Mandurah.

However, for a significant period during the incident, Water Police transmissions were transferred to VHF channel 73 (probably because of heavy traffic). Race Control could listen to only two VHF channels simultaneously and decided it should continue to monitor channels 16 and 82. As a result, the radio room did not always have a clear understanding of what was happening out on the water. A further result is that those on duty at the time have been unable to enlighten the Panel about certain events (which is also partially due to a key operator having a poor recollection).

Race Control continued its normal duties in relation to the 12 yachts which continued to race (apart from Finistere, Fourth Dimension, Huckleberry and Circa). One yacht (Walk on the Wild Side) had withdrawn because of gear trouble and another yacht (Al Fresco) because of minor injury to a crew member diverting to Mandurah.

Because of the continuing congestion of traffic on VHF channel 82, the position reporting scheduled for 05:15 hours on 24 February 2018 was cancelled. In making this decision, race control also took account of the (by then) fairly light conditions and the YBT tracker showing where all yachts were. For the same reasons, the position reporting scheduled for 11:15 hours was also cancelled.

Because yachts would be returning through the area where there was the risk of collision with Finistere’s upturned hull, skippers were warned to keep a ‘more vigilant watch than usual’. However, when skippers responded with the query what they were to look out for, the police would not permit this information to be released.

The first yacht to finish did so at 12:30 hours and the last yacht at 20:00 hours on 24 February 2018. Mr Milton had arranged for each yacht to be radioed as soon as it crossed the line with a request that the skipper phone the Race Officer. This was so he could inform each skipper of the facts about Finistere including that there had been two fatalities. He did this because:

*It is nice for them when they arrive to think they have actually got the story from the Race Officer and know exactly what has happened and don’t have to listen to all of this second hand conjecture. If they had listened to the radio they would have...*
known that there was a boat in trouble and that it was Finistere, and 5 accounted for and 1 missing. That is all they would have known until such time as I briefed them.

The radio room records of the incident

[174] Prior to the Finistere incident, the transmissions sent or received by the Radio Room were recorded in a handwritten log in a bound volume. The entries tended to be very neat and were usually written retrospectively while the operator’s memory of a transmission was still fresh.

[175] The first entry relating to the incident was at 23:50 hours and it read:

Finistere in trouble.

R. Wellington/D. Wedderburn on – J. Milne helping.

See separate rough sheets * *

[176] This entry was made with the benefit of hindsight. At 23:50 hours, it was not then known that Finistere was in trouble. What was known was that a PLB attached to Finistere had sent a signal and that it might be an accidental activation or some other emergency such as a MOB.

[177] The next entry in the log concerning the incident was at 03:30 hours the next day and during the intervening period, transmissions were recorded on the 'rough sheets' referred to in the first entry. These sheets also recorded some (but not all) overheard transmissions by the helicopter or Water Police with each other or to other parties.

[178] The rough sheets comprised four separate sheets of paper with entries recorded from 23:50 hours on 23 February 2018 through to 14:35 hours the next morning. A few entries were not in time order and some did not give details, which with hindsight, would have been useful. Also, the rough sheets did not record all relevant transmissions. The reasons for this were the exceptionally heavy radio traffic on overloaded channels, the problems in hearing some transmissions and the difficulty in finding time between transmissions to properly record them.

[179] As a result, the Panel does not have full information on all relevant radio transmissions made during the incident (for example, there is no radio room record of the position given to Huckleberry when it was diverted to Finistere).
The failure to notify next of kin

[180] The crew lists for each yacht which had to be submitted to RFBYC at least two days before the race included 'Emergency Contact' details for all crew members. This longstanding practice in offshore racing exists so that race control will know who each crew member wants to be notified if he or she becomes adversely involved in some emergency. These contact details are also part of the information RFBYC forwards on to AMSA identifying the names and PLB numbers of the crew who will be on-board particular yachts.

[181] This information is important to AMSA because even though it already has emergency contact details acquired at the time of registration of each PLB, these details often change. It can save lives as shown by the fact that the search and rescue was triggered once it was realised that the two PLB signals came from the same yacht.

[182] In most instances, the person nominated for contact in an emergency is the spouse, partner, parent or some other close relative of the crew member. In the case of Mr Thomas, his emergency contact was his wife, Ms Veronica Bellemore-Thomas (also known as ‘Nikki’ Thomas), who was also the contact for Dr Weaving. In the case of Mr Owens, his emergency contact was his father, Mr Kevin Owens.

[183] After the rescue of the survivors, Mr Milton wanted to notify next of kin what had happened and raised this issue several times with Water Police. The police were being very circumspect about identities and would only say that “five were accounted for, and one was missing”. However, they also asked Mr Milton to provide descriptions of Mr Owens and Mr Thomas (as well as a photograph of Mr Thomas), so he was able to guess who might be dead or missing. He strongly believed their families needed to be informed, so:

*I kept on ringing them as I told them I know the skipper’s wife personally and she is going to get up in the morning and she is going to be ringing me saying what is going on and what do I tell her.*

[184] The response of Water Police was that it was their responsibility to notify next of kin when they were sure of what had happened and he was not permitted to do so. It was not until approximately 04:15 hours, that police confirmed to Mr Milton they were actually looking for a body. About half an hour later, a police officer also told him:

*I am going to tell you this, but you can’t repeat this to anybody. There are two fatalities, but we can’t find the body, but you can’t tell anyone not even your wife.*
Although he was not lawfully obliged to do so, Mr Milton obeyed these directives because in his words “it was part of my upbringing to do what police say”.

These directives did not apply to the scores of sailors and others who heard the VHF radio transmissions throughout the early hours of the morning. They all knew there had been a terrible tragedy involving *Finistere* and most of them had mobile phones. Consequently, word of the tragedy soon spread ashore and by dawn, it had become news on public radio and the subject of commentary in social media.

Meanwhile, Mr Thomas’ wife had gone to bed the previous evening after checking *Finistere’s* progress on the YBT. When she awoke at 06:00 hours, she wondered why she could not find *Finistere’s* track and was puzzled by the odd movements of other yachts offshore from Mandurah.

It was not until later that morning that police officers visited the Owens and Thomas families. Shortly before the police arrived, a friend rang Ms Thomas to say how sorry she was about what had happened but ceased to say anything further when Ms Thomas queried what she was referring to. Other friends arrived while the police were telling her what had happened. She had had no opportunity to adjust to this situation and found it extremely difficult to accept or understand why she was "the last to know". Ms Thomas experienced additional angst when she realised she had not been on hand to support Dr Weaving when the latter was brought ashore.

### The decision not to abandon the race

After the survivors had been rescued, the Race Officer, Mr Milton, considered whether or not the race should continue. The factors he took into account included the precedents set by the 1979 Fastnet and 1998 Sydney to Hobart yachting tragedies (when races were not abandoned), that the conditions were not a problem for the other yachts still racing and the ‘optics’ of continuing to race when there had been at least one fatality.

After consulting with the RFBYC CEO, Mr Bayliss, the Race Officer decided the race should not be abandoned.

This decision was reconsidered and confirmed a few hours later by the Crisis Management Group (referred to below) which had gathered at RFBYC. According to Mr John Longley, the group had ‘quite a long discussion’ about the matter and apart from the factors considered by the Race Officer, took account of:
... the fact that one of the reasons for cancelling the race (would be) to call all the other boats to come into the area to search. But the other boats had all gone and were well past the incident, and the Water Police had said they didn’t want any further assistance ...

We were also concerned that if you cancelled the race and then told the boats to go home effectively you as an organizing authority lose control of your fleet. People immediately go out of race mode, so they are not running scheds. Typically very often damage happens in ocean races when people pull out more than when they are racing... because the pressure comes off... Instead of having a crew all twitched up and working the boat... you suddenly go into a more relaxed mode... and that’s very often when things go wrong.

[192] The group also considered other precedents where races had not been cancelled including an ocean race off Sydney when there was a double fatality after a yacht ran aground and a recent Volvo race when a yacht struck a fishing boat and killed a fisherman. In the end, the group believed it was better to keep control of the fleet and to follow ‘established precedent’, so it confirmed the Race Officer’s decision.

[193] The group then considered whether or not RFBYC’s regular club racing (scheduled for later that day) should be cancelled. There was mixed opinion about that but soon after the discussion started, news came through that FSC (Finistere’s home port) had cancelled its club racing that day. That was enough for the group to unanimously decide that RFBYC should also cancel its club racing (as a mark of respect to the Finistere deceased).

Royal Freshwater Bay Yacht Club’s handling of the aftermath

[194] Commodore McAullay was unaware of early phone messages about the Finistere tragedy and did not arrive at the clubhouse until 06:30 hours on 24 February 2018. After being briefed for approximately an hour, he decided to form a group to manage what he realised was a crisis for the club. This Crisis Management Group comprised certain senior members considered to be ‘wise heads’ who were either at the clubhouse already, or were contacted and asked to attend.

[195] Discussions within the group began before it had fully gathered and the first decision made was to engage the services of a media specialist to handle enquiries from the media. A suitable person (Ms Nicole Moody) was identified and she attended the club from approximately 08:45 hours to advise on media matters.

[196] Another decision made was to arrange a conference call with the President of Australian Sailing (Mr Matt Allen) and its CEO (Mr John Lee), both of whom were known to be experienced in managing the aftermath
of tragic events. As a result, the group received early guidance on matters that should be given priority including prompt availability of counselling for all affected by the tragedy, documenting everything that had occurred, minimising rumours by quickly releasing information which was entirely factual and ensuring that only one person was authorised to speak on behalf of the club.

[197] The group accepted this advice. Counselling services were quickly engaged and a counsellor was at the clubhouse and available to speak with affected volunteers and staff. It was also agreed that Commodore McAullay would be the spokesperson for the club. Other early decisions were to confirm that the 2018 BROR would not be abandoned (as detailed above) and to appoint Mr Skip Lissiman to liaise with FSC.

[198] With regard to media management, any release of information was hampered by the fact that the search for the missing sailor was continuing and the ultimate outcome of the tragedy was not yet known. Nevertheless, the club issued a first press release (when there was one sailor dead and another still missing) and a second at 15:30 hours (by which time, there had been a police announcement that there had been two fatalities).

[199] At 14:00 hours, Commodore McAullay held a press conference and answered questions from the media. Prior to that press conference, Ms Moody briefed media representatives on the ‘rules of engagement’. Over the following days, she continued to field media enquiries on behalf of the club and to monitor social media commentary.
CHAPTER FIVE

Issues and recommendations

Issues raised by the facts

[200] This report has so far (and in the context of RFBYC’s conduct of the 2018 BROR) outlined the relevant background circumstances and summarised all facts surrounding the Finistere incident. The role of the Panel is to examine those facts and circumstances, to determine what lessons can be learned and to make recommendations which might improve race administration or minimise future risks for ocean sailors.

[201] In undertaking that task, the Panel has identified a series of issues relating to race management, the rules of racing and safety considerations. With some of those issues, it is enough that they be identified and commented upon. Other issues will require some change to current rules, procedures, or practices if they are to be resolved. In those instances, the Panel has made recommendations to that effect.

[202] Before addressing these issues, it will be helpful to briefly summarise the key facts and some of the conclusions reached by the Panel after considering all of the information, materials and submissions before it.

Key facts and conclusions

[203] Finistere’s keel separated from its hull at approximately 23:45 hours while it was racing with reefed sails. The yacht immediately rolled over then inverted. The crew had neither the opportunity nor the time to drop sails or take any preventative action.

[204] Three crew above deck were thrown into the sea. Only two of them were wearing lifejackets and only one was tethered to the boat. One of them, Dr Weaving, was shortly thereafter sucked back under the hull into the cockpit space.

[205] Three crew below deck escaped from the cabin and swam out under the stern of the upturned hull. Their ability to do so was facilitated by the very fortunate fact that they were not wearing lifejackets.

[206] All clung with difficulty to the upturned hull which was rising and falling with each wave. Backwash from the hull significantly impeded their breathing and they rapidly tired.

[207] The skipper, who was not wearing a life jacket, drifted away from the hull despite the best efforts of others. He was not seen alive again.
Mr Owens drowned while still clinging to the hull.

Dr Weaving’s AIS beacon automatically activated when she fell into the sea. It transmitted a brief distress signal with an inaccurate position prior to Dr Weaving being swept back under the hull. That signal was received by the nearby yacht, Fourth Dimension, which because of difficulty in identifying its source, sailed away from Finistere towards the inaccurate position.

Meanwhile, two PLB signals from Finistere’s crew were received by AMSA which initiated a search and rescue mission before midnight. A helicopter was quickly deployed and found Finistere’s upturned hull a little more than half an hour later.

At the request of Water Police, nearby yachts were diverted towards Finistere for the purpose of rescuing her crew. Huckleberry was the first to arrive and took three survivors on-board. A Water Police vessel then rescued Dr Weaving who had swum from under the hull, and also recovered the body of Mr Owens.

The yachts, Circa and Fourth Dimension, were later engaged to search a designated area and the latter did so until around noon the following day.

Mr Thomas’ body was located and recovered that same day.

The skippers and crew of these yachts are to be commended for their seamanship and actions that night.

The Panel acknowledges the traumatic effect on some of them and recommends that their clubs continue to reach out to them and check on their wellbeing. The Panel also recommends that RFBYC continue to monitor the wellbeing of its volunteers and staff who were emotionally affected by the tragic events on the night.

The race administration, pre-race preparations and race control operations were generally of a high standard. Nevertheless, there were some flaws.

Mr Milton is a capable, competent Race Officer and a man of substance. He showed initiative during his swift and appropriate responses to the emergency, as well as grit in his dealings with Water Police. However, these leadership qualities were of little benefit to the race control team at RFBYC while he was home during the first hour or so of the incident. This highlights the need for a Deputy Race Officer to be present whenever the Race Officer is absent from the radio room.
The radio room team as a whole performed well, and the Panel particularly notes the widespread praise from race participants of Mr Wellington’s cool, calm and professional handling of VHF traffic. Unfortunately, this high level of performance did not extend to record keeping and the Panel has been deprived of important information as a result of the poor quality of the log at critical times.

**Ocean Racing Western Australia’s system of race control**

ORWA should be commended for initiating its novel race control system under which all organising authority clubs have joined together to use (to a greater or lesser extent) the one race control team for all ocean races. This not only improves efficiency, but brings about greater consistency in race management including the application of standards which enhance sailor safety.

If the Panel has any criticism, it is that too much of the workload of race control seems to fall on too few a number of volunteers' shoulders (most of whom have day jobs). This subject is expanded on below.

**Royal Freshwater Bay Yacht Club’s race control structure**

Under RFBYC’s Constitution (clause VIII), the management of the club is in the hands of its Committee which may appoint sub-committees of members for specific purposes and with delegated powers.

Although Mr Milton is not a member of RFBYC, he was appointed to the 2018 BROR Race Committee. This was done for understandable reasons but is contrary to the Constitution. The temporary membership provisions do not provide any answer because he was not a visitor to the club for the entire time he was on the Race Committee.

Furthermore, the Panel notes the paucity of documentation recording the appointment of the Race Committee as a whole, or the extent of the powers it was delegated. All of these issues can be easily resolved in ways which do not increase the administrative workload but will probably reduce it. In this regard, the Panel recommends that:

a) The club amend its Constitution (clause VIII) to allow the temporary appointment to a sub-committee of a non-member who has expertise of value to that sub-committee.

b) The club’s Committee adopt a standard template for appointing sub-committees and for delegating their powers to act.

Appendix 4 to this report is a suggested model template for the appointment of an ocean race Committee. Its important features are:
• The whole of the Race Committee has delegated power to make all decisions necessary for the conduct of the race.

• During the racing period, that power transfers to the Race Officer but only to the extent necessary to ensure the proper and safe conduct of the race.

• The Race Officer’s power is also limited by the exception that any decision which might result in unbudgeted expense or damage to the club’s reputation, requires the approval of the Deputy Race Officer or Race Committee.

• The appointment of a Deputy Race Officer as well as a Race Officer so there is always a ‘chain of command’. The Deputy Race Officer will be a club member with authority to consent to certain decisions as referred to above.

• At least one of either the Race Officer or Deputy Race Officer must be present in the radio room throughout the race.

The Panel also suggests that RFBYC explores whether there is a need for a Race Committee (RRS 89.2; 90.1) to be a separate entity from the Offshore Committee. An amalgamated committee would result in greater efficiency in the management of RFBYC’s ocean racing program.

The Race Officer’s absence from the radio room

We have earlier referred to the unusual circumstance with the 2018 BROR that the Race Officer was not necessarily expected to attend at the radio room. This practice developed over time, mainly because radio race control was once the Southern Race Control based at a distant location south of Mandurah, and it was convenient for the Race Officer to remain near the start and finish lines at Fremantle.

When these arrangements changed and radio race control returned to RFBYC’s clubhouse, the physical separation between the Race Officer and the radio room continued. However, this separation can cause problems as shown at one point during the early stages of the incident when the radio room had to wait to speak to the Race Officer because he was engaged on another phone call.

Despite the benefits of modern communications which usually allow people to have instant contact with each other, the Panel does not consider this to be a wise arrangement. Ordinary human experience shows that people can best coordinate their activities if they operate in an environment where they are in face to face contact with each other.
There is nothing to suggest that the physical separation of the Race Officer from the radio room at the early stages of the Finistere incident in any way delayed or impacted on the outcomes. Nevertheless, the Panel regards any absence of the person in authority from the command centre as a serious potential weakness.

Obviously, a race officer will need to leave the race control room temporarily from time to time. When this happens, there must be a designated change of command so that a person in authority is always present to make any decisions that may suddenly be required. The template we have suggested for appointment of race committees would achieve that state of affairs, but the Panel in any event recommends that for each ocean race, there be a Deputy Race Officer who has full authority to exercise the Race Officer’s powers during the latter’s absence.

Whether the race was in the right category

The sport of sailing is governed by the Racing Rules for Sailing 2017-2020, commonly referred to as the Blue Book and the Blue Book is expanded by Special Regulation - Part 1 for Racing Boats.

Under the Special Regulation, the organising authority for any ocean race is required to select the category deemed most suitable for the type of race to be sailed (1.01.3(a)).

There are seven race categories ranging from trans-oceanic races (0) to short races in daylight hours in sheltered waters (7).

RFBYC as the organising authority for the BROR deemed it to be Category 3 which is for:

> Offshore races across open water most of which is relatively protected or close to shorelines.

Category 2 is defined as:

> Offshore races of extended duration along or not far removed from shorelines or in large unprotected bays or lakes, where a high degree of self-sufficiency is required of the yachts.

The category of a race determines what safety equipment must be carried and what minimum standards of experience the crew must demonstrate.

An important difference between Category 2 and Category 3, is that Category 2 requires the yacht to carry a life raft and each crew member to carry a PLB.
The SSIs for the 2018 BROR however required that in addition to Category 3 requirements, all boats had to have a PLB registered with AMSA for each crew member. Also, the PLB numbers had to be submitted with the crew lists two days before the start of the race.

Accordingly, the safety requirements for the 2018 BROR went beyond those for Category 3 and partially met those applicable to Category 2. No doubt the reason for that decision was that the BROR was thought to present a higher level of challenge for sailors than most Category 3 races.

The Panel queries whether the BROR is properly a Category 3 race. In the Panel's opinion, it is a race of 'extended duration', is certainly 'along or not far removed from shorelines', and for some of its length is in a 'large unprotected bay'. The only real issue is whether 'a high degree of self-sufficiency is required of the yachts'. In particularly strong conditions, that level of self-sufficiency would be required and in the Panel's opinion, Category 2 better describes the event.

The Panel recommends that RFBYC in consultation with Australian Sailing, reconsider the category prescribed for the race.

Untimely or inaccurate crew lists

It is acknowledged that in the weeks leading up to a race, a skipper will be very busy as there are many tasks to complete. One of those tasks is to compile and submit the crew list with names and contact details of crew members as well as those they wish to be contacted in the event of an emergency.

This task can be complicated by changes in the relevant details as well as changes in the crew themselves. In this regard, late crew changes are increasingly common and skippers are sometimes placed in great difficulty in quickly finding a replacement for a crew member who has suddenly become unavailable.

For these reasons, there is often a small minority of skippers who fail to comply with the two day pre-race deadline for submission of crew lists. This failure causes immense trouble for offshore administrators who have to prepare the totality of crew list information in a form suitable for AMSA and to forward it only when the form is complete. In this regard, some skippers do not seem to appreciate that offshore administrators have their own deadlines which simply must be met.

Also, the crew lists are sometimes prepared in haste without enough regard to accuracy. The Panel has itself observed misspelled surnames as
well as incorrect phone numbers in crew lists (discovered when trying to contact the people concerned).

[246] Failure to provide accurate and timely crew information has the potential to prejudice the safety of participants in a race. If the problem persists, organising authority clubs may need to consider the sanction of disqualification in the event the deadline is not met.

[247] The Panel does not make any recommendation to this effect but flags that such a response might ultimately be necessary if the risks of inaction become too great.

**Australian Maritime Safety Authority having the wrong telephone number**

[248] When shortly prior to 23:50 hours on 23 February 2018, AMSA first tried to contact race control and was unable to do so on the number it had been given. This was due to administrative inadvertence within RFBYC in allowing that particular phone service to be disconnected because of non-renewal.

[249] However, normal communications were soon established as a result of AMSA having a backup number. Importantly, this short delay in making contact had no impact on the search and rescue operation which was still to commence. That operation was later triggered (without the need to contact race control) when AMSA received the second PLB signal.

[250] Obviously in different circumstances, this error might have had dire consequences. Although something that should never have happened, it is the type of human mistake that sometimes occurs even in the most-well run organisations.

[251] The Panel has not sought to identify the staff member or members responsible for this error. It is enough that this report highlights the error so there will be greater care to ensure it never happens again.

**The decision to start the race**

[252] The Panel examined evidence of the projected weather conditions and heard from the Race Officer, Mr Milton, and others. The decision to race was discussed amongst members of the Race Committee and others outside the committee were consulted.

[253] The Race Officer took all relevant matters into account including the number of yachts and their experience. He decided to start the race having had regard to the weather.
Other sailors when asked by the Panel considered the decision had been the correct one and expressed no concern about the conditions, which were forecast to moderate later in the race.

At best, one yacht withdrew before the start after weighing up the predicted conditions and the limited experience of some of its crew. In respect of the remaining boats, the Blue Book (RRS.4) provides that:

*The responsibility for a boat’s decision to participate in a race or to continue racing is hers alone.*

This fundamental rule of racing does not relieve the Race Officer of responsibility to carefully consider and consult on all relevant factors when deciding whether or not to start a race.

In the Panel’s opinion, the Race Officer fulfilled this standard of care and responsibility when deciding to start the race. It believes his decision was the correct one but only came to this conclusion after considering the views of a number of participating skippers and hearing from the Race Officer himself.

In this regard, there is no written record how the decision was made or of the factors that were taken into account. Good governance requires that there always be such a record for what is probably the most important decision when conducting a race.

Accordingly, the Panel *recommends* that a contemporaneous record be made of the decision to start or not start a race and that record include all factors taken into account in reaching that decision.

Appendix 5 to this report is an example of what the Panel considers to be a suitable model template for recording these decisions. This document should be easy to use and can be modified to meet the particular needs of any individual race.

**The radio room**

As can be expected, the radio room team of nine dedicated volunteers comprised individuals with varying skills and capabilities. Most of them were elderly and had long experience helping to run previous annual BROR.

Despite wide experience in the radio room, the Panel has identified some shortcomings which undoubtedly detracted from their performance (particularly with regard to log keeping).

The majority of the team had retained up to date skills and were fully capable of doing all that was required of them on the night. However, one
team member ‘got annoyed’ shortly after the start of the incident because a more elderly volunteer told him “I don’t use mobile phones” and “I don’t know anything about computers”. He then had to demonstrate to this other team member how to use a mobile phone and how to access the computer to view the YBT.

[264] This demonstration occurred in the background while the incident was being managed by the two operators at the radio desk. There is no reason to believe that the elderly volunteer’s unfamiliarity with mobile phones and computers in any way affected the radio room’s response to the incident or that it delayed the search and rescue. However, it shows there were problems in the selection of the volunteers who were rostered for that night.

[265] Furthermore, the fact that the Guidelines for Radio Room Operations included instructions for use of its mobile phone, computer and YBT shows there was also a problem in ensuring that volunteers could follow those instructions.

[266] Volunteers are a cherished and precious asset for organisations such as RFBYC. Their contributions are vital to the life of the club and enable its core activities to take place. But in a working situation where lives may depend on the skills of volunteers, respect for venerability must give way to a thorough and realistic assessment of their abilities. (It is significant in this regard that two team members have separately suggested there are others who should not be on the team.)

Accordingly, the Panel recommends that RFBYC carry out a full reassessment of all existing radio room arrangements with a view to:

a) Selecting a volunteer to take charge of the roster (ideally the Deputy Race Officer).

b) Ensuring all volunteers have the basic skills required in a modern working environment with up to date technology.

c) Allocating roster duties to each volunteer which are consistent with their overall abilities.

d) Teaming pairs of volunteers on duty so they have complementary skills.

e) Establishing a set of standards for radio room operators to follow.

f) Training radio room operators to meet those standards.

g) Ensuring that at times of heavy traffic a proper log is kept (the Panel suggests that digital recordings during busy periods may assist).
h) An ongoing program of renewal including recruitment of younger volunteers.

The role of nearby yachts during an Australian Maritime Safety Authority sea and rescue

[267] It is fair to conclude from all of the information gathered by the Panel that AMSA and Water Police prefer to conduct search and rescue operations without the need of external resources, but will do so if that becomes necessary.

[268] The reasons are understandable. When external resources become involved, this may require additional and unpractised coordination with organisations that have only infrequent involvement in operations that AMSA and Water Police regularly conduct every day. From their perspective, any external involvement in critical decisions which need to be quickly made can only reduce efficiency, complicate management of the emergency response, and perhaps cause delay.

[269] A further problem in coordinating with external bodies during emergencies is that AMSA and Water Police now use encrypted UHF channels for their critical communications. This is a sensible practice because it avoids the need to use VHF channels which may be cluttered with heavy traffic. This quarantining of critical communications obviously increases the efficiency of the operation and is likely to result in a swifter rescue. It also allows communications which should not be in the public domain to remain private.

[270] When AMSA or Water Police use external resources, they also take on the burden of communicating necessary information to additional parties on traditional VHF channels. In this respect, their usual experience is that they need to communicate on VHF to only the vessel in distress, which is easy to do. It can be very different when external parties become involved in the search and rescue. During the Finistere incident, Water Police had to communicate on VHF with race control and the three yachts engaged in the rescue and later search. This had to be done on already crowded VHF channels.

[271] For these reasons, it is easy to appreciate why AMSA and Water Police request external help only when the assets they usually work with are unavailable or cannot provide a swifter response. A request by Water Police for assistance from a ‘nearby yacht’ should always be seen in that context.
It is relevant to note that yacht skippers, must in any event, comply with the International Convention for Safety at Sea (SOLAS). SOLAS requires the master of any vessel which can do so without serious danger to itself:

a) to render assistance to any person found at sea in danger of being lost; and

b) to proceed with all possible speed to the rescue of persons in distress, if informed of their need of assistance, in so far as such action may reasonably be expected of him.

These obligations reflect the honourable tradition of the sea that vessels in the position to do so should always render assistance to other sailors in distress.

The time taken for Huckleberry to reach Finistere

When Huckleberry was diverted by race control to carry out the rescue, it was told the position where Finistere would be. The only radio room record of that transmission is in the 'rough sheets' and it states:

12.27 Huckleberry told by us to divert.

As can be seen, that entry did not record the position given to Huckleberry. The only other entry in the 'rough sheets' which may possibly relate to that transmission, was two minutes earlier which read:

12.25 Pan Pan – Coast Ra.

32.33.48 115.27.47

PBL [sic] activated.

However, that position does not seem relevant because it was well to the south of Huckleberry’s YBT track while on its way to the rescue and was even further south of Finistere’s actual position. Furthermore, '12.25' was not the time of the second PLB activation which had been notified to Ms Ghent (by AMSA) at about 12:15 hours.

The Panel was not able to resolve these anomalies during interviews because the key operator who made the transmission at 12:27 hours and wrote both entries, could not recall any pertinent details. A great many things were happening at the time and it may well be that the '12.25' entry was made retrospectively by when memories were confused by a poor recollection of events.

Despite the Panel’s best endeavours, it has been unable to determine the position that *Huckleberry* was instructed by the radio room to divert to.

What is known is that the position where *Huckleberry* first arrived, was not the right one. Based on the YBT tracks of *Huckleberry* and *Fourth Dimension*, the only reasonable conclusion is that *Finistere* was a considerable distance away to the north-north-west. It was only after a crewman sighted the distant silhouette of *Finistere’s* upturned rudder that *Huckleberry* headed in the right direction.

In these circumstances, all that can be said is that there may have been some delay in *Huckleberry* reaching *Finistere* (because of the course taken to get there) but if so, the reasons for that happening are unknown.

For a number of reasons, it also very difficult to estimate any period of delay. An analysis of *Huckleberry’s* YBT data suggests it took about 20 minutes to reach *Finistere* from the most south-westerly point in its track where it had made a sharp starboard turn to head north-north-west. That does not mean there was a delay of 20 minutes because there are other factors to consider.

Firstly, by the time *Huckleberry* was diverted, the wind (as recorded at Mandurah) had veered to the south-east. If *Huckleberry* had headed directly for *Finistere’s* actual position, the wind would have come directly from behind with the risk of dangerous gybes (ie wind gusts causing the main sail boom to suddenly crash across to the opposite side of the yacht with consequent loss of control and danger to the crew).

Good seamanship would have required the skipper to decide whether to sail a zigzag course towards *Finistere* or alternatively drop the sails and use the motor to take a direct course. This would have been a matter of judgment based upon the wind and wave states as well as the likely speeds under sail or under motor. It would be highly speculative to try and guess what the skipper might have done, and even more speculative to attempt any estimate of possible savings in time.

For these reasons, the Panel is unable to say whether a direct course would have resulted in an earlier rescue. This is an issue which will have to remain unresolved.

**Notification of next of kin**

This report has already outlined the appalling situation whereby Mr Thomas' next of kin was ‘the last to know’ that *Finistere* had capsized and that her husband was missing.
Mr Owens’ emergency contact was his father, Mr Kevin Owens, who was away interstate at the time of the incident. The police discovered this when they visited his home around 08:00 hours on 24 February 2018. After speaking to neighbours, they located Mr Owens’ sister and informed her of the capsize and death at about 13:30 hours. The Owens family does not raise any issue about the time it took to inform them.

The cause of late notification to the Thomas family was the standard police policy that in cases of sudden or suspected death, the next of kin should not be informed until there is certainty as to the facts and the identity of the victim.

The reasons for this policy are understandable and no doubt there have been incidents in the past of families being mistakenly informed of a loved one’s demise, when in fact the person was alive. The trauma caused in these circumstances would be immense and police must necessarily be cautious when approaching families about a death which is believed to have happened but not yet confirmed.

In the present instance and until the body was found, Water Police were not completely certain that Mr Thomas had drowned, but had strong reasons to believe this had happened. It was their decision to delay informing the family of this situation. However, many friends and acquaintances of the family were aware of what had happened and news of the incident was spreading amongst the general public. This is to be expected in an age of mobile phones and social media.

The Race Officer was in a difficult situation because he knew the next of kin and strongly believed they should be informed of the incident. However, each time he expressed this view to Water Police, he was told it was their role to perform this task and he was not permitted to do so. The Race Officer reluctantly complied with those assertions because of his upbringing that he should ‘do what police say’.

In these circumstances and given the pressures the Race Officer was under, the Panel does not criticise his failure to notify the families. He was unaware there was no law which prevented him informing next of kin and it was reasonable for him to accept the police assertions as to their role.

When sailors provide emergency contact details, most of them expect that race control will notify the nominated person of any event which adversely impacts on them during the race. Others might not wish that to happen (perhaps because of the worries caused to next of kin) but submit their emergency details because they are required to do so. The Panel considers there is a moral obligation to comply with the wishes of each sailor whatever they may be. There is also a need for clarity about race
control’s responsibility to notify next of kin when police object to it doing so.

[293] For these reasons, the Panel **recommends** that the SSIs for future races include a provision to the effect:

Prior to submitting crew lists skippers must confirm with each crew member that he or she requests race control to notify their emergency contact of any incident at sea detrimental to their health or wellbeing. Unless advised to the contrary (on the crew list), race control will assume each crew member requests this be done.

[294] Skippers might think this requirement will increase the burden of their pre-race preparations. However, with regular crew members, they will know what their wishes are in this respect. With any new crew member, it is simply a matter of asking an extra question at the time of obtaining emergency contact details.

[295] Emergency incidents at sea occur in a wide variety of circumstances but whatever their nature, the race officer is always very busy responding to them. The decision to notify next of kin is a difficult and sensitive task, particularly in circumstances (such as the *Finistere* incident) where not all of the facts are known. The Race Officer will not always have the time required to carefully consider whether, when, and what facts next of kin should be told.

[296] It will be extremely helpful to Race Officers in this situation to have a set of guidelines outlining the considerations they should take into account when making such a decision. Accordingly, the Panel **recommends** that:

RFBYC firstly approach the WA Police Force to see whether it is willing to revise its procedures so as to avoid any future need for Race Officers to notify next of kin of serious emergencies at sea. Failing a positive response to that request, RFBYC (in consultation with other yachting authorities as it considers appropriate) develop guidelines for Race Officers to notify next of kin of such emergencies. These guidelines should include suggestions that the Race Officer:

- First check with police whether they already have, or intend to contact next of kin (and if so when).
- Consider what facts about the incident can be stated with certainty and what facts are merely assumptions or speculation.
- Carefully consider the facts to be told to next of kin bearing in mind that these should be completely truthful and accurate.
- Ascertain whether or not news of the incident has spread to the public or to people other than next of kin.
- Carefully consider the time when next of kin should be told.
- Consider whether counselling services should be made available prior to next of kin being told.

**The decision not to abandon the race**

[297] When it became known that one or more people had died, the Race Officer conferred with RFBYC as to whether or not the race should be abandoned.

[298] After considering other races, including the Sydney to Hobart 1997 and Fastnet 1979, the decision was made to let the race continue until completion. There was no particular danger to the yachts still racing which would require the race to be abandoned.

[299] However, the Panel does have some concerns about the decision. Firstly, past decisions are not always useful precedents, particularly when the decision to continue may have occurred because it was impractical or unsafe to do otherwise.

[300] In the present instance and in light of the improving weather conditions, the Panel does not consider that it was impractical or dangerous for the race to be abandoned. Race control would have continued to monitor VHF channels 16 and 82 and in the Panel’s opinion, there would not have been any additional safety risks arising from yachts ceasing to race.

[301] Secondly, and although the Race Officer and Crisis Management Group did have regard to the ‘optics’ of continuing to race when there had been at least one fatality, it is our opinion that they should have given that factor greater weight. Most reasonable people would agree it was not a ‘good look’ to have returning yachts racing to the finish through the area of the grid search for a missing skipper, and this continued to happen when it was known he was dead. Some reasonable people might also think this was disrespectful to both deceased.

[302] RFBYC did make the decision to abandon all club events scheduled for Saturday afternoon out of respect for those who had lost their lives. It does seem odd that similar considerations did not play a greater part in the decision to continue the BROR.

[303] Despite the above, the Panel does not criticise the Race Officer for his decision or the Crisis Management Group for confirming it. With the leisure of hindsight, it is very easy to differ on what was done and the
Panel has not had to reach its opinion while stressed and under pressure. There can be no doubt that the Race Officer and the Crisis Management Group gave very earnest and genuine consideration to the matters they had to decide and it would be unfair to ‘second guess’ them. The Panel does emphasise though, the limited significance of precedent. Every incident is different.

**The comparative benefits of Automatic Identification System beacons and Personal Locator Beacons**

[304] Expert opinions differ as to the relative merits of AIS beacons as against PLBs and also on which system is the best for yachts to use. The Panel has compared the circumstances of the *Finistere* incident with other types of emergencies and considered which of the alternative distress signal systems would be best in various different situations.

[305] Before outlining the Panel’s conclusions on this subject, it is helpful to put a proposition of the ‘what if’ variety. If Dr Weaving had not been swept back under the hull after falling into the sea, her automatically activated AIS beacon would have continued transmitting signals to its full range with a position which would have become increasingly reliable and accurate.

[306] *Fourth Dimension* would have received that signal and soon realised the beacon was located at the position which (with hindsight) was that of *Finistere*, and not the false position it actually went to. Obviously, *Fourth Dimension* would have then changed course and (unbeknown to those on-board) headed directly towards *Finistere*.

[307] At the time the AIS signal was first received, *Fourth Dimension* was sailing hard on the wind on a parallel course to the east of that of *Finistere* (prior to the capsize). The YBT data indicates that *Fourth Dimension* was then travelling at a speed of 6.2 knots and was no more than two miles away. To change course towards *Finistere*, *Fourth Dimension* would have eased its sails, thus increasing its speed.

[308] There would have been some reaction time while *Fourth Dimension* assessed the situation and changed course in response to the signal. As it approached *Finistere*, the constantly recalibrating AIS bearing and distance data would have guided *Fourth Dimension* to the precise location of the beacon.

[309] The time it would have taken *Fourth Dimension* to do this, is a simple matter of calculation based upon assumptions as to speed and reaction time. A very conservative calculation produces the result that it would probably have taken twenty minutes and no more than half an hour. A
rescue commenced at the end of that period would probably have had better outcomes than those which actually occurred.

However, the rescue did not happen in that way but occurred as a result of two PLB signals received by AMSA. The search and rescue operation was not initiated until after the second of those signals was received. Here again there was reaction time including the marshalling of resources. The PLB signals were obviously accurate and there was another nearby yacht available which arrived in the immediate vicinity of Finistere at about 01:04 hours (approximately one hour twenty minutes after capsize).

Although the rescue resulting from the PLB signals was comparatively swift, the potential that Dr Weaving’s beacon had to bring about a much quicker outcome (if she had not been sucked under the hull) is obvious.

The Panel has considered all of the above as well as the potential capabilities of each distress system in the varying circumstances of the different type of emergencies that can occur. It believes the following propositions to be true.

The advantages of AIS beacons are that:

- If fitted properly, they will activate automatically and immediately send a distress signal when a lifejacket inflates. This makes an AIS beacon very appropriate for MOB situations. It has significant advantages over PLBs if the sailor is unconscious or if others on-board were unaware that an MOB had occurred (it is the AIS audible and visual alarm on the plotter which alerts them).

- It also follows that there are better prospects for a swifter and successful rescue in those situations. An unconscious sailor cannot manually activate a PLB and crew who did not observe an MOB would only become aware a significant time later if notified by AMSA, or if noticing in the meantime that someone was missing. By then, the MOB would be a long way astern, so an AIS beacon in these situations has a huge advantage over PLBs.

- If programmed to do so, an AIS beacon can also transmit the identity of the boat it has come from but only in the form of the boat’s Maritime Mobile Access Service Identity (MMSI) number and not its name. This is done by the sailor manually pressing a button on the device. (With PLBs, the boat is identified by AMSA from the registration details or from information supplied by organising authority yacht clubs).
• Whatever the circumstances, if a signal is received from an AIS beacon, the rescue will usually be much swifter than with a PLB because the boat receiving it will be within a four to five mile range (this is so whether or not the boat is the one the sailor fell from).

• Rescue will also be much more certain in response to an AIS signal. This is because the beacon constantly recalibrates its bearing and distance on the rescuing vessel’s plotter. In this way the vessel is continuously guided to the exact location of the sailor.

• Accordingly, there is no search required in response to an AIS signal and it is simply a rescue.

• For the above reasons, an AIS beacon also has a big advantage over PLBs for rescues at night or in conditions of poor visibility.

[314] The disadvantages of AIS beacons are:

• The signal from an AIS beacon can only be received by yachts within a four to five nautical mile range, whereas PLBs have the capacity to bring AMSA alerted search and rescue from vessels outside that range, as well as from helicopters and professional sea rescue services.

• A vessel can only receive an AIS signal if it has a compatible plotter and not all boats have this facility.

• The Panel has established that current AIS mobile phone apps do not allow handheld devices to receive distress signals directly. Signals can only be relayed from shore stations or vessels equipped to do so. Accordingly, the potential benefits of such apps in search and rescue situations are very limited.

• For the above reasons, rescue is much less likely when a boat is suddenly abandoned in circumstances where there is no opportunity to send a mayday or set off flares, and there is no other compatible vessel within a four to five nautical mile range.

[315] The advantages of PLBs are:

• PLBs are the only beacon which will attract a rescue response in circumstances where the AIS beacons host vessel and its mounted EPIRB is disabled or sinking, and no other AIS compatible vessels are within a four to five nautical mile range. This is a very big advantage.
• Once a PLB signal is received by AMSA, it has the potential to trigger a much more massive response than one from an AIS beacon. A greater range of assets for rescue will usually be available.

• AMSA is in a better position to coordinate the response to emergencies which require multiple assets and/or complex methods of search and rescue.

The disadvantages of PLBs are:

• They require a search to be conducted as well as a rescue.

• The position given by a PLB is less precise than that transmitted by an AIS beacon.

• In MOB situations, there will always be some delay (and perhaps difficulty) in manually transmitting a PLB signal as compared to an automatically activated AIS beacon. There is always scope for more things to go wrong with a manually activated transmission than with one that is automatically activated.

• There will always be at least a small delay in AMSA responding to a PLB signal (eg by checking it was not an accidental activation). With an AIS signal, provided there is a compatible boat within range, the response (apart from any reaction time) is immediate.

• Rescue vessels responding to a PLB signal lack the precise constantly recalibrated guidance provided by an AIS beacon.

In the Panel’s opinion, when all of these factors are taken into account, it is obvious that each distress signal system has particular advantages over the other in certain (but differing) situations. The ideal is to have the best of two worlds with each crew member carrying both beacons, which are preferably (and certainly in the case of the AIS beacon) properly fitted to lifejackets.

AIS beacons currently cost about $350 and the expense of equipping crew members would not trouble some yacht owners but would be a worry for others. Although the Panel believes it is highly desirable that all ocean sailors should carry both beacons, it considers that it is a decision for each skipper to make.

Accordingly, the Panel recommends that:

a) The SSI’s for its future Category 2 and/or 3 ocean races should include a 'strong recommendation' that all crew carry an AIS beacon properly
fitted so that it will automatically activate upon inflation of a lifejacket;

b) Those SSIs include a further 'strong recommendation' that prior to each race, skippers check that all crews' AIS beacons have been programmed with the yacht's MMSI number; and

c) ORWA be requested to include in the annual Yellow Book a list of MMSI numbers against names of yachts so these may be easily identified.

The Yellow Brick Tracker

[320] YBTs are now routinely issued for regattas and are often used in ocean racing. They are a valuable aid to people wishing to follow a race but are not designed for use as an instrument for the purposes of search and rescue.

[321] A tracker will update a yacht's position periodically and broadcast an update at specified times depending on the contractual arrangements. For the 2018 BROR, the position of each yacht was updated every five minutes and broadcast every 15 minutes.

[322] The last broadcast from Finistere's YBT was at 23:30 hours and there was no broadcast 15 minutes later, which strongly indicates that the capsize occurred before 23:45 hours. The recorded tracks of other yachts while involved in the search and rescue have been of great help in understanding all that happened. These tracks will similarly assist readers of this report so the Panel has attached the following screen shots (the first on 23 February 2018 and the others the next day) from the YBT replay of the race:

- Appendix 6.1: at 23:30:38 hours showing Finistere at its last broadcast position and the tracks of the then nearest yachts.

- Appendix 6.2: at 01:00:00 hours showing Huckleberry after turning towards Finistere; Fourth Dimension after diverting from its intended search of the AIS signal location; as well as Circa.

- Appendix 6.3: at 01:30:00 hours showing Huckleberry and Fourth Dimension after they had reached Finistere, as well as Circa nearby.

- Appendix 6.4: at 02:00:00 hours showing Huckleberry after rescuing three survivors and heading towards Fremantle; Fourth Dimension beginning to search the MOB/AIS signal location and Circa conducting a wider search downwind of that position.
Appendix 6.5: at 02:00:00 hours showing a wider view including all yachts still racing.

Some submissions have called for the YBT system to play a greater role in search and rescue, but the Panel lacks the expertise and resources to judge the merits of the proposal. It is a decision which should be left to AMSA and yachting’s governing bodies. The Panel makes no recommendation.

Problems with local sailing culture regarding safety

The minimum safety standards prescribed by the Special Regulation in the Blue Book have developed over time as a result of lessons learned from past yachting tragedies. Each time a life was lost at sea, the causes were mulled over and consideration given to how it could have been prevented (this Panel has embarked on the same process).

Often, it was decided that minimising the risk of future such tragedies required additional safety measures in the Blue Book. When this happened, some yacht owners accepted the added measures stoically but others grumbled about the inconvenience and cost. In this regard, there can be little doubt that increasing costs of safety compliance have put downward pressure on the fleet numbers of ocean racing yachts. This is also a factor that has sometimes influenced organising authorities in their choice of category for a race.

Sailing is a magnificent but challenging sport and no matter what precautions are taken to minimise the inherent risks, there will always be occasions when lives are lost at sea.

In the end, any decision about appropriate safety standards for ocean going yachts is a matter of balancing the extent and degree of a particular risk against the reasonableness, effectiveness and costs of proposed measures to reduce it.

When making that decision, another factor to be considered is whether existing safety measures have been effective in minimising the risk. In the present instance, there is reason to believe otherwise because an experienced and highly respected senior sailor was on deck for a lengthy period of time after sunset without wearing a lifejacket. The Panel does not consider this was a unique example of failure to heed the basic safety requirements of the Blue Book.

In this regard, the Panel accepts that most skippers adhere to the minimum safety standards as prescribed in the Blue Book. Some are known to observe even higher standards as noted earlier in this report.
Nevertheless, and as a matter of common knowledge, some are less diligent than others in looking after themselves and their fellow crew.

[330] In these circumstances, if there are inexpensive measures which can be taken to improve safety for all sailors, it is no answer to say that those failing to comply with existing requirements should be left to face the consequences of their own negligence. Organising authorities should recognise a potential for legal liability notwithstanding RRS Rule 4 or Special Regulation 1.02.

[331] Depending on the circumstances, a duty of care may arise even in respect of those who are careless for themselves.

[332] In recommending changes to the safety requirements for RFBYC ocean races, the Panel has taken into account all of the above considerations. It is not within the Panel’s remit to recommend changes to the safety standards in the Blue Book itself.

[333] But those standards are only minimum standards and RFBYC is in a position to implement additional safety standards for each of its own ocean races.

**Sprayhoods on lifejackets**

[334] The Blue Book requires that each crew member have a lifejacket which complies with the detailed standards set out in Special Regulation 5.01.01. These standards ensure that all lifejackets are modern inflatable personal floatation devices (PFDs) and not the bulky ‘Mae Wests’ of the past. Accordingly, lifejackets are now much more comfortable and less physically restraining than they used to be.

[335] Added requirements are that each lifejacket have marine grade retro reflective tape, a whistle attached and a crotch strap or thigh straps fitted. Also, for Category 1, 2 and 3 races:

> It is strongly recommended that lifejackets be fitted with a splashguard/sprayhood.

[336] The use of splashguards or sprayhoods on lifejackets is not as widespread as it should be. All sailors who have undergone an AS SSSC would understand the difference these devices make to the prospects of survival for sailors in lifejackets adrift in rough seas. Without a spray guard of some sort, sea water is inevitably swallowed and may lead to drowning.

[337] One of the lessons learned from the circumstances of the *Finistere* incident, is that splashguards or sprayhoods are essential to the survival
of sailors in situations where they are being repeatedly immersed by the waves.

[338] Although the particular experiences of the *Finistere* crew were unique, there can be many types of situations where splashguards or sprayhoods are vital for survival.

[339] After taking account of the considerations (including cost) referred to earlier, the Panel **recommends** that for all Category 2 and 3 RFBYC ocean races, the fitting of splashguards or sprayhoods to lifejackets should not just be ‘strongly recommended’ but mandatory.

**The wearing of lifejackets generally**

[340] The Blue Book in Special Regulation 5.01.1(g) requires that:

> A lifejacket shall be worn by each member of the crew when on deck between the hours of sunset and sunrise.

[341] A significant factor which contributed to the tragic outcomes of the *Finistere* incident was that in one instance, the rule was ignored and in others, the crew members did not have any opportunity to comply (because of the swiftness of the capsize).

[342] That there may be a more widespread failure to wear lifejackets at night is confirmed by the Panel’s surprising discovery that some experienced sailors are genuinely unaware of the rule. This perhaps indicates the extent to which some skippers do not bother to enforce the rule.

[343] With regard to the wearing of lifejackets, it is also relevant to note that Special Regulation 5.01.1(h) makes this additional recommendation:

> It is strongly recommended that a lifejacket be worn by each member of the crew at times, such as, but not limited to:

- (i) When alone on deck
- (ii) When the true wind speed is 25kts or above
- (iii) When visibility is less than one nautical mile

[344] Obviously, different considerations apply below deck where lifejackets generally should not be worn. In this regard, the *Finistere* incident provides the example of the crew member below deck who responded to the capsize by starting to don his lifejacket which then inflated and hampered his exit out of the cabin.

[345] The Panel has given serious consideration to the wider question whether the wearing of lifejackets should be mandatory at all times during an ocean race. This is a standard requirement for double-handed sailing and
does not seem to have caused a problem with those races. There is also
the example of the yacht that has adopted the practice of requiring crew
members to don lifejackets before leaving the pen and to wear them
while on deck until the race has finished. Despite grumbling from some
new crew unaccustomed to this regime, it is considered to be a success.

[346] Opinions differ amongst the sailing community as to the efficiency of
wearing lifejackets at all times on deck and the comments sometimes
made are that they would be oppressive in hot weather and unnecessary
in calm conditions. These were valid objections in the time of Mae Wests,
but perhaps ignore the fact that modern lifejackets are now more
comfortable and slim.

[347] The fallout from the Finistere tragedy and the angst it has caused presents
a window of opportunity for these issues to be totally reconsidered. The
starting point for this exercise must be a common acceptance by all that
issues of comfort and convenience must always be secondary
considerations to the reasonable requirements of safety.

[348] The Panel **recommends** that RFBYC in consultation with Australian
Sailing:

a) Review and determine the measures that should be implemented to
ensure universal observance by racing sailors of the rules for wearing
lifejackets.

b) Makes the 'strong recommendations' in RRS 5.01.1 of the Special
Regulation mandatory requirements for all Category 2 and 3 RFBYC
ocean races.

c) Gives serious consideration (if the first of the above recommendations
cannot realistically achieve its aim) to requiring that lifejackets always
be worn by crew when on deck.

**Personal Locator Beacons**

[349] The SSIs for the 2018 BROR made it compulsory for all boats to have a PLB
for each member of the crew. RFBYC is to be congratulated for that
requirement because without it, there probably would have been more
lives lost during the Finistere incident.

[350] The best place for a crew member to carry a PLB is to have it attached to
the lifejacket but if not, a carry bag (or bum bag) worn around the waist
is suitable. Another option is for the PLB to be attached to the wearer by
a lanyard.
When deciding how to carry their PLB, all sailors should consider the experiences of Finistere survivors in this regard. One sailor experienced a small delay in getting the PLB out of his pocket before deployment. It was then necessary for him to try and hold it with the aerial pointing skywards, which was extremely difficult in the conditions.

Clearly, the better choice is to have the PLB properly fitted to the lifejacket so that when the sailor is in a floating position, it will automatically point skyward.

Several submissions have questioned the accuracy of the positions initially broadcast from the PLBs held by two of the Finistere survivors. It should be noted that the AMSA website indicates it may take 20 minutes to obtain an accurate fix.

The important lesson about PLBs to be learned from the Finistere tragedy is that the signals from two crew members’ beacons were critical to their relatively swift rescue. But for those two PLB signals, it is likely the search would have concentrated on the position two miles away provided by the AIS beacon. This would have delayed the rescue with possibly very dire consequences for those who in fact survived.

The Blue Book currently makes the carrying of PLBs by crew members compulsory only for Category 1 and 2 races. In the Panel’s opinion, PLBs should also be compulsory for Category 3 races.

Certainly the Panel has no hesitation in confirming the RFBYC rule that requires PLBs to be carried by crew members in all of its Category 3 ocean races.

The Panel recommends that RFBYC consider, in consultation with Australia Sailing, whether its Sailing Instructions for Category 2 and 3 races should include a requirement that PLBs have a lanyard for attaching to the wearer.

Crew training

The crew of Finistere were all highly experienced ocean sailors.

For Category 2 races, at least 30 per cent of the crew shall have undertaken training in accordance with the AS SSSC.

Special Regulation 6.01.1(b) strongly recommends that all crew members do likewise.

The Panel supports this recommendation.
Training and experience helped the crew of Finistere when confronted with a difficult, confusing and life threatening situation.

The training of ocean sailors must always be about awareness of potential risks and dangers, preparedness to meet them, familiarity with the safety equipment necessary to do so, as well as the appropriate responses to varying types of emergencies.

There are a number of ways to achieve these aims including formal courses such as the AS SSSC, experiences gained from ocean sailing and its exigencies over a number of years, safety briefings of the type recommended below, and the simple guidance often given by caring skippers to their crew.

In seeking to achieve these aims an exemplar of commendable standards for preparedness, concern for safety, and appropriate responses in an emergency, is Dr Weaving. When Finistere capsized she was the only crew member on deck who was both wearing a lifejacket and tethered to the yacht. Also, she was the only crew member to have her lifejacket fitted with both a PLB and an automatically activated AIS beacon.

After being sucked under the hull and into its cockpit space, Dr Weaving had the presence of mind to coolly assess her situation, test whether she could exit from under the hull when she needed to, and then calmly decide that it would be best for her own wellbeing to remain where she was. Her reasoning when making that decision included the thought “If Tony Bullimore can do this for five days, I can do it for a few hours”.

The experiences of the other Finistere crew members are also instructive for sailors undergoing training. They demonstrate the dangers that can occur in emergencies when lifesaving gear and equipment which might have saved lives cannot be accessed due to lack of preparation, lack of opportunity, or (without intending disrespect) failure to observe basic safety rules.

Sailors undergoing training should be asked to consider the consequences which in fact followed for some of those crew, such as:

- Trying to cling to a slippery hull in rough seas without a lifejacket and while being repeatedly immersed by waves.
- Clinging onto the hull with one hand while trying to activate and hold up a PLB with the other.
- Keeping a firm grasp of the PLB in these circumstances when it did not have a wrist lanyard.
Also, lessons of the ‘what if’ variety can be learned from the fact that search resources were partially diverted to the wrong location because of the false AIS signal. This provides a valuable opportunity for trainee sailors to discuss and fully understand the differences between AIS beacon and PLB signals.

Coroner Abernethy’s findings into deaths during the 1998 Sydney to Hobart Yacht Race "From the evidence of the survivors of the yacht *Winston Churchill* and the test concluded by Mr Tony Boyle (NSW Water Police) at AMC, it is indisputable that trained crew have a greater likelihood of survival than untrained crew".

The Panel **recommends** that any sailor with an interest in ocean racing undertake a training course and keep accreditation current every five years. The Panel **recommends** that 30 per cent of the crew be qualified in AS SSSC survival training for all Category 3 races that extend beyond 12 hours.

**Safety briefings**

During an interview with one of the surviving crew of *Finistere*, he did not know (when asked) where the flares on-board were located. He also later volunteered the embarrassing fact that he was not sure how to partially deflate a lifejacket.

These were refreshingly frank and honest disclosures from an experienced offshore sailor who ordinarily could be expected to be reluctant to make such admissions. It is disturbing that a sailor with his background lacked knowledge on these matters. It also raises the question of how many other sailors are in a similar situation.

Crew do not always sail on the one yacht and there is an increasing trend for sailors to swap from boat to boat. This may be a reason why an experienced offshore sailor might not know where certain items of safety equipment are stored on a particular boat.

The Panel also has reason to believe that adherence to basic safety precautions on some yachts is not as vigilant as it should be. Amongst other things, crew members must always know where items of vital safety equipment are stored, eg by means of a stow chart and how to use them: they must already have been allocated a lifejacket which has been adjusted and fitted; and they must have been briefed on the appropriate MOB procedures for that particular boat.

In the Panel’s opinion, this requires there be a standard safety briefing to all crew members collectively or individually before the start of each race
(already carried out by most sensible skippers). No doubt, like airline safety briefings, regular crew will find these briefings quite boring. However, repetition brings greater familiarity and one day, those crew may be very glad that all on-board knew exactly what to do in an emergency.

The Panel **recommends** that RFBYC in consultation with Australian Sailing:

a) Develop a standard safety briefing to be carried out on-board all participating yachts before the start of a race.

b) That a yacht be disqualified if that briefing does not take place.

**Post-race declarations**

The Panel’s attention has been drawn to the widespread practice amongst ocean racing clubs in the United Kingdom for skippers to lodge a declaration within a limited time of finishing which confirms that all safety requirements were complied with during the race.

This practice has spread to some clubs in Australia, including the Ocean Racing Club of Victoria which requires a post-race declaration within four hours of finishing that the skipper “adhered to all rules and conditions” of the race. FSC recently adopted a similar system involving forms handed out at the pre-race briefing which must be completed, signed and handed back to race control within six hours of finishing. The form has a simple ‘tick box’ arrangement whereby the skipper declares that there was either compliance or non-compliance with the “SIs, Special Regulations, and RRS”.

The Royal Yacht Club of Tasmania has taken a different slant on post-race declarations. There, a skipper must lodge a declaration “as soon as practicable” after the finish only if there was some breach of requirements during the race. The sailing instructions also provide that:

In electing to refrain from lodging a Declaration the skipper is acknowledging that the boat complied fully with the rules, regulations and sailing instructions throughout the race.

It has been suggested that post-race declarations will create an unnecessary administrative burden for skippers by “doubling up” on their previous confirmation of the boat’s compliance with safety requirements when they registered their entry for the race. However, this pre-race confirmation is at most, a promise that safety requirements (such as wearing of lifejackets) will be complied with. It does not have the strength of a post-race declaration that this did in fact occur.
The Panel considers there is merit in RFBYC adopting a system of post-race declarations but believes it should do more than simply confirm compliance in general with the Blue Book and Sailing Instructions. The declaration form should also specifically draw the skipper’s attention to safety requirements not capable of confirmation prior to the race. These include that lifejackets were worn as required, that each crew member carried a PLB and that there was a pre-start safety briefing (if the recommendation on that is adopted). Appendix 7 is a basic template for such a declaration.

The Panel points out that adoption of a system of post-race declarations would go some way towards meeting the aim of the recommendation relating to the wearing of life jackets.

The Panel also suggests that it should be possible to devise an electronic system of post-race declarations whereby skippers are emailed the form prior to the race and given the option of using their mobile phones after the race to make their declarations. The declaration could simply be the word ‘Yes’ texted to race control in the same way that doctors’ appointments are now commonly confirmed. No doubt, more agile technical minds are capable of devising a better electronic system.

For all of these reasons, the Panel recommends that:

a) RFBYC adopt for its ocean races a system of post-race declarations similar to that used by ocean racing clubs in the United Kingdom.

b) The system use a form of declaration that draws the attention of skippers to compliance with specific safety requirements which can only be confirmed after the race.

c) RFBYC endeavour to implement the system in a way (preferably electronically) which reduces any inconvenience when lodging the declaration.

Appendix 7 is a draft template for a post-race declaration.

Incident management and the media

RFBYC did not have an incident management consultant on contract. However, Ms Moody of Hunter Communications was engaged early on the Saturday morning, attended and stayed for that day and also worked over the following days as necessary.

She gave valuable advice to the committee, handled media enquiries and drafted media statements, which were updated as more information came through.
The media strategy adopted was to be candid and open. The Commodore was the appropriate spokesperson and he was assisted by advice from Ms Moody.

Obviously, engagement of an incident management consultant comes at a cost. That cost must be weighed against the reputational damage that can occur if an incident is mismanaged.

The Panel recommends that a formal arrangement for an incident management service be put in place so that its services can be retained at short notice. Because sailing is largely a weekend sport, it is important to contract with a company with the resources to respond at any time.

**Royal Freshwater Bay Yacht Club’s Ocean Risk Management Plan**

RFBYC has a current Emergency Response Guide. That said, it is in urgent need of revision. For example, it assumes that RFBYC will be the first point of contact by a yacht in distress.

While that might be so in some situations such as MOB, this event illustrates that often the contact will be in reverse with AMSA, becoming aware through deployment of EPIRB or PLB and initiating search and rescue.

This may be a wider issue. In response to a request, Yachting WA provided an emergency procedures operations sheet. The sheet was from the 2011 ISAF regatta, suitable for that type of event conducted in protected waters only.

RFBYC does not conduct search and rescue operations, its role is to assist in any way if asked by a rescue authority.

The Panel recommends the Emergency Response Guide be reviewed for the 2018-2019 ocean racing season.

**Submissions not adopted**

The Panel is very grateful for all of the submissions it has received. Many of these have influenced the contents of this report but others after being carefully considered, were not adopted (usually because they were not believed to be realistic or practical proposals).

The effort put into these latter submissions is nevertheless very much appreciated. Collectively, they have stimulated discussion about important issues and sometimes also triggered ideas for improved solutions to particular problems.
Appendix 8 is a summary of those submissions together with brief explanations as to why they were not adopted.
CHAPTER SIX

Conclusions and recommendations

[399] It is clear that the keel detachment from *Finistere’s* hull (for reasons as yet unknown) led to an immediate capsize in sea conditions which made it very difficult for most of the crew outside the hull to survive for more than an hour or two.

[400] Fortunately, the deployment of two PLBs set in train a search and rescue operation which reached the yacht comparatively quickly. Also, the use of *Huckleberry* and the seamanship displayed, enabled the rescue of most survivors before they succumbed to the waves.

[401] The rescue authorities appropriately called for assistance from the nearest yachts, *Huckleberry* and *Fourth Dimension*. It is often the case in emergencies that other nearby competitors will be the closest vessels to sailors in distress and yacht clubs should encourage their use, and give all possible assistance to AMSA and Water Police for them to do so.

[402] The Panel has found deficiencies in the race management of the 2018 BROR but do not consider these to be contributory causes of the tragic outcomes of the capsize. The Panel is satisfied that all involved in responding to the incident used the best efforts they were capable of to secure an early rescue of *Finistere’s* crew. The fact that two lives were lost is not a reason for them to feel ashamed or responsible for that outcome.

[403] If any positive emerges from the *Finistere* tragedy, it is that it provides the opportunity and right environment for yachting authorities (in consultation with the local sailing fraternity) to totally reassess the current procedures and standards for the safety of sailors at sea.

[404] The best way the sailing community can mark its respect to the memories of Mr Thomas and Mr Owens is to support all reasonable measures which will ensure that lives of offshore sailors are never unnecessarily lost at sea.

[405] As is the case with any event such as this, unjustified rumours and fragments abound.

[406] The Panel has been able to have regard to all of the evidence obtained from many sources. It has endeavoured, indirectly, to answer these rumours in the narrative and in its treatment of the issues.
Finally, this report was commissioned by RFBYC and is its property. Members of the Review Panel were assured however that it would be made available to the sailing community. There are lessons to be learned that go beyond the procedures of a single club. It has been written for a wider audience.

Summary of recommendations

Recommendation one

The Panel acknowledges the traumatic effect on the skippers and crew members of the yachts involved and recommends that their clubs continue to reach out to them and check on their wellbeing.

Recommendation two

The Panel recommends that RFBYC continue to monitor the wellbeing of its volunteers and staff who were emotionally affected by the tragic events on the night.

Recommendation three

The Panel recommends that:

a) The club amend its Constitution (clause VIII) to allow the temporary appointment to a sub-committee of a non-member who has expertise of value to that sub-committee.

b) The club’s Committee adopt a standard template for appointing sub-committees and for delegating their powers to act.

Recommendation four

The Panel recommends that for each ocean race, there be a Deputy Race Officer who has full authority to exercise the Race Officer’s powers during the latter’s absence.

Recommendation five

The Panel recommends that RFBYC in consultation with Australian Sailing reconsider the category prescribed for the race.

Recommendation six

The Panel recommends that a contemporaneous record be made of the decision to start or not start a race and that record include all factors taken into account in reaching that decision.
Recommendation seven

[414] The Panel recommends that RFBYC carry out a full reassessment of all existing radio room arrangements with a view to:

a) Selecting a volunteer to take charge of the roster (ideally the Deputy Race Officer).

b) Ensuring all volunteers have the basic skills required in a modern working environment with up to date technology.

c) Allocating roster duties to each volunteer which are consistent with their overall abilities.

d) Teaming pairs of volunteers on duty so they have complementary skills.

e) Establishing a set of standards for radio room operators to follow.

f) Training radio room operators to meet those standards.

g) Ensuring that at times of heavy traffic a proper log is kept (the Panel suggests that digital recordings during busy periods may assist).

h) An ongoing program of renewal including recruitment of younger volunteers.

Recommendation eight

[415] The Panel recommends that the SSIs for future races include a provision to the effect:

Prior to submitting crew lists skippers must confirm with each crew member that he or she requests race control to notify their emergency contact of any incident at sea detrimental to their health or wellbeing. Unless advised to the contrary (on the crew list) race control will assume that each crew member requests that this be done.

Recommendation nine

[416] The Panel recommends that:

RFBYC firstly approach the WA Police Force to see whether it is willing to revise its procedures so as to avoid any future need for Race Officers to notify next of kin of serious emergencies at sea. Failing a positive response to that request, RFBYC (in consultation with other yachting authorities as it considers appropriate) develop guidelines for Race Officers to notify next of kin of such emergencies. These guidelines should include suggestions that the Race Officer:
First check with police whether they already have, or intend to contact next of kin (and if so when).

Consider what facts about the incident can be stated with certainty and what facts are merely assumptions or speculation.

Carefully consider the facts to be told to next of kin bearing in mind that these should be completely truthful and accurate.

Ascertain whether or not news of the incident has spread to the public or to people other than next of kin.

Carefully consider the time when next of kin should be told.

Consider whether counselling services should be made available prior to next of kin being told.

Recommendation ten

[417] The Panel recommends that:

a) The SSIs for its future Category 2 and/or 3 ocean races should include a 'strong recommendation' that all crew carry an AIS beacon properly fitted so that it will automatically activate upon inflation of a lifejacket;

b) Those SSIs include a further 'strong recommendation' that prior to each race, skippers check that all crews' AIS beacons have been programmed with the yacht's MMSI number; and

c) ORWA be requested to include in the annual Yellow Book a list of MMSI numbers against names of yachts so these may be easily identified.

Recommendation eleven

[418] The Panel recommends that for all Category 2 and 3 RFBYC ocean races, the fitting of splashguards or sprayhoods to lifejackets should not just be 'strongly recommended' but mandatory.

Recommendation twelve

[419] The Panel recommends that RFBYC in consultation with Australian Sailing:

a) Review and determine the measures that should be implemented to ensure universal observance by racing sailors of the rules and regulations for wearing lifejackets.
b) Makes the 'strong recommendations' in Racing Rules of Sailing (RRS) 5.01.1 of the Special Regulation mandatory requirements for all Category 2 and 3 RFBYC ocean races.

c) Gives serious consideration (if the first of the above recommendations cannot realistically achieve its aim) to requiring that lifejackets always be worn by crew when on deck.

Recommendation thirteen

[420] The Panel recommends that RFBYC consider, in consultation with Australia Sailing, whether its Sailing Instructions for Category 2 and 3 races should include a requirement that PLBs have a lanyard for attaching to the wearer.

Recommendation fourteen

[421] The Panel recommends that any sailor with an interest in ocean racing undertake a training course and keep accreditation current every five years.

Recommendation fifteen

[422] The Panel recommends that 30 per cent of the crew be qualified in AS SSSC survival training for all Category 3 races that extend beyond 12 hours.

Recommendation sixteen

[423] The Panel recommends that RFBYC in consultation with Australian Sailing:

a) Develop a standard safety briefing to be carried out on-board all participating yachts before the start of a race.

b) That a yacht be disqualified if that briefing does not take place.

Recommendation seventeen

[424] The Panel recommends that:

a) RFBYC adopt for its ocean races a system of post-race declarations similar to that used by ocean racing clubs in the United Kingdom.

b) The system use a form of declaration that draws the attention of skippers to compliance with specific safety requirements which can only be confirmed after the race.
c) RFBYC endeavour to implement the system in a way (preferably electronically) which reduces any inconvenience when lodging the declaration.

Recommendation eighteen

[425] The Panel recommends that a formal arrangement for an incident management service be put in place so that its services can be retained at short notice. Because sailing is largely a weekend sport, it is important to contract with a company with the resources to respond at any time.

Recommendation nineteen


Recommendation twenty

[427] The Panel recommends that the Offshore Racing Committee be the Race Committee for all of RFBYC’s ocean races.

Finally …

[428] RFBYC appointed the Panel for their experience and independence. We have endeavoured and done the best we can to fulfil the responsibility given to us.

Dated this 16th day of October 2018

John McKechnie, QC  Peter Blaxell  Manfred Speicher
Chair
APPENDIX 1

Terms of Reference for the Review

The Enquiry will examine all the circumstances pertaining to the conduct of the 70th Annual Bunbury and Return Ocean Race and in particular:

a) Consider relevant administrative procedures and race documentation and organisation.

b) Review the emergency management procedures in place and their effectiveness.

c) If thought fit, make recommendations as to:

i) any changes to the race rules, procedures, administration documentation, boats or equipment that might further mitigate risk;

ii) emergency management procedures; and

iii) any other matters relating to the conduct of the race as the Enquiry considers appropriate.

The Enquiry is to provide its final report to the General Committee. A preliminary report may be provided if it is considered necessary to highlight any safety recommendations that may require immediate attention.

RFBYC will accept a minority report.

RFBYC may from time to time provide additional Terms of Reference to the report.

Powers and restrictions

The Enquiry may do all things necessary and convenient to comply with the Terms of Reference.

The Enquiry will determine its own procedure and decide who may be invited to meet with the Enquiry and/or make written submissions.

RFBYC will cooperate fully with the Enquiry and make available all documents and records sought by the Enquiry.

The Enquiry is not to enquire into the causes surrounding the capsize of yacht *Finistere* and the subsequent loss of life, except to the extent whether the conduct of the race contributed in some way.

The Enquiry has no power to require people to attend its sittings or answer the Panel's questions. The Enquiry is to function on a voluntary basis. People are
invited to attend. If attending, they can determine what, if anything, they may wish to say.

The Enquiry has no power to make findings of fact or to make any determinations including any alleged breaches of any rules or regulations by a person or a yacht.

The Enquiry and any report produced by it, is not to attribute blame or allege any breaches of any rules or regulations against any person or yacht involved in the race.

Before finalising its report, the Enquiry will give interested persons the opportunity to comment on any matter they may regard as adverse.
APPENDIX 2

Members of the Panel
The General Committee appointed the following to comprise the Panel:

- John McKechnie, QC (Chair)
- Peter Blaxell
- Manfred Speicher

Panel biographies

Hon John McKechnie, QC
A former Senior Supreme Court Judge, presently Commissioner of Corruption and Crime Commission (WA). He is a long term sailor in both multi-hull and mono-hull classes and is a member of Nedlands Yacht Club and RFBYC. He is a national race officer and has officiated at numerous regattas and championships.

Hon Peter Blaxell
A retired Supreme Court Judge and a lifetime sailor. He raced offshore on his yacht Pegasus during the 1980's and 1990's and has sailed in five Fremantle to Bali races. He is a past Commodore, life member, Trustee of Fremantle Sailing Club and a Governor of the Leeuwin and Ron Tough Foundations.

Mr Manfred Speicher Esq
Is an Australian Sailing/World Sailing, Safety at Sea Instructor, Australian Sailing/Yachting WA, Senior National Equipment Auditor for WA & National Senior EA Panel. He is a member of RFBYC, Offshore Committee – Safety – Race Management, International and National Offshore Sailor (racing and cruising), Yacht Master and Sailing Instructor.

Members of the Panel declared any conflict of interests to the other members. All conflicts of interest were appropriately managed.

Each member has served in an honorary capacity and has received no financial or other reward.

The conclusions and recommendations expressed in the report are unanimous.
APPENDIX 3

2018 Bunbury and Return Ocean Race course

Finisterre last tracker report:
5.1 knots @ 196.15°
Position @ 23 Feb 2018 23:30 AWST
32°31.741 119°30.631

SCALE:
10 mm between pins

Turning point in Koombana Bay
APPENDIX 4

Suggested template for appointing Race Control Committee
Organising authority

(Name of Race)

Delegation of authority to conduct the race

1. **The Race Committee**: The club is the organising authority for the race under the Racing Rules of Sailing 2017-2020 (the Blue Book) Rule 89, and has appointed the following Race Committee:

*(insert names of Race Committee members)*

2. **The race officials**: The club has also directed that the following members of that committee shall hold the following positions:

Race Officer:

Deputy Race Officer:

3. **Authorities and responsibilities**:

3.1 The Race Committee shall have overall authority and responsibility to conduct the race (in accordance with the Blue Book) on behalf of the club, including the organisation of facilities, equipment, race documentation, staff support, and appropriately trained volunteers.

3.2 However, during the period which commences two hours before the start of the race and ends two hours after the last yacht has finished (racing period), the Race Officer shall have the delegated authority and responsibility to make all decisions required for the proper and safe conduct of the race.

3.3 That delegation of authority and responsibility is subject to the exception that the Race Officer who is not a member of the club, does not have sole power to make any decision which might:

- burden the club with unbudgeted expense, or
- damage the club’s reputation.

In those instances, the Race Officer shall consult with the Deputy Race Officer who has full authority to approve such a decision on behalf of the club.

3.4 The Deputy Race Officer will also take over the Race Officer’s authority and responsibility whenever the Race Officer is absent. In this regard, the
Race Officer and the Deputy Race Officer are to ensure that during the racing period, there is always at least one of them physically present in the race control room.

3.5 At least one of the Race Officer and Deputy Race Officer shall attend the pre-race briefing for participating skippers.

4. **Handover to the Race Officer:** The Race Committee is to ensure that at least two days before the start of the race, the Race Officer is supplied with copies of:

- A list of participating yachts including crew names, their PLB numbers and contact details.
- The roster of volunteers attending the radio control room.

____________________________

Signed by Commodore XXXX on behalf of the General Committee
APPENDIX 5

Suggested template for recording decisions to race
Record of decision to start (or not start) a race

(For completion by the Race Officer no earlier than two hours prior to scheduled start)

Name and date of race:

Name of Race Officer:

The factors to be considered in making the decision: (Please record your brief comments in respect of each factor):

1. The latest BOM weather forecasts: (please attach photocopies).
2. Having regard to those forecasts:
   2.1 The likely duration of the race until all yachts finish:
   2.2 The likely weather conditions over that period:
   2.3 The worst conditions that are reasonably possible:
   2.4 The proximity of any safe havens or protected anchorages where a yacht might shelter from those worst conditions.
   2.5 Any other factor that the Race Officer considers relevant.
3. The remoteness/availability of rescue craft and services if a yacht requires emergency assistance:
4. Whether yachts will be sailing at night:
5. The likely quality of communications throughout the race:
6. Any other factor that you consider is relevant:
7. The opinions of other Race Committee members and of a representative sample of participating skippers as to whether or not the race should start: (Please list names and a brief indication of each opinion):

Decision Made:

Time and Date:

Race Officer’s signature:
APPENDIX 6

Yellow Brick Tracker screen shots
APPENDIX 6.1

At 23:30:38 hours showing *Finistere* at its last broadcast position, and the tracks of the then nearest yachts.
APPENDIX 6.2

At 01:00:00 hours showing *Huckleberry* after turning towards *Finistere*; *Fourth Dimension* after diverting from its intended search of the AIS signal location; as well as *Circa*. 
APPENDIX 6.3

At 01:30:00 hours showing Huckleberry and Fourth Dimension after they had reached Finistere, as well as Circa nearby.

Finistere last tracker report:
5.1 knots @ 186.16°
Position @ 23 Feb 2018 23:30 AWST
32°31.745 115°30.655E

Circa

Huckleberry

Fourth Dimension

SCALE:
2 nm between pins

Zoom x 10
Yacht Tracker – Race Viewer
YB Tracking
24 February - 01:30:00 AWST
APPENDIX 6.4

At 02:00:00 hours showing *Huckleberry* after rescuing three survivors and heading towards Fremantle; *Fourth Dimension* beginning to search the AIS signal location, and *Circa* conducting a wider search downwind of that position.
APPENDIX 6.5

At 02:00:00 hours showing a wider view including all yachts still racing.
APPENDIX 7

Suggested template for post-race declaration
XXX Offshore Race

Declaration form to the Race Committee

All competitors shall complete a declaration and forward to the Race Committee within six hours of their finish time confirming their compliance or non-compliance with the SI’s, Special Regulations and RRS.

The declaration form can be hand delivered or emailed to the race office or a photograph of the completed form sent by SMS to mobile number xxxx xxx xxx

Yacht name

Owner's name

First name

Last name

Owner's email address

Sailing Instructions, Racing Rules of Sailing and Special Regulations

☐ All SI’s and RRS and Special Regulations were COMPLIED with.

☐ All SI’s and RRS and Special Regulations were NOT COMPLIED with as detailed below.

If all SI’s, RRS and Special Regulations were not complied with, please provide details.
Please provide any other relevant feedback for the Race Committee.

Sign

___________________________

First name

___________________________

Last name

Email

☐ Owner
☐ Navigator
☐ Boat Representative

Please ensure all check box items are complete prior to submission.
APPENDIX 8

Summary of submissions not adopted

1. Variations in offshore procedures between clubs create problems for skippers and volunteers.

The Panel cannot comment on this claim because it has not examined the offshore race procedures of any organising authority other than RFBYC.

However, the evidence indicates that there is increasing consistency between clubs as a result of the new system of ORWA race control. If in fact there are any differences in procedure, then these should be quickly identified and acted upon. This is because inconsistencies tend to degrade compliance with safety rules. It is much easier for skippers to comply if they know exactly what to do and do not have to check each club’s paperwork in order to meet requirements.

2. The present RFBYC radio room duty roster schedule can be improved.

Assuming that Recommendation seven is adopted, the person appointed to take charge of radio room arrangements should decide on any new schedule.

3. At the commencement of each radio room watch period, the incoming team should sign a written acknowledgement of receipt of the Race Instructions Handbook and that they understand its contents.

This is a matter for the person in charge of radio room arrangements to consider.

4. It would have assisted the radio operators on duty during the incident if nonessential personnel had been cleared from the room.

This claim is based on hearsay and the operators on duty at the time have not asserted this. The operating area of the radio room is relatively small, and obviously it is highly desirable during a busy period that that those manning the radio are not distracted.

5. The three rescued crew on Huckleberry should have been hospitalised at Mandurah rather than taken to Fremantle.

Of the three survivors taken on-board Huckleberry, Mr van Didden was thought by the skipper to be in the worst condition. However, he noticed that once taken below, had put on dry clothes and rehydrated, they all improved rapidly.
At the end of the rescue, *Huckleberry’s* engine had failed (due to sea water entering the air intake while it was pitching in the waves). Taking the survivors to Mandurah would have involved tacking into a wind blowing from the opposite direction in conditions that “were not pleasant”. The decision then made was to take them to Fremantle in a direction off the breeze and on a course which would make it a comfortable journey.

The three survivors were aware of that decision at the time it was made and did not dispute it either then or subsequently. After being landed at Fremantle, none of them required hospitalisation. The skipper’s decision was clearly the right one.

6. **Participating yachts should be required to set storm sails in a sail past prior to each race start.**

There are sensible underlying reasons for this submission. The need to raise storm sails does not often occur and sailors can become unfamiliar with their use. It is not a good thing if they are either learning or trying to remember how to use them at a time of peril.

Given that storm sails played no part in the *Finistere* tragedy the issue does not fall within the Terms of Reference. Nevertheless, the Panel suggests that boats be required to perform a pre-start sail past with storm sails set once a year at any Category 2 or 3 race of their choosing by an organising authority.

7. **Skippers should be made personally responsible for any failure by crew to wear lifejackets at night.**

The Panel does not understand this submission to refer to legal liability which in any event would not be within its remit. The Blue Book already makes skippers personally responsible for compliance by crew with all rules and regulations relating to safety including those relating to lifejackets. The Panel has addressed some problems with the culture of compliance by the recommendations it has made.

8. **Crew should be made to remove self-inflating PFDs while off watch below deck.**

The circumstances of particular emergencies vary greatly. During a capsize, it is dangerous for crew below deck to be wearing lifejackets. However, in more common types of emergencies, it may be advantageous for crew below to be wearing lifejackets.

Depending on the conditions and circumstances, it will always be a matter of discretion whether crew down below should be wearing lifejackets. There can be no hard and fast rule and the Panel makes no recommendation.
9. The accuracy of the initial GPS data should be queried.

It is an established fact that the initial data from a PLB is unreliable. According to AMSA, it may take up to 20 minutes for a PLB to acquire an accurate and reliable position.

There is nothing that the Panel can recommend which would change this situation.

10. It is preferable that PLBs and AIS beacons operate automatically.

The Panel’s response to this proposition is an emphatic “yes”.

AIS beacons can be made to operate automatically if properly fitted to a lifejacket. However, the Panel understands that the technology is still to be developed for PLBs.

11. The strobe lights for PLBs should be made more visible.

Because of limited battery power, the need for high visibility of a strobe light must always be weighed against the need for it to flash for as long as possible. This is a judgment which has to be made by each manufacturer of PLBs.

When the helicopter found Finistere’s upturned hull, it also reported that it could see four lights. This suggests that the strobe lights on the two PLBs had adequate visibility. It is also relevant that, as required by the Blue Book, those strobe lights were SOLAS approved as being adequate lights.

12. There should be laser lights attached to PLBs.

One of the Finistere survivors has stated that two of the crew in the water tried to signal the searching helicopter with LED pocket torches which appeared to be ineffectual in attracting attention (the helicopter in fact saw those lights because it reported there were four all together). He suggests that laser lights in PLBs may be a way to overcome this problem in future.

The Panel lacks the expertise to assess whether this proposal is technically feasible but is aware that laser beams (as distinct from laser pointers which are illegal) might be effective. However, laser beams are understood to be expensive.

The Panel has insufficient information to support the proposal.

13. Crew should be required to carry strobe lights in addition to PLBs.

The Blue Book SR 5.03 already requires crew to carry a personal locator light (either a strobe or a light complying with SOLAS requirements).
14. **Yachts should be required to carry an automatic float free strobe light.**

This would require a change to Blue Book requirements and it is not within the scope of the Panel to make such a recommendation. The Panel suggests that the matter be considered by those who have that responsibility.

15. **Yachts should be required to have a watertight torch affixed adjacent to the companionway.**

The Blue Book (SR 4.06.1) requires a yacht to carry a watertight high powered flashlight and two water resistant floating flashlights. Boat configurations vary as do the types of emergencies. The places where these items are fixed or located are best left to the judgment of the skipper.

16. **Yachts should be required to have a waterproof VHF radio in the cockpit.**

The Panel assumes this submission to refer to the small handheld VHF radios commonly used in addition to a fixed VHF installation below deck.

The Blue Book SR 3.25.2 already mandates that yachts in Categories 1, 2, and 3 races have a waterproof handheld VHF transceiver (recommended with lanyard). The location of the radio is best left to the judgment of the skipper.

17. **Crew should in some way be provided with handholds on an upturned hull.**

The *Finistere* crew may have experienced better outcomes if handholds had been built into the hull for them to cling to. Accordingly, one of the survivors has suggested that boats have handles of a “pop up cleat design” positioned where they do not cause water drag and can be easily accessed if the hull is upside down.

No doubt manufacturers of future boat hulls could incorporate such devices and yachting authorities should lobby for this to happen if they think they should do so.

In the meantime, owners of existing yachts who contemplate retro fitting handles would need to weigh the prospects of these ever being used against the difficulties and possible risks of doing so.

The separation of a keel from a hull is a fairly rare type of emergency. Also, the retro fitting and embedding of handles may affect a hull’s watertight integrity.

The design of every boat is different and on some sterns, it may be possible to screw on external stainless steel handles in suitable positions without causing any problems.
For these reasons, the Panel considers that the provision of 'cling handles' should not be mandatory, but a decision to be made by each individual yacht owner.

18. **Yachts should have an emergency safety rope with a luminous floater.**

While this is a good idea in principle, it is difficult to conceive of any way that such a rope could be rigged so that it would always float free in an emergency but not at other times when it might entangle the propeller. The trailing rope would have to be long enough for it to be reached by a stricken sailor some distance from the stern.

In any event, the mandatory life buoy (AS SR 4.21) with float mounted on the stern pulpit can assist a sailor in the water in much the same way as the proposed safety rope.

19. **Yacht hulls should have retroreflective tape or stripes of luminous paint underneath.**

The implementation of this proposal would only be useful in an emergency involving an upturned hull.

Having regard to the rarity of keel separations leading to capsize, the difficulties in ensuring that tapes will adhere over time and anti-fouling issues, the Panel does not support the proposal.

20. **Flares should be mounted on the outside of yacht hulls which activate automatically after five minutes in water.**

Even if it is feasible to develop such devices, the Panel cannot conceive how the flares would not be triggered by repeated immersions (particularly in rough weather) in the ordinary course of sailing the yacht.

The submission is not supported.

21. **Life rafts should be mandatory for all Category 3 races longer than 20 miles.**

The Panel has expressed its doubts that the BROR is appropriately categorised as Category 3. If the race is recategorised as Category 2, then all yachts will be required to carry a life raft.

Failing that, the Panel does not see the sense in making a length of more than 20 miles a criterion for requiring a life raft to be carried in a Category 3 race. It is easy to imagine such a race with a return element off the Perth metropolitan coast where such a requirement would be clearly unjustified.
22. When it first becomes known that a yacht is subject to an emergency, race control should determine its position on the data then available and communicate that position to the rest of the fleet. That position should then be regularly updated and communicated to the fleet as and when further data becomes available.

This is a sensible submission and reflects what always has been the practice for radio operations during emergencies at race control. To the extent this practice was not followed during the *Finistere* incident, it was due to volume of traffic and related factors as referred to earlier in this Review.

23. When an emergency occurs, one of the first steps race control should take is to notify all yachts of the extent of the likely search zone. This will alert yachts within the zone to keep a watchful lookout.

This is already what happens whenever an emergency is of the type that makes that step appropriate. However, when an emergency response has been triggered by a PLB or EPIRB signal, AMSA is in charge and determines the extent of the search zone.

It is then a matter for AMSA to communicate that information to race control so that boats within the zone can be told to keep a lookout.

24. The YBT system should be used to alert the need for a search and rescue operation.

This submission raises the question whether the YBT is capable of providing such an alert. The only feature of the system which might do this is when a YBT device ceases to transmit, the symbol of the yacht on the computer screen stops moving and its colour changes to grey. (This is what happened with *Finistere’s* YBT track as observed by Ms Ghent).

Cessation of a yacht’s track sometimes occurs when there is not an emergency (eg when the battery of the device goes flat or there is some other malfunction). Also, emergencies can occur when the device keeps on tracking (eg a MOB).

In the Panel's opinion, nothing more can be done with the YBT system that is not already being done by race control’s monitoring of the YBT screen.

25. The YBT should also be used to assist during a search and rescue operation.

For the reasons stated near the beginning of this report, the Panel is not in the position to comment on or recommend ways in which a search and rescue operation should be conducted. This includes any commentary on the electronic aids which should be used in such an operation.

The suggestion in the submission is entirely a matter for AMSA.
26. There should be some standard signal by which searching aircraft can indicate to survivors that they have been found.

It is very important for the morale and determination of sailors in distress that they be signalled that they have been located. The Panel can think of no better way to do this (at night) than by shining a spotlight on them.

28. The helicopter should have provided lighting assistance to Huckleberry and Water Police at the time of the rescue.

Obviously, such assistance should occur whenever requested by rescuers but it is an issue entirely within AMSA’s purview and outside the Panel’s Terms of Reference.

Nevertheless, the Panel is unaware of any complaint that the rescuers could not see what they were doing and notes it is sometimes better that night vision not be impaired by the presence of lighting.

29. Something should be done to reduce overload in radio traffic following an incident.

The Panel raised this issue with expert radio operators and none could suggest a viable solution.

The only way in which the volume of traffic could be significantly reduced is for the participants in search and rescue to use additional channels. However, this can lead to difficulties in coordination as well as to confusion in some quarters (as did happen to some degree during the Finistere incident). Also, the more channels that are monitored, the greater the risk that a particular transmission will be missed because of the need to listen to another.

Standard radio procedure allows a controlling station to call "Seelonce Mayday" or "Seelonce Distress" following which, all other stations must remain silent until "Seelonce Feenee" is broadcast.

30. Modern emergency distress systems should put greater emphasis on GPS beacons, thereby reducing reliance on flares.

The Panel does not understand this submission to say that flares should be reduced in number or done away with. For the foreseeable future, there will be some types of emergencies where flares might be critical to rescue.

Modern emergency distress systems are already putting greater emphasis on GPS beacons and this trend is likely to increase as new technologies are developed.
31. AMSA tends to be dismissive of the availability of nearby yachts and there should be an established protocol for their use in search and rescue operations.

The Panel does not agree that AMSA is ‘dismissive’ on this subject. As shown during the Finistere incident, it will utilise nearby resources whenever this is appropriate.

32. There should be bi-annual safety practice drills involving yacht clubs, AMSA, and Water Police.

The Panel does not agree with this submission. Given the wide variety of emergencies, it is difficult to envisage a drill which will be useful in all situations. In any event, offshore sailors already have the skills required to participate in search and rescue operations.

33. There should be annual ultrasound checks or some other form of technical monitoring of the structural integrity of hulls, keels and masts of yachts.

This submission is obviously a response to the fact that Finistere’s keel fell off and proposes ways of preventing similar events from occurring in the future.

Whether there should be a recommendation along the lines of the submission is entirely a matter for the Coroner, and the Panel makes no comment.

34. The internal structures of hulls and keels should also have embedded monitors for dampness.

For the same reasons, the Panel does not comment on this submission.

35. RFBYC did not take sufficient steps after the incident to counsel/debrief volunteers and staff.

As a result of the early decisions made by the Commodore and Crisis Management Group the Panel considers that RFBYC was commendably prompt in making counselling services quickly available, and in ensuring that those services continued over the following days for as long as was necessary.

The Panel does not agree with the submission.

36. RFBYC has engaged in a ‘cover-up’ of the circumstances surrounding the incident.

The Panel received a submission that RFBYC was engaged in a cover-up. The Panel treated this allegation seriously and reviewed reports from everyone at RFBYC who had involvement with the race or the incident. The Panel conducted extensive interviews. The Panel examined primary source documents including contemporaneous records and accounts.
From its examination, the Panel is firmly of the opinion that no officer or member of RFBYC has attempted to cover-up any perceived deficiencies or in any way attempted to deflect the Panel from its task.

The Panel regards this allegation as unfounded.

37. **Review Panel members have conflicts of interests.**

Part of this “cover up’ was said to be the appointment of two RFBYC club members to the Review Panel (who were thereby conflicted). It was also said that one of them stood to gain as a result of his private interests related to yacht safety.

As to the first assertion, the contents of this report make it clear that the Panel members have not held back in identifying any shortcomings in RFBYC’s conduct of the race.

The second assertion against one Panel member was considered by the others at the time it was made, but rejected it because of his undoubted integrity. Their views about this are shown to be correct by the way in which all Panel members have dealt with the issues. Each recommendation was reached after careful analysis and only on the basis of its true merits. Also, each recommendation was reached unanimously.
70th Bunbury and Return Ocean Race
23-24 February 2018

Incident Review – RFBYC Response to the Report

Introduction

Royal Freshwater Bay Yacht Club acknowledges receipt of the review into the conduct of the 70th Bunbury and Return Ocean Race and thanks the Review Panel for their time and effort in deliberating on the various aspects of the race and the thoroughness of the investigation.

The Club wishes to express its sincere condolences to the families of the deceased, and to the many persons affected by the incident.

The Club wishes to acknowledge the large volume of work that has been done. The Club is also mindful of its responsibilities for presenting the findings and/or considering the recommendations. This document outlines the Club’s response to the report, in terms of actions to be taken in light of the report, where responsibility is to be redirected to a higher body, or where there are areas of the findings where there is non-alignment in the views held.

The safety regulations of both World Sailing and Australian Sailing cover a wide variety of scenarios. It is clear that in the Finistere incident, a major factor in the incident was how fast events unfolded from start to the fully capsized situation. It appears that the speed of this was a major barrier to the successful deployment of safety equipment and potentially of additional safety equipment were it to have been carried. The Club understands that the Review Panel has not addressed issues regarding the condition of the Finistere and the adequacy of any repairs, maintenance and inspections that did occur or ought to have occurred prior to this race, as those were not matters within the control of the Club. The Club anticipates and expects that these issues will be addressed by the ongoing coronial inquiry into the tragic incident.
### Analysis of the Findings

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Response and/or Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The Panel acknowledges the traumatic effect on the skippers and crew members of the yachts involved and recommends that their clubs continue to reach out to them and check on their wellbeing.</td>
<td>The Club recognises the impact this incident has had, and has been active in this area, however will reinforce the message with the Clubs involved and will continue to liaise with all of its members volunteers, race officials, and competitors who were affected by the tragedy.</td>
</tr>
<tr>
<td>2. The Panel recommends that RFBYC continue to monitor the wellbeing of its volunteers and staff who were emotionally affected by the tragic events on the night.</td>
<td>As for Recommendation 1.</td>
</tr>
<tr>
<td>3. The Panel recommends that:</td>
<td></td>
</tr>
<tr>
<td>3a. The club amend its Constitution (clause VIII) to allow the temporary appointment to a sub-committee of a non-member who has expertise of value to that sub-committee.</td>
<td>The Club is currently conducting a wholesale review of the Rules of Association of the Club and will address this as part of the review.</td>
</tr>
<tr>
<td>3b. The club’s Committee adopt a standard template for appointing sub-committees and for delegating their powers to act.</td>
<td>This will form part of the new Rules of Association as per 3a.</td>
</tr>
<tr>
<td>4. The Panel recommends that for each ocean race, there be a Deputy Race Officer who has full authority to exercise the Race Officer’s powers during the latter’s absence.</td>
<td>The Club agrees with this recommendation.</td>
</tr>
<tr>
<td>5. The Panel recommends that RFBYC in consultation with Australian Sailing reconsider the category prescribed for the race.</td>
<td>The Club has considered the Panel’s recommendation and remains of the view that the categorisation of the race was appropriate in the circumstances, and believes that the characteristics of the BROR are in line with the descriptions contained in</td>
</tr>
<tr>
<td></td>
<td>The Panel recommends that a contemporaneous record be made of the decision to start or not start a race and that record include all factors taken into account in reaching that decision.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>6</td>
<td>The Club has, and will continue to, consider the categorisation each year. Should any changes be made by Australian Sailing to the descriptions of the safety categories, the Club will reconsider the categorisation in light of those changes. The Club otherwise notes that as Australian Sailing is not an OA, it cannot determine the category of a particular race.</td>
</tr>
<tr>
<td>7</td>
<td>The Panel recommends that RFBYC carry out a full reassessment of all existing radio room arrangements with a view to:</td>
</tr>
<tr>
<td>7a</td>
<td>Selecting a volunteer to take charge of the roster (ideally the Deputy Race Officer).</td>
</tr>
<tr>
<td>7b</td>
<td>Ensuring all volunteers have the basic skills required in a modern working environment with up to date technology.</td>
</tr>
<tr>
<td>7c</td>
<td>Allocating roster duties to each volunteer which are consistent with their overall abilities.</td>
</tr>
<tr>
<td>7d</td>
<td>Teaming pairs of volunteers on duty so they have complementary skills.</td>
</tr>
<tr>
<td>7e</td>
<td>Establishing a set of standards for radio room operators to follow.</td>
</tr>
<tr>
<td>7f</td>
<td>Training radio room operators to meet those standards.</td>
</tr>
</tbody>
</table>
7g | Ensuring that at times of heavy traffic a proper log is kept (the Panel suggests that digital recordings during busy periods may assist). | The Club broadly agrees with each of these recommendations and will implement a policy document to address these items.

7h | An ongoing program of renewal including recruitment of younger volunteers. | The Club broadly agrees with each of these recommendations and will implement a policy document to address these items.

8 | The Panel recommends that the SSIs for future races include a provision to the effect:

*Prior to submitting crew lists skippers must confirm with each crew member that he or she requests race control to notify their emergency contact of any incident at sea detrimental to their health or wellbeing. Unless advised to the contrary (on the crew list) race control will assume that each crew member requests that this be done.* | The Club agrees with this recommendation subject to Recommendation 9 below.

9 | The Panel recommends that:

RFBYC firstly approach the WA Police Force to see whether it is willing to revise its procedures so as to avoid any future need for Race Officers to notify next of kin of serious emergencies at sea. Failing a positive response to that request, RFBYC (in consultation with other yachting authorities as it considers appropriate) develop guidelines for race Officers to notify next of kin of such emergencies. These guidelines should include suggestions that the Race Officer: | The Club has already commenced a dialogue with the Water Police to ensure that next of kin are advised of serious incidents in an appropriate and timely fashion. However, the Club remains concerned about the suitability of Club staff or volunteers to conduct this task, having due regard for both the person delivering the message and those receiving it.
• First check with police whether they already have or intend to contact next of kin (and if so when).
• Consider what facts about the incident can be stated with certainty and what facts are merely assumptions or speculation.
• Carefully consider the facts to be told to next of kin bearing in mind that these should be completely truthful and accurate.
• Ascertain whether or not news of the incident has spread to the public or to people other than next of kin.
• Carefully consider the time when next of kin should be told.
• Consider whether counselling services should be made available prior to next of kin being told.

10 The Panel recommends that RFBYC consider in consultation with Australian Sailing whether:

The Club agrees that these recommendations should be referred to Australian Sailing as "key learnings" for consideration for adoption into the Special Regulations. However, it would be incongruous for the Club to mandate individual requirements without support from the National Governing Body, making the race materially inconsistent with other races on the ORWA programme.

10a The SSIs for its future Category 2 and/or 3 ocean races should include a 'strong recommendation' that all crew carry an AIS beacon properly fitted so that it will automatically activate upon inflation of a lifejacket;

As above, however the Club does not agree that automatic activation should be mandated. We do however strongly support the recommended use of AIS units.

10b Those SSIs also include a 'strong recommendation' that prior to

The Club agrees with this recommendation.
<table>
<thead>
<tr>
<th>Number</th>
<th>Recommendation</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>10c</td>
<td>ORWA be requested to include in the annual Yellow Book a list of MMSI numbers against names of yachts so these may be easily identified.</td>
<td>The Club agrees with this recommendation in principle but recommends that MMSI numbers be requested when owners revalidate for the ORWA season. This can then be confirmed by OA’s as part of their race entry acceptance. Trying to include numbers in an annual magazine ORWA Handbook (yellow book) is impractical for timing reasons. We otherwise agree with RRS SR 3.25.1 (b) and (c) and recommend that MMSI details be included in the ORWA online registration system. Organising Authorities to confirm that all race entrants have a valid MMSI registration for Cat 1 to 4 races. RFBYC agree that the sport should be moving to mandatory MMSI compliance.</td>
</tr>
<tr>
<td>11</td>
<td>The Panel recommends that for all Category 2 and 3 RFBYC ocean races, the fitting of splashguards or sprayhoods to lifejackets should not just be 'strongly recommended' but mandatory.</td>
<td>The Club agrees that this should be referred to Australian Sailing for consideration for adoption into the Special Regulations. However, it would be incongruous for the Club to mandate individual requirements without support from the National Governing Body. It would be unfair on owners to have important and significant difference in safety demands from one race to the next depending on which club is conducting a race.</td>
</tr>
<tr>
<td>12</td>
<td>The Panel recommends that RFBYC in consultation with Australian Sailing:</td>
<td>The Club will refer this recommendation to Australian Sailing. As a matter of practicality, this is impossible to enforce or regulate as offshore racing is a self-regulating sport particularly during racing. However, an ongoing program of</td>
</tr>
<tr>
<td>12a</td>
<td>Review and determine the measures that should be implemented to ensure universal observance by racing sailors of the rules and regulations for wearing lifejackets.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>12b</td>
<td>Makes the 'strong recommendations' in Racing Rules of Sailing (RRS) 5.01.1 of the Special Regulation mandatory requirements for all Category 2 and 3 RFBYC ocean races.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Club agrees with this recommendation and will request Australian Sailing to consider making 5.01.1 (e) sprayhoods and 5.01.1 (h) when to wear lifejackets, mandatory in the RRS SR’s for all races Cat 3 and above.</td>
<td></td>
</tr>
<tr>
<td>12c</td>
<td>Gives serious consideration (if the first of the above recommendations cannot realistically achieve its aim) to requiring that lifejackets always be worn by crew when on deck.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Club will raise this recommendation with Australian Sailing. The Club notes that wearing a life jacket at all times may not be practical. The Club considers that the issue of wearing a lifejacket during yacht races, and the importance of doing so, is most appropriately addressed through education.</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>The Panel recommends that RFBYC consider in consultation with Australian Sailing whether its Sailing Instructions for Category 2 and 3 races should include a requirement that PLBs have a lanyard for attaching to the wearer.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Club agrees with this recommendation and will liaise with Australian Sailing regarding its inclusion in the Special Regulations.</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>The Panel recommends that any sailor with an interest in ocean racing undertake a training course and keep accreditation current every five years.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Club believes that this is part of the above-mentioned program of education, which should include sea survival training for offshore sailors as appropriate.</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>The Panel recommends that 30 per cent of the crew be qualified in AS SSSC survival training for all Category 3 races that extend beyond 12 hours.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Club agrees that this should be referred to Australian Sailing for consideration for adoption into the Special Regulations. However, it would be incongruous for the Club to mandate individual requirements without support from the National Governing Body, potentially giving rise to materially different requirements for yacht owners from race to race in the same State.</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>The Panel recommends that RFBYC in consultation with Australian</td>
<td></td>
</tr>
<tr>
<td>Sailing:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16a</td>
<td>Develop a standard safety briefing to be carried out on-board all participating yachts before the start of a race.</td>
<td></td>
</tr>
<tr>
<td>16b</td>
<td>That a yacht be disqualified if that briefing does not take place.</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>The Panel recommends that:</td>
<td></td>
</tr>
<tr>
<td>17a</td>
<td>RFBYC adopt for its ocean races a system of post-race declarations similar to that used by ocean racing clubs in the United Kingdom.</td>
<td></td>
</tr>
<tr>
<td>17b</td>
<td>The system use a form of declaration that draws the attention of skippers to compliance with specific safety requirements which can only be confirmed after the race.</td>
<td></td>
</tr>
<tr>
<td>17c</td>
<td>RFBYC endeavour to implement the system in a way (preferably electronically) which reduces any inconvenience when lodging the declaration.</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>The Panel recommends that a formal arrangement for an incident management service be put in place so that its services can be retained at short notice. Because sailing is largely a weekend sport, it is important to contract with a company with the resources to respond at any time.</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>The Panel recommends the Emergency Response Guide be reviewed for the 2018-2019 ocean racing season.</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>The Panel recommends that the Offshore Racing Committee be the Race Committee for all of RFBYC’s ocean races.</td>
<td></td>
</tr>
</tbody>
</table>

- As for Recommendation 15.
- The Club agrees with this recommendation.