MAIB
MARINE ACCIDENT INVESTIGATION BRANCH

ACCIDENT REPORT

VERY SERIOUS MARINE CASUALTY | REPORT NO 10/2024 | SEPTEMBER 2024

Fatal man overboard from the sail training vessel *Pelican of London* at Sharpness, England on 2 October 2023

Email: maib@dft.gov.uk
Tel: +44 (0)23 8039 5500

SUMMARY

On the night of 2 October 2023 the volunteer relief cook of *Pelican of London* fell from the top of the vessel's gangway into the water. His absence was not noted until the next morning when a search was started. In the early afternoon of 3 October, police divers recovered the relief cook's body to the quay where he was declared deceased.

Pelican of London

The investigation found that the gangway was not rigged to provide safe access to *Pelican of London* as the arrangement of gangway guard ropes and safety net did not prevent the relief cook's entry into the water. The investigation also found that the relief cook was under the influence of alcohol when he fell and that risk assessments were not robust.

Recommendations have been made to Seas Your Future to review and amend policies, procedures and training for rigging and approving the gangway arrangement; adapt its drugs and alcohol policy to include specific guidance for those returning on board from recreational time ashore; and, to refresh its risk assessments for means of safe access to ensure adoption of the guidance contained in the Code of Safe Working Practices for Merchant Seafarers[1].

FACTUAL INFORMATION

Narrative

At 0803[2] on 27 September 2023, the sail training vessel *Pelican of London* moored starboard side to at Sharpness shipyard **(Figure 1)** for maintenance and repair ahead of a planned dry-docking on 4 October. Shortly after arrival the vessel's master departed without relief, leaving the chief mate to run the maintenance period. Later that day, holding off lines were rigged and adjusted to keep the ship from touching the sides of the dock and the gangway was also moved to align with a gap in shoreside safety barriers. On 28 September, a volunteer joined *Pelican of London* to act as relief cook while the permanent cook was away on training courses and leave.

[1] 2015 edition – amendment 7, October 2022.

[2] All times are British Summer Time – universal time coordinated +1 hour (UTC+1).

Reproduced from Admiralty Chart 0002-0 and (inset) 1166-4 by permission of HMSO and the UK Hydrographic Office

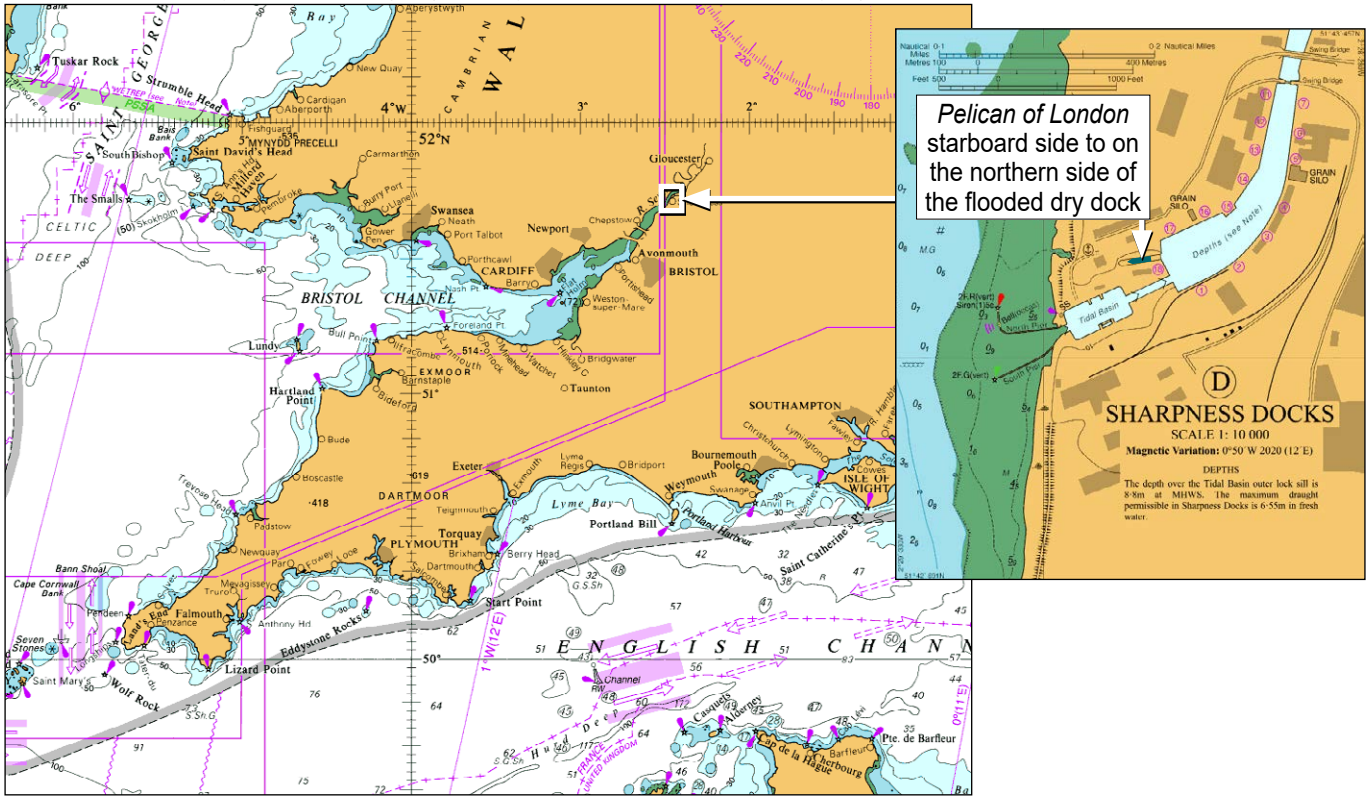


Figure 1: The accident location

Image courtesy of Sanders Stevens as part of Victoria Group

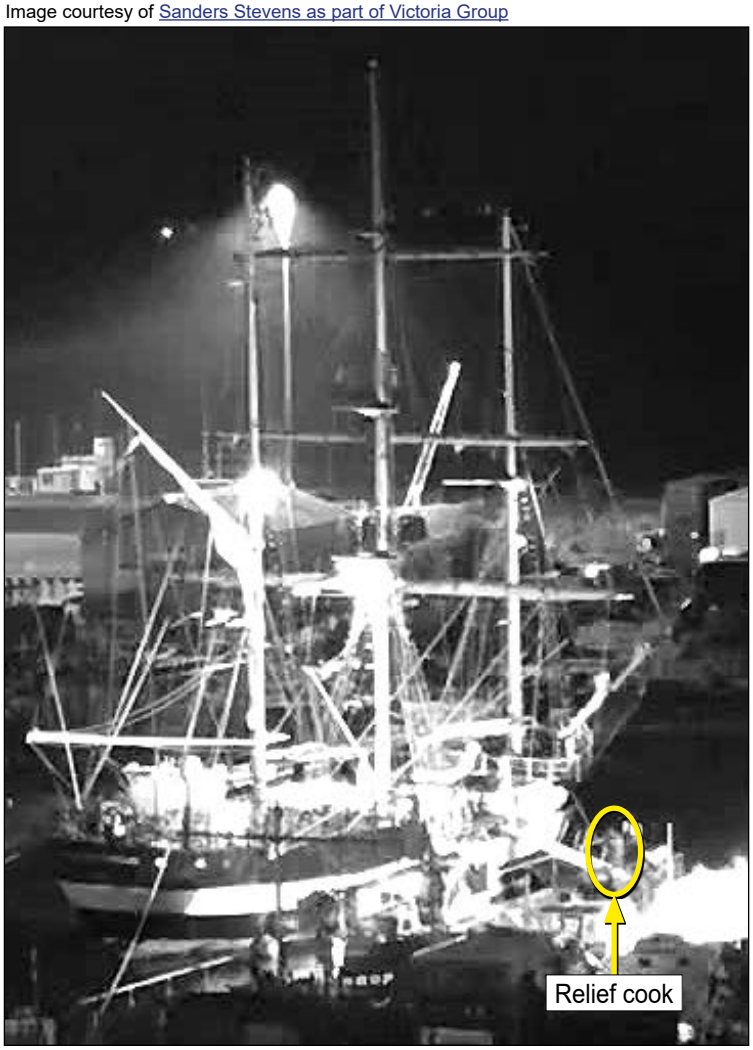


Figure 2: CCTV image of the relief cook ascending the gangway

On the evening of 28 September, the relief cook received a handover from the permanent cook and an induction brief from the chief mate before starting his duties the next morning. On the nights of 30 September and 1 October, the relief cook went ashore to a local bar where some of the crew noted that he was drinking several double whiskies and ice.

At 2009 on 2 October, the relief cook joined his *Pelican of London* colleagues at the local bar where, over the next 2 hours and 42 minutes, he drank at least nine double whiskies and ice. The relief cook was the last customer in the bar when he left at 2251, walking back to *Pelican of London* alone. Arriving at the ship at 2307, the relief cook slowly ascended the gangway **(Figure 2)** and then paused for a few seconds to step down towards the deck via the bulwark ladder.

At 2308, the relief cook fell from the left-hand (aft) side of the top of the gangway, landing with a splash into the dock. The chief engineer (C/E) heard the noise and ran up from their cabin to the well deck, arriving within 7 seconds. The C/E looked

to starboard, towards the gangway, then went to check the port side of the well deck; as they did this there was further movement in the water directly underneath the gangway. The C/E stepped up onto the gangway and looked around for the source of the noise but saw nothing. Twenty-one seconds after the fall there was no further movement in the water. The C/E then walked ashore and searched the area forward of the gangway. After 2 minutes of searching, the C/E had seen nothing of concern and so went to bed, unaware that the relief cook was in the water.

At breakfast the next morning the crew noticed the relief cook was absent and started searching for him. After a review of Sharpness Port's closed-circuit television (CCTV) the police were called to search for the relief cook. At 1401, his body was recovered to the jetty.

Environmental conditions

On the evening of 2 October, it was drizzling and the wind was gusting up to 12 knots (kts) from the south-west. Water temperature was not measured, although the air temperature dropped from 16°C to below 14°C so the water temperature was likely to be around 15°C when the relief cook entered the water. In-water visibility was very poor. Sharpness shipyard was non-tidal and the water levels in the dock had remained near constant since *Pelican of London*'s arrival on 27 September.

Pelican of London

Pelican of London was a 34.6m mainmast barquentine[3] sail training vessel, built in 1948 as a fishing trawler. In 1995, *Pelican of London* was purchased by the UK registered charity Adventure Under Sail (operating as Seas Your Future) and converted into a sail training vessel; its maiden voyage for the charity started in September 2007. Seas Your Future owned two vessels, *Pelican of London* and *Fridtjof Nansen*.

The three decks on *Pelican of London* comprised a lower deck, a main working deck and an upper deck, which was split into forecastle, well deck and poop deck areas **(Figure 3)**.

The vessel was crewed by a mix of permanent professional crew members and volunteers. The permanent crew normally fulfilled the roles of master, chief mate, second officer, C/E, bosun, bosun's mate and cook. The volunteers carried out general duties, assisting the permanent crew as befitted their interests and talents. During normal operation the vessel embarked trainees; none were on board in Sharpness. The permanent crew were qualified to serve in their positions on board and the deck officers either held Efficient Deck Hand (EDH) certificates[4] or held qualifications that predated this requirement from June 2015.

Pelican of London was coded to The Code of Practice for Safety of Large Commercial Sailing and Motor Vessels,1997, as amended. One such amendment was the introduction of a requirement to employ a safety management system as described in the Large Commercial Yacht Code, published in 2007. *Pelican of London* was not required to comply with the International Ship and Port Facility Security Code requirements for maintaining a gangway security watch.

The gangway

Pelican of London had a ship's gangway that was 5.6m in length and constructed from two separate 2.8m sections. The gangway had a total of four guard rope stanchions fitted on each side and these were each threaded with two guard rope lines, the top line being at a 1m height. On arrival in Sharpness, the gangway had been rigged from the forward end of the starboard well deck to the shore. Later that same day, the gangway was shifted slightly and rerigged[5] **(Figure 4)** as some of the other berthing ropes and holding-off lines had been adjusted to stop *Pelican of London*'s hull from touching the side

[3] A sailing vessel of three or more masts where the mainmast is square rigged and the other two are rigged fore and aft.

[4] The Efficient Deck Hand certificate established a standard of knowledge in practical and theoretical seamanship and shipboard organisation and management.

[5] The gangway was adjusted again before the investigation team arrived on board, following Maritime and Coastguard Agency (MCA) advice. This was to ensure the gangway was safe for further use. The investigation recovered detail from the site and from photographs of the gangway as it was at the time of the accident.

Base image courtesy of Midship Boats Services Ltd

For illustrative purposes only: not to scale

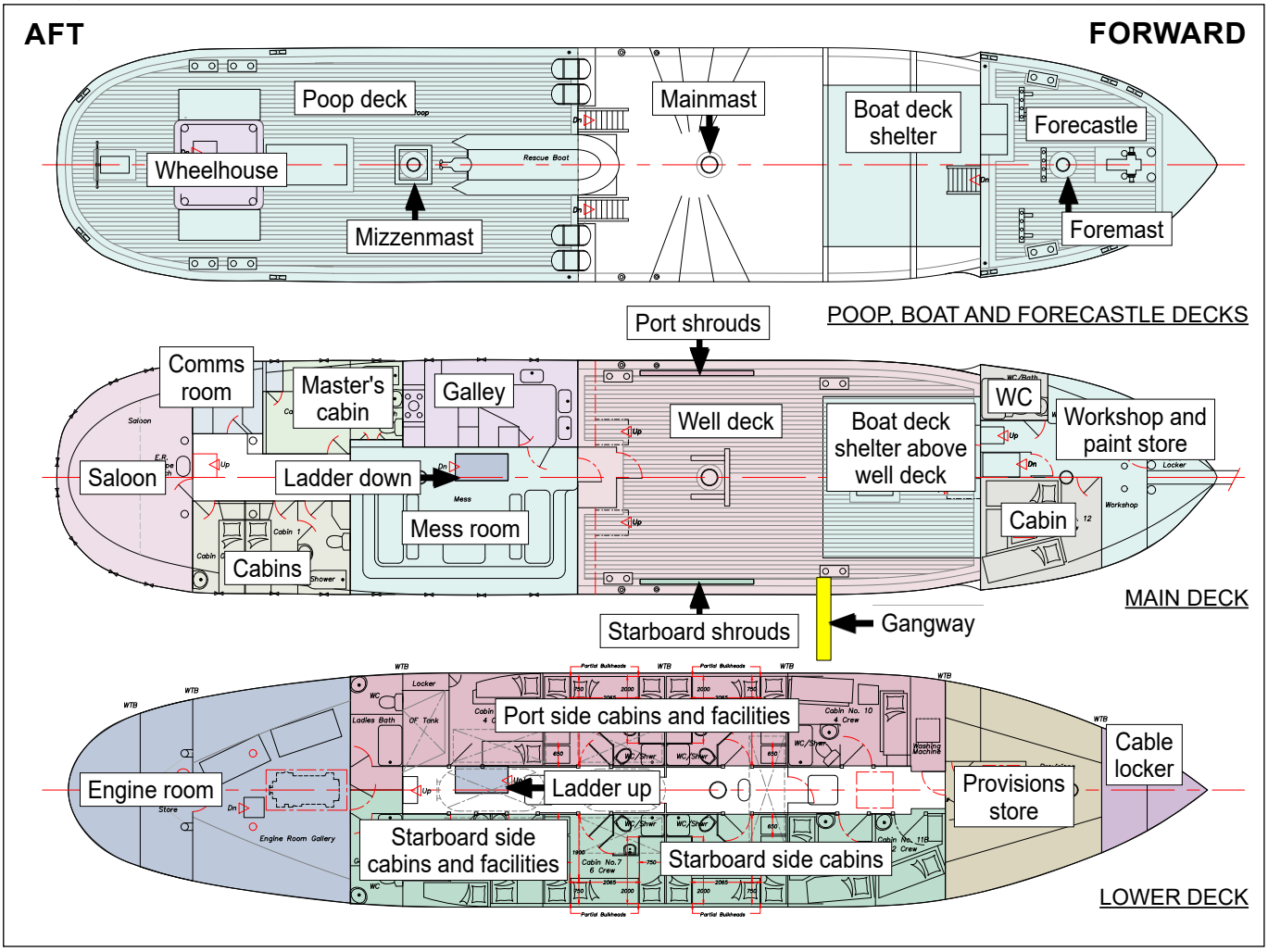


Figure 3: *Pelican of London* general arrangement

Images courtesy of Gloucestershire Constabulary

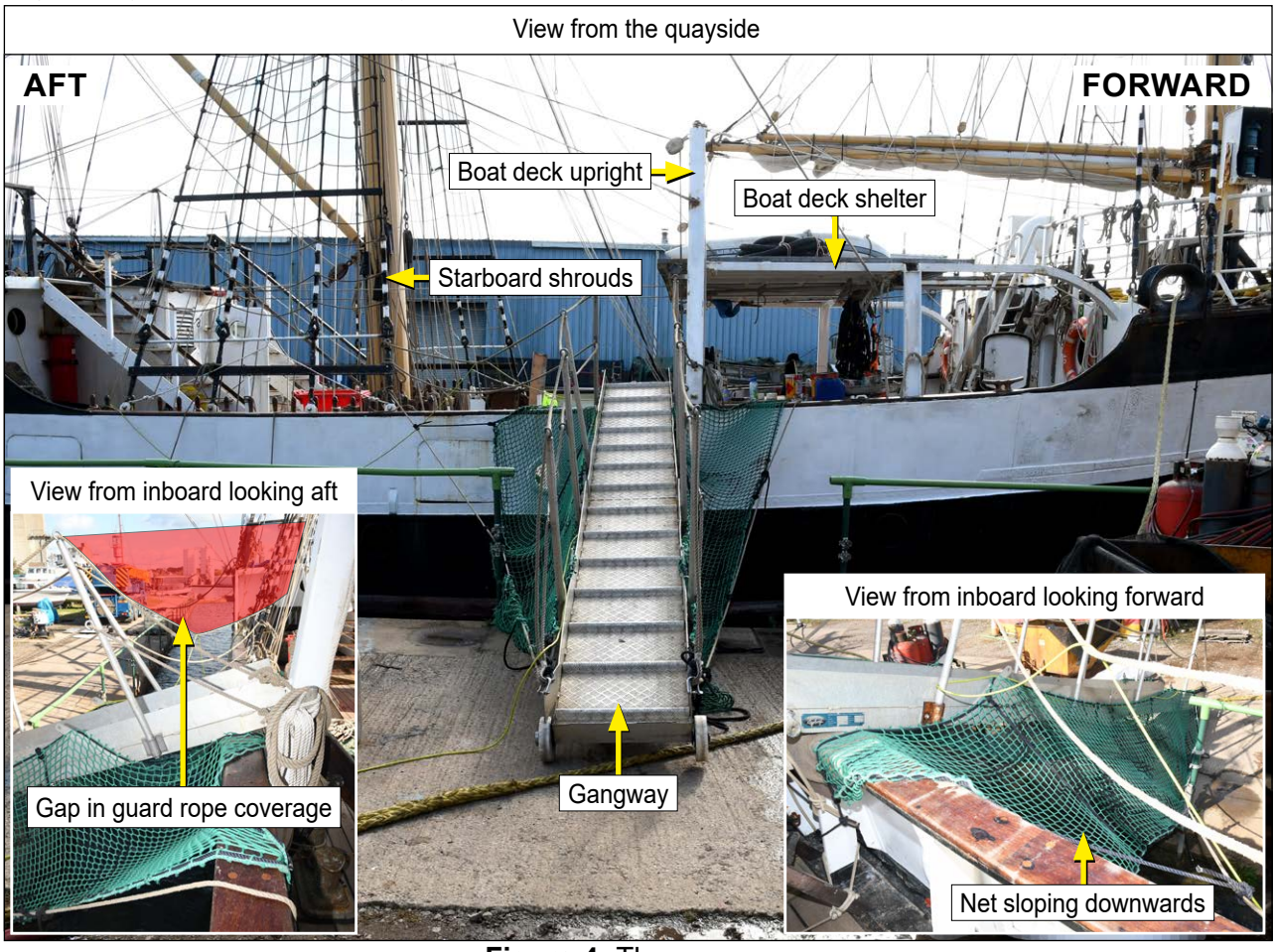


Figure 4: The gangway

of the dry dock. This meant that the forward inboard end of the gangway was next to one of the boat deck uprights with the aft inboard end of the gangway halfway between the boat deck upright and the mainmast's starboard shrouds.

At the top end of the gangway the aft side's guard ropes had been tied off slack on the forward shroud line at a height of approximately 0.5m above the top of the bulwark. An electric cable had been run over the top of the aft guard ropes and along the aft side of the gangway to a position on the quay. The electric cable served to depress the guard ropes such that they were roughly 0.3m high at their lowest point. The guard ropes at the inboard end of the forward side of the gangway had been tied off on a cleat on the aft upright of the boat deck (approximately 0.25m above the bulwark top) and at the base of the same upright.

The gangway net was rigged in two rectangular sections (approximately 1m x 5m). Each rectangular net section was arranged with its long edge lashed to the edge of the gangway; one forward and one aft. The outer long edges of the gangway net sections were lashed to lines run from the shore end of the gangway to points on board. On the forward side, this line was secured to the base of a bulwark stanchion about 2m forward of the gangway. Aft, this line was secured to the base of the forward starboard shroud. This meant that, on either side of the gangway, the nets sloped downwards away from the gangway edges by approximately 30° from the horizontal.

Crew learned how to rig the gangway from others through word of mouth and by the example set by their peers, and a significant number believed that the net was there *to catch parcels* dropped by people crossing the gangway. The crew directly involved in rigging the gangway did not refer to onboard risk assessments or other safety-related documentation though some crew were aware that these existed. *Pelican of London*'s crew did not maintain a dedicated gangway watch in Sharpness.

Onboard safety information

Seas Your Future staff and *Pelican of London* crew had produced a safety management system (SMS) and risk assessments. Document TSP RA 008 assessed the risks associated with gangway operations on board *Pelican of London* **(Figure 5)**. It was updated post-accident following an inspection by the Maritime and Coastguard Agency (MCA). The original risk assessment was not available to the investigation. TSP RA 008 considered the population at risk to be members of the crew, both when rigging and derigging the gangway and when using the gangway. All the other risk assessments held on board followed the same format as TSP RA008. A copy of the Code of Safe Working Practices for Merchant Seafarers (COSWP)[6] was held on board, though few cited it as being used to guide their activities.

The volunteer code of conduct set the standards of behaviour expected by Seas Your Future and applied to all volunteers on board the charity's vessels. Permanent crew and trainees had their own, similar, codes of conduct. On drugs and alcohol, the volunteer code of conduct stated that:

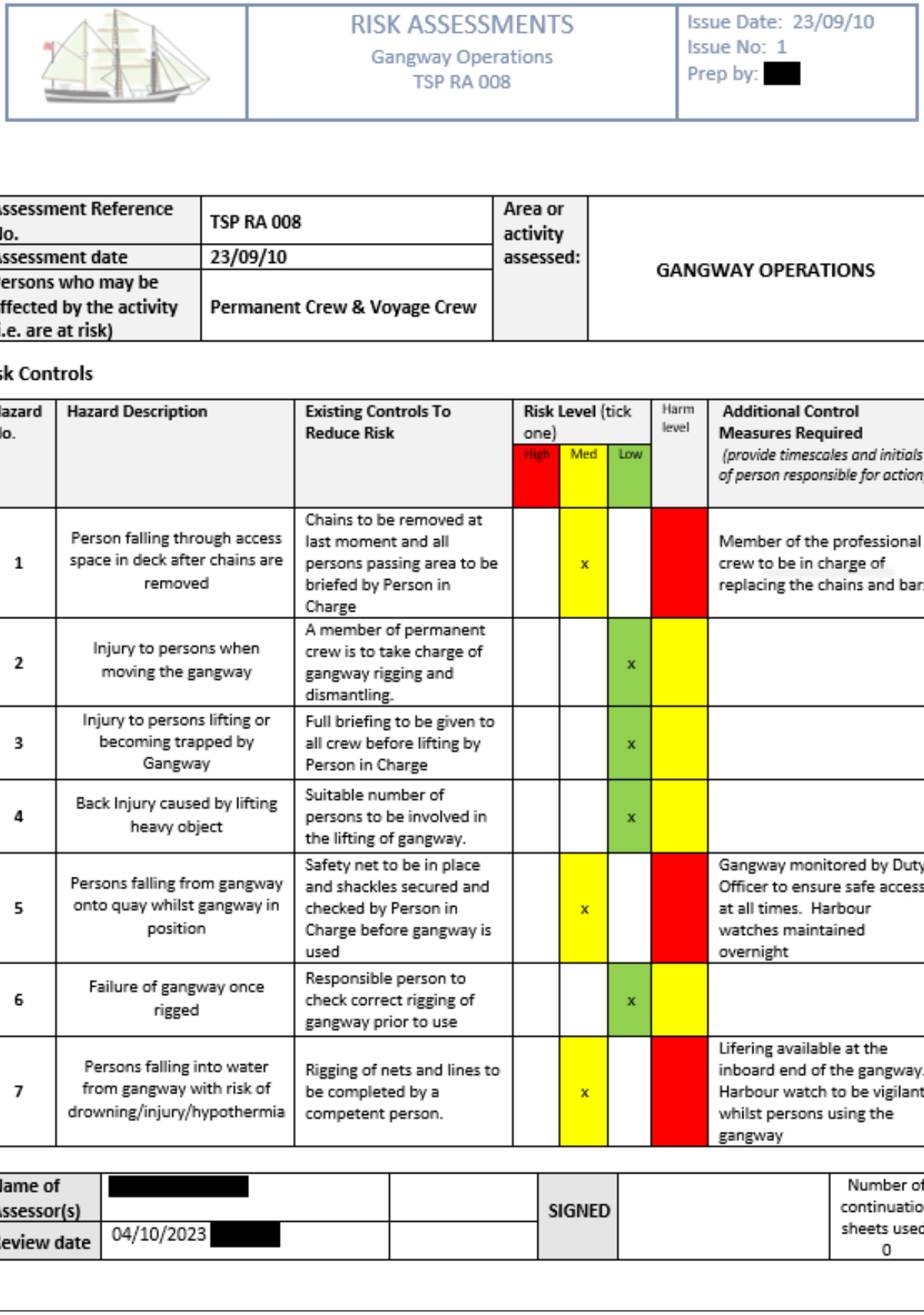
> [Seas Your Future] *prohibit…being under the influence of alcohol, illegal drugs or any other substances that may affect your performance and behaviour in the workplace. Consumption of alcohol…prior to and/or during a work shift is not allowed. Consumption of alcohol…should be enjoyed in moderation. You must ensure that your actions do not bring into question the professionalism of yourself or the charity.*

Annex 4 of *Pelican of London*'s ship operations manual highlighted excerpts of a drugs and alcohol policy though did not reference which one and referenced the alcohol limits detailed in the Railways and Transport Safety Act 2003. The policy did not specifically mention crew returning on board from recreational time ashore, though Annex 4 did state that *the only guarantee* [to stay under the prescribed limits] *is not to drink for several hours prior to a duty period*. This guidance was not replicated in the volunteer code of conduct. A copy of a drugs and alcohol policy was posted on the vessel's main noticeboard that, while similar to the policy described in the code of conduct, had slightly different phrasing.

[6] 2015 edition – amendment 7, October 2022.

Annex 4 also stated that there was a *breathalyser* on board *for the purpose of assessing levels of alcohol in breath*. The breathalyser was available on 2 October, although the crew on board did not know its exact location in the captain's cabin. The breathalyser had not been used.

Image courtesy of Seas Your Future



	RISK ASSESSMENTS Gangway Operations TSP RA 008	Issue Date: 23/09/10 Issue No: 1 Prep by: [redacted]

Assessment Reference No.	**TSP RA 008**	**Area or activity assessed:**	**GANGWAY OPERATIONS**
Assessment date	**23/09/10**		
Persons who may be affected by the activity (i.e. are at risk)	**Permanent Crew & Voyage Crew**		

Risk Controls

Hazard No.	**Hazard Description**	**Existing Controls To Reduce Risk**	**Risk Level** (tick one) High	Med	Low	Harm level	**Additional Control Measures Required** *(provide timescales and initials of person responsible for action)*
1	Person falling through access space in deck after chains are removed	Chains to be removed at last moment and all persons passing area to be briefed by Person in Charge		x			Member of the professional crew to be in charge of replacing the chains and bars
2	Injury to persons when moving the gangway	A member of permanent crew is to take charge of gangway rigging and dismantling.			x		
3	Injury to persons lifting or becoming trapped by Gangway	Full briefing to be given to all crew before lifting by Person in Charge			x		
4	Back Injury caused by lifting heavy object	Suitable number of persons to be involved in the lifting of gangway.			x		
5	Persons falling from gangway onto quay whilst gangway in position	Safety net to be in place and shackles secured and checked by Person in Charge before gangway is used		x			Gangway monitored by Duty Officer to ensure safe access at all times. Harbour watches maintained overnight
6	Failure of gangway once rigged	Responsible person to check correct rigging of gangway prior to use			x		
7	Persons falling into water from gangway with risk of drowning/injury/hypothermia	Rigging of nets and lines to be completed by a competent person.		x			Lifering available at the inboard end of the gangway. Harbour watch to be vigilant whilst persons using the gangway

Name of Assessor(s)	[redacted]		**SIGNED**		Number of continuation sheets used: 0
Review date	04/10/2023 [redacted]				

Figure 5: Gangway risk assessment

The volunteer relief cook

Mark Glover was a 64-year-old professional seafarer who had served as a cook on dredgers. He could swim and, although he was on board *Pelican of London* as a volunteer and was therefore not required to hold a seafarer medical fitness certificate, he held an ENG1[7] that limited his sea service to coastal waters. He had a history of excessive alcohol use, type 2 diabetes and atrial fibrillation[8].

On 28 September, Mr Glover had signed on to *Pelican of London* as a volunteer relief cook for the period the vessel was planned to be alongside. This was to allow the permanent cook time ashore for training and to take leave. The cook's duties while on board were to prepare all the meals, purchase food stores, maintain galley hygiene and order, and respond to emergencies. Mr Glover was somewhat familiar with *Pelican of London*, having served on board 4 years earlier. An induction form had not been completed, although the chief mate had conducted a walkaround of the vessel and briefed the relief cook on his duties and organisational expectations; this did not cover the drugs and alcohol policy.

At the time of the accident, the relief cook was wearing a T-shirt, hooded jacket, trousers, and slip-on safety boots that, despite the age of them, were in reasonable condition with a good tread. His right safety boot was missing when he was recovered from the water.

The postmortem concluded that the relief cook had suffered a minor blow to the nose on entry into the water and had 190 milligrams (mg) per 100 millilitres (ml), equivalent to 190mg per decilitre (dl), of alcohol in his blood and 212mg/dl in his urine. His liver was described as normal and his lungs *contained watery fluid*. While alcohol *may have contributed to* [his] *toxicity/death* the postmortem recommended that *drowning* be recorded as the cause of death.

Alcohol and its effects

The effects of alcohol worsen with increasing amounts of alcohol per dl of blood or urine and result in:

- increasingly impaired coordination, judgement and risk perception;
- a decreasing capacity to balance;
- visual disturbances, including reduced night vision;
- increased reaction times and confusion.

The Railways and Transport Safety Act 2003 prescribed a seafarer's blood alcohol limit as 50mg/dl and urine alcohol limit as 67mg/dl.

The body's metabolism stops at the point of death so the alcohol levels noted during the postmortem examination would not have changed significantly between the accident and when the relief cook's body was examined. The shorter the period of time between when someone stops drinking alcohol and their death, the closer the blood and urine alcohol levels. National Health Service guidance[9] indicated that it takes, on average, approximately one hour for an adult to process one unit of alcohol and eliminate it from their body.

Cold water immersion

Sudden immersion in water temperatures of less than 15°C can result in cold water shock and/or cold incapacitation. Cold water shock is an immediate reaction to entering the water and is associated with a gasp reflex, hyperventilation and a rapid increase in heart rate and blood pressure as the body encounters the cold water, increasing the risk of drowning or heart failure.

[7] The standard medical fitness certificate for UK seafarers on UK vessels.

[8] A heart condition that causes an irregular and often abnormally fast heart rate.

[9] https://www.nhs.uk/live-well/alcohol-advice/calculating-alcohol-units/

Cold incapacitation usually occurs within 2 to 15 minutes of entering the water. The blood vessels become constricted as the body tries to preserve heat and protect vital organs. This results in the blood flow to the extremities being restricted, causing cooling and consequent deterioration in the functioning of muscles and nerve ends, which leads to progressive incapacitation that impedes the ability to swim.

Regulation and guidance

Chapter 1 of the COSWP, Managing Occupational Safety, detailed how to deliver an effective risk assessment process that identified hazards; who might be harmed and how; the likelihood and severity of that harm; how to record findings and implement control measures; and, how to conduct effective reviews and updates. Annex 1.4 to the COSWP detailed an example risk assessment in three sections.

The boarding arrangements outlined in Chapter 22 of the COSWP stated that:

- *The means of access should be inspected to ensure that it is safe to use after rigging and that guard ropes…should be kept taut at all times.*
- Where reasonably practicable, *safety nets must be mounted and the whole length of the means of access should be covered*.
- When the inboard end of a gangway rests on the top of the bulwark, *Any gap between the bulwark ladder and the gangway should be adequately fenced to a height of at least 1 metre*.

Marine Guidance Note 533 (M) Amendment 2 Means of Access (MGN 533), published in 2022, described the duty placed on shipowners, employers and persons *in control of the matter* to provide a *safe means of access* between the ship and the quay. MGN 533 directed seafarers to Chapter 22 of the COSWP for more detail on the standards to be applied.

The Nautical Institute's 2009 publication Mooring and Anchoring Ships, Volume 1, Principles and Practice provided guidance on rigging a gangway, including that spreader bars could be used to ensure that the safety *net can be properly stretched out over the gap between the ship and the quay*.

Merchant Shipping Notice 1858 (M) Amendment 1 (MSN 1858), *Training and Certification Guidance: UK Requirements for Deck Officers on Large Yachts (24m and over)*, required *Pelican of London*'s deck officers to hold an EDH certificate attained from approved courses that, since 1999, had included training on how to rig a gangway. Officers who had fully qualified before 11 June 2015[10] were not required to hold an EDH certificate.

Previous similar accidents

On 23 September 2017, a crew member of the commercial fishing vessel (FV) *Constant Friend* fell into the water at Kilkeel Harbour while attempting to board the boat under the influence of alcohol[11]. Five days later, the crew member died in hospital due to a hypoxic-ischaemic brain injury caused by drowning. The investigation report (MAIB report 4/2018[12]) made a recommendation (2018/109) to review and amend MGN 337 (M+F) Provision of Safe Means of Access to Fishing and Other Small Vessels *to highlight the need for risk assessments to specifically include the hazards associated with crew members proceeding to and from the shore for recreational activities*. The investigation also recommended (2018/111) that FV *Constant Friend*'s owner review the risk assessments *relating to boarding and leaving the boat* and include *the hazards associated with crew members proceeding to and from the shore for recreational activities*. The recommendations were accepted: MGN 337 (M+F) was updated accordingly, and the owner updated the vessel's risk assessments.

On 12 November 2017, a crew member of the commercial FV *Illustris* fell into the water and drowned at North Shields after boarding the vessel while under the influence of alcohol[13]. The investigation

[10] The requirement for EDH certificates was reflected in MSN 1858, published on 11 June 2015.

[11] A hospital blood test showed shortly after admittance showed a blood alcohol concentration of 291mg/dl.

[12] https://www.gov.uk/maib-reports/man-overboard-from-stern-trawler-constant-friend-with-loss-of-1-life

[13] The postmortem showed a blood alcohol concentration of 346mg/dl.

report (MAIB report 15/2018[14]) made a recommendation (2018/122) that the owner *Take account of the hazards associated with crew members proceeding to and from shore for recreational activities by*, in part, *establishing a formal drug and alcohol policy that will apply to the crew at all times when living and working on board*. The recommendation was accepted and enacted.

ANALYSIS

The accident

Pelican of London's volunteer relief cook lost his balance when returning on board as he went to step down from the inboard end of the gangway onto the top step of the bulwark ladder. His fall aft was neither prevented by the guard ropes nor arrested by the gangway net. Under the influence of alcohol and probably suffering from cold water shock the relief cook was unable to climb out of the water and rapidly succumbed to drowning.

The gangway

When the gangway was rerigged on 27 September the guard ropes from the stanchions on the inboard end of the gangway were tied off aft on the shrouds near the top of the bulwark, and forward low down on the starboard aft boat deck upright. This left significant gaps in the effective fencing between the top of the bulwark ladder and the inboard end of the gangway on both sides. These gaps were worsened by the electric cable that ran across the guard ropes and did not provide a sufficient barrier to prevent anyone from falling overboard from the top of the gangway.

The safety net, which should have arrested the fall of anyone toppling from the gangway, was rigged without a spreader bar. With the net's outer edges tied low onto the shrouds aft, and onto the bulwark forward, the net sloped downwards away from the gangway, creating a chute that did nothing to arrest the relief cook's fall.

The gangway was not formally inspected by someone holding an EDH certificate after it was rerigged to make sure it was safe to use and complied with the COSWP guidance.

Without reference to the COSWP, the Nautical Institute's Mooring and Anchoring Ships publication, or a local work instruction, those rigging and inspecting the gangway had no direction to assist them in their duties. This meant that there was a reliance on crew learning best practice from experience; however, without those formal references and guides, crew replicated what had become accepted as normal and were unaware it was unsafe.

Having rigged the gangway *as it was normally rigged*, poor practice was passed on over time without question and without a true understanding of the purpose of either the guard ropes or the safety net. Normalised to this approach, the permanent crew, volunteers and shore workers all used the gangway over the subsequent days without considering, or being alerted to, the risks associated with someone falling from its inboard end. The inadequate fencing and inappropriately rigged safety net exposed all gangway users to serious hazard as they traversed the gangway, whether they were conducting administrative duties, carrying stores or returning from recreational time ashore.

An onboard procedure for the rigging of *Pelican of London*'s gangway, based on industry guidance, would have provided a sound basis for both crew training and post-rigging inspection to ensure the gangway was safe to use.

The risk assessment

The version of TSP RA 008 in force before the accident was not available to the investigation, but several issues were noted in the updated risk assessment as available on 4 October 2023. By conflating the activity of rigging the gangway with its use the population at risk was misidentified. The risk assessment had not considered the risk of any gangway user (including trainees and members of the public) slipping,

[14] https://www.gov.uk/maib-reports/man-overboard-from-stern-trawler-illustris-with-loss-of-1-life

stumbling or falling while boarding or leaving the vessel. As a result the role of guard ropes and safety nets as vital mitigating measures in the event of a fall were not highlighted. Formal checks of the gangway by trained individuals were lacking as were any specific procedures to be followed to ensure that a safe gangway had been rigged. As in the FV *Constant Friend* and FV *Illustris* fatal accidents, by not considering the hazards associated with crew proceeding to and from the shore for recreational activities key areas of risk were missed. Each hazard identified in TSP RA 008 did not attribute specific severities and likelihoods of harm to then define the resultant risk level, and no timescales and responsibilities were defined for the additional control measures required. The risk assessment did not include the bulwark ladder in its consideration of the gangway as a means of providing safe access to and from the ship. This lack of integration resulted in there being no focus on ensuring that any gap in fencing between the inboard end of the gangway and the bulwark ladder was appropriately addressed.

TSP RA 008 did not include reference to the COSWP, nor to any other guidance for those checking the *correct rigging of* [the] *gangway*. The COSWP represented the collation of years of experience in the maritime environment and the contents of Chapter 1 provided excellent advice to seafarers conducting and capturing risk assessments. This did not appear to have been followed closely, resulting in onboard risk assessments that did not sufficiently mitigate the risk of a fall from the gangway.

Drugs and alcohol policy

The drug and alcohol policies published by Seas Your Future for use by those on board *Pelican of London* were relatively clear and the different versions available all prohibited drinking on board in most circumstances. As in the FV *Illustris* fatal accident, none of the available policies referred to individuals living on board and returning to the vessel from recreational time ashore. Further, the policies did not provide crew and trainees with clear guidance on drug and alcohol consumption while ashore nor how others might intervene effectively.

The relief cook went ashore and drank to excess at a local bar on 2 October. It is likely that he had also drunk to excess on the previous two evenings ashore. Having consumed at least 18 shots of whisky that resulted in a blood alcohol level measured postmortem at 190mg/dl, the relief cook was 3.8 times over the legal limit when he died. As the alcohol levels recorded postmortem were similar for both his blood and urine, the relief cook's death occurred shortly after he stopped drinking and returned to *Pelican of London*. With these levels of alcohol in his system it was probable that he was experiencing poor balance and coordination, low levels of risk perception, markedly impaired judgement, increasing visual disturbances and lengthy reaction times. Had he made it on board safely the relief cook would probably have been almost twice the legal limit by 0730 the next morning when he was expected to start duty. It is likely that the relief cook experienced cold shock on entering the water when he fell from the gangway and that his state of intoxication hindered his ability to raise the alarm or attempt to self-rescue.

On all three evenings before the accident the relief cook was drinking ashore, to some extent accompanied by other crew members. Interventions were available; however, none were exercised. The relief cook was not advised to stop drinking and return on board, nor was he escorted back or advised to seek alternative accommodation. The duty officer was not alerted to the probable intoxication of the relief cook such that they could attend his return on board, and no use was made of the on board breathalyser to measure the degree to which the relief cook was influenced by alcohol and assess his ability to carry out his duties. The drug and alcohol policies did not help crew members recognise the limits that applied to crew returning from recreational time ashore. There were early indications of a problem with the relief cook's alcohol consumption, but this did not result in an effective intervention.

CONCLUSIONS

- *Pelican of London*'s gangway did not provide a safe means of access to the vessel. Specifically, inadequate fencing and an inappropriately rigged safety net exposed all gangway users to serious hazard as they traversed the gangway, whether they were conducting administrative duties, carrying stores or returning from recreational time ashore.

- Document TSP RA 008, assessing the risks associated with gangway operations did not consider the risks to all gangways users, nor did it refer to the guidance in the COSWP or other industry publications. The result was a lack of guidance and training for those rigging and those inspecting the gangway before use. As such, it did not sufficiently mitigate the risk of a fall from the gangway.
- The relief cook was under the influence of alcohol when he fell from the gangway and was above the legal limit for duty on board *Pelican of London*. It is likely that the relief cook experienced cold shock on entering the water when he fell from the gangway and that his state of intoxication hindered his ability to raise the alarm or attempt to self-rescue.
- The drug and alcohol policies did not help crew members recognise the limits that applied to crew returning from recreational time ashore. There were early indications of a problem with the relief cook's alcohol consumption, but this did not result in an effective intervention.

ACTION TAKEN

MAIB actions

The MAIB has issued a safety flyer to the shipping industry highlighting the lessons to be learned from this accident.

Actions taken by other organisations

The **Seas Your Future** charity has:

- Revised its procedures and introduced an approval process for rigging and making a gangway safe.
- Fitted bulwark stanchions to provide secure handholds when joining or departing the ship and to assist in the adequately fencing of any gap between the bulwark ladder and the inboard end of the gangway.
- Promulgated a revised drug and alcohol policy that is consistent across policies, induction proformas, code of conduct and joining instructions, and on local noticeboards.
- Reviewed the organisation's SMS to reflect internal lessons from this case and introduced an audit process to ensure adoption of best practice.
- Amended the SMS and emergency procedures to include procedures for missing persons and introduced a flow process to triage potential emergency situations.

RECOMMENDATIONS

Seas Your Future management is recommended to:

2024/130 Review and amend fleet policy, procedures and training for rigging and approving the gangway arrangement to include guard ropes to prevent falls and gangway nets to arrest the fall of a person.

2024/131 Review and amend the onboard risk assessment procedure, as guided by the COSWP Annex 1.4, such that:

- operational risks can be mitigated to a level that is as low as reasonably practicable
- local work instructions are produced that control the hazards.

2024/132 Review and amend the fleet policy and procedure on drugs and alcohol to include specific consideration of:

- individual responsibilities
- alcohol testing
- returning on board from recreational time ashore.

SHIP PARTICULARS	
Vessel’s name	*Pelican of London*
Flag	UK
Classification society	Unclassified
IMO number/fishing numbers	5273339
Type	Large commercial yacht
Registered owner	Seas Your Future (Adventure Under Sail)
Manager(s)	Seas Your Future (Adventure Under Sail)
Year of build	1948
Construction	Steel hull
Length overall	34.6m
Registered length	31.56m
Gross tonnage	226
Minimum safe manning	6
Authorised cargo	Not applicable

VOYAGE PARTICULARS	
Port of departure	Sharpness, England
Port of arrival	Not applicable
Type of voyage	Alongside
Cargo information	Not applicable
Manning	7

MARINE CASUALTY INFORMATION	
Date and time	2 October 2023 at 2308 (UTC +1)
Type of marine casualty or incident	Very Serious Marine Casualty
Location of incident	Sharpness, England
Place on board	Starboard side well deck gangway
Injuries/fatalities	1 fatality
Damage/environmental impact	None
Ship operation	Alongside maintenance
Voyage segment	Alongside
External & internal environment	Wind from south-west, 5 to 12kts; sea state 1; light drizzle, good visibility; waning gibbous moon.
Persons on board	19