

**MARINE OCCURRENCE REPORT**

**MAN OVERBOARD**

**FROM THE FISHING VESSEL "SEA LEVEL"  
YARMOUTH, NOVA SCOTIA  
29 APRIL 1996**

**REPORT NUMBER M96M0040**

The Transportation Safety Board of Canada (TSB) investigated this occurrence for the purpose of advancing transportation safety. It is not the function of the Board to assign fault or determine civil or criminal liability.

**MARINE OCCURRENCE REPORT**

Man Overboard

from the Fishing Vessel "SEA LEVEL"  
Yarmouth Harbour, Nova Scotia  
29 April 1996

**REPORT NUMBER M96M0040**

**Summary**

While the lobster-fishing vessel "SEA LEVEL" was outward bound from Johns Cove, Yarmouth Harbour, at approximately 0450 on 29 April 1996, a deck-hand fell overboard and drowned.

*Ce rapport est également disponible en français.*

**Other Factual Information**

**Particulars of the Vessel**

|                  |                              |
|------------------|------------------------------|
| Name             | "SEA LEVEL" ex-"CAPE RUSTY"  |
| Official Number  | 393535                       |
| Port of Registry | Yarmouth, N.S.               |
| Flag             | Canadian                     |
| Type             | Cape Island - fishing        |
| Gross Tonnage    | 21.1                         |
| Length           | 12 m                         |
| Propulsion       | GM diesel 671, 157 kW        |
| Built            | 1980, Clarke's Harbour, N.S. |
| Owner/Operator:  | S.N. Ward<br>Yarmouth, N.S.  |

The vessel departed her berth at Johns Cove, Yarmouth Harbour, at approximately 0445 in darkness on 29 April 1996, with the owner/operator and two deck-hands on board. The vessel was bound for an area where lobster traps had been laid earlier, to harvest any lobsters caught and rebait the traps. The bait to be used was deep-frozen and packed in waxed cardboard containers.

The owner/operator was alone in the wheel-house, hand-steering the vessel. One deck-hand was in the slaughterhouse preparing the bait. The second deck-hand, the victim, handed in the boxes of bait to the inside of the doorway. Having done so, he apparently climbed onto the 21 cm-wide port side decking to make his way forward to coil down the forward mooring rope. At the after end of the slaughterhouse, the top of the bulwark is at the same height as the side decking and is 64 cm above the level of the afterdeck. The handrail is positioned 142 cm above the side decking, on top of the wheel-house. It is essential to hold the handrail to pass safely.

The atmosphere on board was casual and comfortable with the deck-hands carrying out their duties, to which they were accustomed, without specific instructions.

There was no set routine for the deck-hands to carry out their respective tasks. Sometimes, the second deck-hand would stow the mooring lines immediately after leaving the dock, and sometimes, as in this instance, he would perform other work first.

The second deck-hand preferred to use the port side of the wheel-house to gain access to the foredeck. Passage along the starboard side decking is more visible to the owner/operator in the wheel-house as the steering wheel, engine control and electronic equipment are concentrated toward the starboard side of the

wheel-house. The windows on the port side of the slaughterhouse and

---

<sup>1</sup> All times are AST (Coordinated Universal Time (UTC) minus four hours) unless otherwise stated.

wheel-house are sealed units.

As is typical in this type of vessel, the main engine exhaust pipe passes from the uninsulated engine compartment through the slaughterhouse, creating a high noise level area in the slaughterhouse.

At approximately 0450, the owner/operator turned to look astern, as other fishing vessels located ahead, off to port, and astern were departing at about the same time. Navigation of the vessel and collision avoidance were uppermost in his mind at that time.

When the owner/operator saw only one deck-hand in the slaughterhouse, he asked the whereabouts of the other. He was told that the second deck-hand had gone to the bow, but from his vantage point, he realized that there was no one forward. He turned the "SEA LEVEL" through 180 degrees and shone the searchlight on the boat which was originally astern, approximately 122 m away.

He called that vessel on the very high frequency radiotelephone (VHF R/T) working frequency, channel 68, and advised that a man was lost overboard. The other vessel reported that nothing untoward had been seen. No cry for help had been heard.

Immediately after that conversation, the owner/operator reported the incident to the Marine Communications and Traffic Centre (MCTC) at Yarmouth, on VHF R/T channel 16.

The other deck-hand reportedly had seen the victim some two to five minutes before the owner/operator realized a man was missing.

The weather on the morning of 29 April in Yarmouth Harbour was fine and clear with little or no wind and calm seas. The air temperature was approximately 3°C and the water temperature, 4°C. In that area, high water was predicted to be at 0519 with a height of 4 m above chart datum. Between 0440 and 0500, the vessel was not rolling, and course alterations were gradual without any induced heel.

The victim, a non-swimmer, had ceased wearing a floater jacket approximately two weeks earlier as he felt the weather was sufficiently warm for him to do his work without it.

At the time of the accident, the victim was wearing good quality rubber boots, purchased approximately two weeks earlier. The manufacturer's literature states, in part, that: "Natural rubber is more flexible" and "the sole pattern provides sure-footed traction on slippery surfaces". His outer garb included a pair of green coveralls, and he was wearing raised-finish vinyl-coated

gloves with a soft liner. He had been wearing these gloves while handling the boxes of bait.

In response to the owner/operator's VHF call on channel 68, some

30 to 40 other local fishing vessels joined in the search, and in response to his call on channel 16 to the Yarmouth MCTC, the Search and Rescue (SAR) Centre in Halifax was informed.

At 0515, a Canadian Coast Guard (CCG) helicopter was tasked and the Royal Canadian Mounted Police (RCMP) was requested to organize a shore search. A Canadian Forces Labrador helicopter was also tasked at 0715 to be used as the primary SAR aircraft.

At 1506, the air search was discontinued and the search was handed over to the RCMP as a missing person case.

The RCMP dive team commenced searching the area at about the time of low water, predicted for 1127 that day. Divers found the body of the deceased on the morning of 30 April. An autopsy confirmed that the cause of death was by drowning, and toxicological tests determined that neither alcohol nor drugs were a factor in the occurrence.

The Canadian Red Cross has provided figures which indicate that a person can survive approximately one hour when immersed in water at a temperature of 4°C, and has slim chances of survival after one and a half hours of immersion.

In collaboration with the fishing industry and safety equipment manufacturers, the CCG has funded the development of a thermal worksuit suitable for working on deck.

In 1991, the CCG and the Department of Fisheries and Oceans (DFO) started a joint initiative to inform the fishing industry of the hazards of cold water exposure and of the advantages of anti-exposure worksuits. DFO distributed information pamphlets on the subject to fishermen seeking to renew their fishing licences.

The Small Fishing Vessel Regulations have been the subject of consultation between the CCG and the fishing industry for a number of years. One proposed amendment was to require small fishing vessels to carry an anti-exposure worksuit or an immersion suit for each member of the complement. This proposed requirement was opposed by some fishing interests because the suits were uncomfortable to wear and costly.

In its report on the sinking of the "STRAITS PRIDE II" (TSB Report No. M90N5017), the Board noted the perennially high risk to Canadian fishermen and recommended that:

The Department of Transport expedite its revision of the Small Fishing Vessel Safety Regulations which will require the carriage of anti-exposure worksuits or survival suits by fishermen.

(M92-07, issued in March 1993)

In its response, Transport Canada acknowledged the utility of the recommendation. It further indicated that, in the proposed revised Small Fishing Vessel Regulations ultimately agreed to by the fishing industry and the CCG, anti-exposure worksuits are provided for as alternative equipment, and that the CCG would continue to actively promote the voluntary carriage of the worksuit.

### **Analysis**

As no one witnessed the deck-hand falling overboard, the precise cause of his fall cannot be established. However, it would appear that he lost his footing or his handhold, or both, as he attempted to make his way from the afterdeck to the foredeck via the comparatively narrow side decking on the port side of the slaughterhouse and wheel-house.

Since there is no noise barrier between the engine-room and the slaughterhouse and the exhaust pipe passes through the slaughterhouse, a high noise level is created in the area, especially when the engine is operating at full speed, as it was on the morning of 29 April. Furthermore, the sealed windows on the port side of the wheel-house probably would make any outside sound inaudible to anyone in the wheel-house. Hence, a cry for help, if any, would have gone unnoticed aboard the vessel.

Because of the view of the starboard side decking afforded from the conning position, the owner/operator would have been in a better position to monitor the deck-hand's progress if he had passed on that side of the wheel-house.

The victim, a non-swimmer, was not wearing any form of flotation device. Consequently, his ability to survive was greatly reduced when he fell into the cold water.

The rubber boots the deck-hand was wearing are considered to be of better-than-average quality and were almost new. His vinyl-coated gloves were ideal for working in cold water but not good for climbing on the outboard side of the wheel-house.

### **Findings**

1. The deck-hand, without the knowledge of the other crew members, attempted to make his way from the afterdeck to the foredeck via the narrow, 21 cm-wide port side decking.
2. The cause of the deck-hand's fall overboard cannot be positively established. However, it is likely that he lost his footing or his handhold, or both, and fell overboard.
3. The deck-hand elected to use the narrow port side decking to

gain access to the foredeck; the owner/operator would have been in a better position to monitor the deck-hand's progress if he had used the starboard side decking, which was of the same width.

4. The high level of engine noise and the sealed wheel-house windows on the port side could preclude any call for help from being heard.
5. The deck-hand, a non-swimmer, was not wearing any form of flotation device, which greatly reduced his ability to survive when he fell overboard into the cold water.
6. The CCG and the fishing industry have agreed that anti-exposure worksuits are alternative (safety) equipment for small fishing vessels, and the CCG actively promotes the voluntary carriage of worksuits on these vessels.

#### **Causes and Contributing Factors**

The precise cause of the deck-hand's fall overboard cannot be established; however, it is likely that he lost his footing or handhold, or both, and fell overboard. The deck-hand's ability to survive was greatly reduced because he was not wearing any form of flotation device.

*This report concludes the Transportation Safety Board's investigation into this occurrence. Consequently, the Board, consisting of Chairperson Benoît Bouchard, and members Maurice Harquail, Charles Simpson and W.A. Tadros, authorized the release of this report on 22 May 1997.*