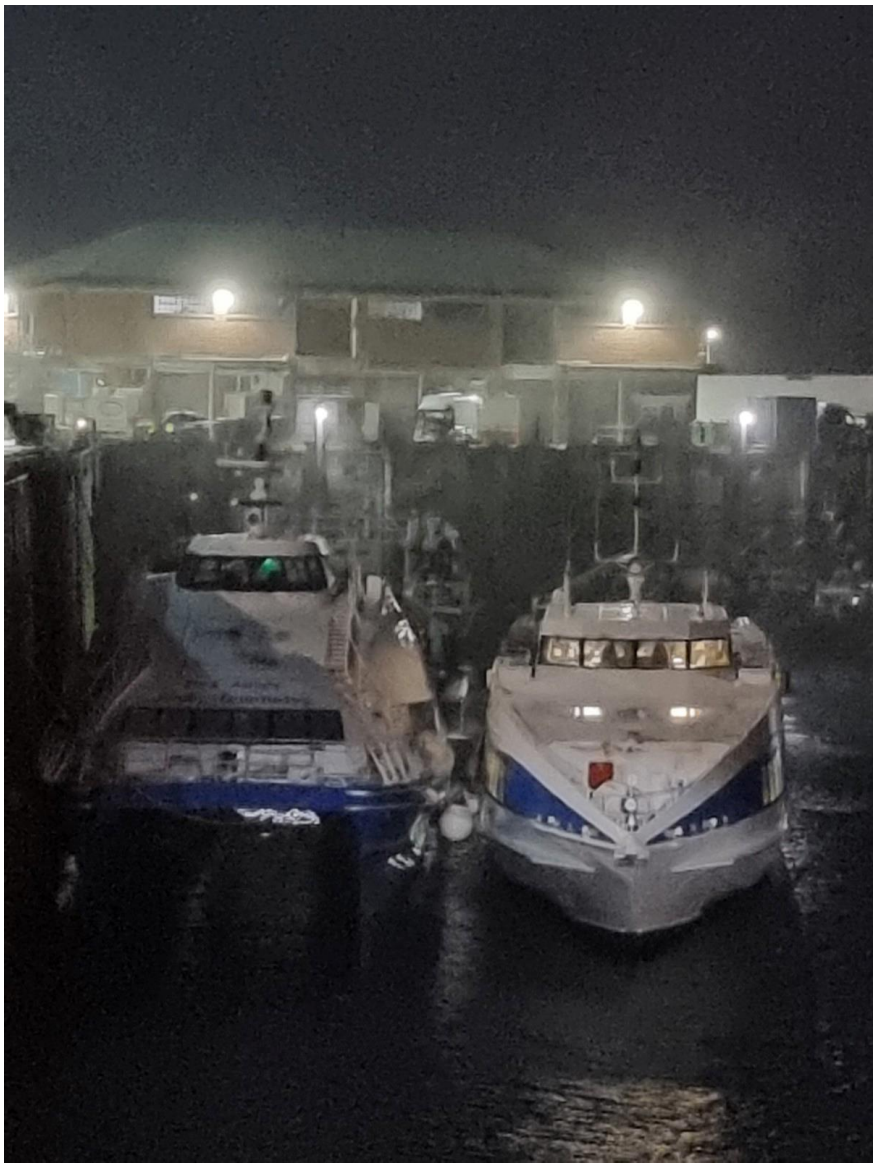
INVESTIGATION INTO THE DEATH OF ONE CREW MEMBER OF THE FRENCH FLAGGED PASSENGER FERRY VICTOR HUGO WHEN ATTEMPTING TO TRANSFER FROM ANOTHER VESSEL MOORED ALONGSIDE, WHILST BOTH VESSELS WERE BERTHED AT VICTORIA PIER, ST HELIER, JERSEY ON 23RD JULY 2023



Passenger vessels *Victor Hugo* and *Granville* moored alongside Victoria Pier, St Helier 23/07/2023

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Preamble

The Jersey Maritime Administration, on behalf of the appointed Minister, conducts marine safety and other investigations on ships flying the flag of the Bailiwick of Jersey and ships which are not flying the Jersey flag which are within Jersey waters in accordance with the obligations set forth in international conventions to which Jersey is a party (either directly or through the United Kingdom).

In accordance with the IMO Casualty Investigation Code, mandated by the International Convention for the Safety of Life at Sea (SOLAS) Regulation XI-1/6, investigations have the objective of preventing marine casualties and marine incidents in the future and do not seek to apportion blame or determine liability.

It should be noted that provisions in the Shipping (Jersey) Law 2002 require Masters, Officers and Owners of vessels to provide such information as is reasonably required by those appointed to conduct such investigations.

If the contents of a report were subsequently submitted as evidence in court proceedings relating to an accident there is a risk that this could offend the principle that individuals cannot be required to give evidence against themselves.

It is for this reason that the Minister is prevented under the above law from authorising publication of a report until a decision has been made not to prosecute any individual in connection with the incident concerned or any prosecution including any appeal has been completed.

The Jersey Administration makes this report available to any interested individuals, organizations, agencies or States on the strict understanding that it will not be used as evidence in any legal proceedings anywhere in the world. You must re-use it accurately and not in a misleading context. Any material used must contain the title of the source publication.

The obligation to publish accident and incident reports in accordance with the IMO Casualty Investigation Code and the International Convention for the Safety of Life at Sea (SOLAS) Regulation XI-1/6, is an acceptable reason for publication of this report in its current format under data protection legislation.

Vessel Details:

Name: Victor Hugo
IMO No: 9157806
Flag: France
Tonnage: 387
Type: High Speed Passenger Craft
Main Propulsive power (kW): 2560
Maximum number of passengers: 236

Name: Granville
IMO No: 9356476
Flag: France
Tonnage: 325
Type: High Speed Passenger Craft
Main Propulsive power (kW): 2709
Maximum number of passengers: 245

1. Executive Summary

1.1 On the evening of 22 July 2023, the French flagged passenger ferry *Victor Hugo* was moored alongside the Victoria Pier in St Helier Harbour. Another French flagged passenger ferry *Granville* was moored alongside the *Victor Hugo.*

1.2 In the early hours of Sunday 23rd July 2023, one crew member of the *Victor Hugo*, an experienced 63-year-old male seafarer fell overboard when attempting to transfer to the *Victor Hugo* from the neighbouring vessel *Granville*. The crew member lost consciousness before he could be recovered from the water. Attempts to resuscitate him by the vessels crew members and subsequently the emergency services in attendance were unsuccessful.

2. Narrative

*2.*1 *Victor Hugo* and *Granville* are two passenger ferries operated by the French company *DNO,* trading as *Manche Iles Express.* The vessels operate on various routes between France and Jersey. On the morning of 22 July 2023, the *Victor Hugo* arrived in St Helier from the port of Granville. After disembarking passengers, the vessel was scheduled to proceed to Guernsey, but due to a deteriorating weather forecast the vessel came out of service, moving from the passenger berth to moor starboard side to the north side of the Victoria Pier. This allowed the vessels crew to investigate an engine problem during the afternoon which had become apparent during the passage from France. *Victor Hugo* was joined by the *Granville* which rafted alongside in the late afternoon and the crews from both vessels subsequently stood down for the day.

2.2 The weather forecast for the Channel Islands area issued by the Jersey Met Office at 1500 UTC on 22 July 2023 for the period 1200 UTC Saturday 22 July until 1200 UTC Sunday 23 July predicted south westerly winds of Beaufort force 5 – 7, decreasing force 4 – 6 after midnight and 3 – 5 during Sunday morning. The forecast noted that gale warnings were in force for sea areas Wight, Portland and

Plymouth (which includes the Channel Islands) and a strong wind warning was in force for the Channel Islands area.

2.3 It had been arranged with the agreement of the company that some crew members from the vessels were to be accommodated overnight in local hotels, whilst others were to stay aboard their respective vessel overnight.

2.4 In the evening, the masters of both vessels together with some of their crew members departed their vessels for hotel accommodation. During the evening, they visited a restaurant and several bars in St Helier.

2.5 Other crew members spent the evening aboard the *Granville* with an invited guest, a previous employee of the company. Statements provided to the States of Jersey Police from crew members suggest that some members of the vessels crew spent the evening socialising, it being very unusual for the two vessels to be together overnight in Jersey. Other crew members took rest in the forward part of the vessel on makeshift, portable beds.

2.6 After the evening ashore and before proceeding to his hotel, the master of the *Victor Hugo* returned to his vessel to collect his mobile phone which he had forgotten to take ashore earlier. He was accompanied by a crew member who also returned to collect some personal effects. Discovering that the adverse weather conditions made boarding from the fixed ladders on the Victoria Pier difficult, the master managed to attract the attention of crew members aboard the *Granville.* The master estimated that after ten to fifteen minutes, two crew members rigged a portable ladder from the *Victor Hugo* to the quay allowing the master and the returning crew member to board the vessel. In a statement to the States of Jersey Police, the master acknowledged that this boarding arrangement was “not very safe.”

2.7 Wind speeds recorded at the harbour in the period 0001 to 0500, 23 July 2023 were south to southwest force 5 to 7 with gusts to 34 knots. Winds of this direction and strength would have held the vessels off the berth and may have brought some swell into the harbour which would have resulted in movement of the vessels at their berth.

2.8 Once aboard the *Victor Hugo,* the master, crew member, and the 2 crew members who rigged the ladder passed across to the *Granville.* The master commented in his statement that this was “dangerous” due to the movement of the vessels but was accomplished successfully despite a gangway not being in place.

2.9 The master of the *Victor Hugo* found several crew members and their guest still socialising. The master estimated that the time was approximately 02:55. After exchanging pleasantries, the master and crew members of the *Victor Hugo* departed from the *Granville.*

2.10 Several people transferred across to the *Victor Hugo* from the *Granville.* The invited guest and the crew member who accompanied the master of the *Victor Hugo* back to the vessel followed by the master himself all transferred successfully. The next was a crew member of the *Victor Hugo* who had been aboard the *Granville* for the evening. He was unable to transfer successfully and aborted his attempt to cross to the *Victor Hugo.* The master of the *Victor Hugo* then offered to rig the gangway to enable him to pass safely. This was declined by the crew member who made a second attempt to transfer to the *Victor Hugo.* This attempt was also unsuccessful, and he fell into the water between the vessels.

2.11 The crew member immediately started to swim towards a vertical ladder on the Victoria Pier behind the two vessels. Shortly before reaching the ladder the crew member was seen to become

unresponsive by his colleagues. Realising that the situation had become critical, one of the crew members entered the water via the ladder on the Victoria Pier. He was soon joined by the master of the *Victor Hugo*. Quickly making contact with the unresponsive crew member, they ensured his head remained above water but realised that they couldn't lift him up the ladder. They then attempted cardiopulmonary resuscitation (CPR) whilst still in the water, partially supported by the ladder.

2.12 Meanwhile, the invited guest made contact with the emergency services. One crew member proceeded to the ladder to assist his two colleagues, and another launched the rescue boat of the *Victor Hugo,* which was stowed on the transom and could be launched easily. Once this had been accomplished, the rescue boat was quickly deployed to the steps at Victoria Pier, and two crew members transferred into the rescue boat to lift the unconscious crew member aboard. CCTV coverage of the area showed the rescue boat in the water and in the vicinity of the Victoria Pier steps at approximately 03:30. Emergency service vehicles were on the Victoria Pier at approximately 03:29. Once aboard, CPR continued, and the rescue boat was taken across to the nearby slipway where the emergency services were waiting and took over treatment of the unconscious crew member. Unfortunately, attempts at resuscitation were unsuccessful.

2.13 A post-mortem of the deceased revealed that the cause of death was:

(a) Immersion in Water, Coronary Atheroma, Pathologically Enlarged Heart with left Ventricular Hypertrophy (Cardiomegaly)

(b) Acute Alcohol Intoxication

2.14 The master and crew members providing assistance were uninjured apart from minor cuts and scratches and from the affects of the cold.

3. Events Following the Accident

3.1 Following the accident, on 23 July 2023 a targeted port state control inspection was undertaken aboard *Victor Hugo* by the Jersey authorities. This inspection targeted the following areas: safe manning, hours of work and rest and safe means of access. No deficiencies were raised as a result of the inspection. Recommendations were made for the vessels flag state to consider crew accommodation and associated welfare issues.

3.2 On the morning of 23 July 2023 the master of the *Granville* was instructed to conduct alcohol testing of his crew by his company. He reported that no positive tests were recorded.

3.3 *Victor Hugo* and *Granville* were permitted to depart St Helier by the Jersey Authorities on 24 July 2023. A request to depart on 23 July 2023 by the vessels operator was declined due to crew members being insufficiently rested.

4. Analysis

4.1 Emergency Response

4.1.1 The response to and recovery of the crew member falling into the water was undertaken swiftly, and effectively.

4.1.2 Attempts from the master and crew members to provide assistance in the water from the Victoria Pier ladder were selfless but presented some risk to those involved. Attempting CPR in this location was very difficult to undertake effectively.

4.1.3 Although it is not likely to have led to a different outcome, the master of the *Victor Hugo* might have been better to undertake a role in coordinating and managing the emergency response rather than taking an active role in the recovery of the casualty.

4.1.4 The stowage of the rescue boat at the transom of the *Victor Hugo* made deployment straightforward when the vessel was moored alongside with another vessel moored outboard. The use of this asset was fundamental in recovering the unconscious crew member without outside assistance. Although CCTV coverage from harbour cameras show difficulty in starting the engine of the rescue boat, this probably didn't have a significant effect on the recovery time of the crewmember from the water or transfer to the emergency services.

4.1.5 CCTV coverage from harbour cameras show that the emergency services were on scene rapidly and took over treatment of the unconscious crew member as soon as the *Victor Hugo's* rescue boat arrived at the adjacent slipway.

4.2 Means of access from *Victor Hugo* to the shore

4.2.1 The following comment was made by port state control inspectors in the report issued following the inspection of the *Victor Hugo* on 23/07/2023.

> With respect to safe means of access from the quayside to VICTOR HUGO. The vertical quayside ladder is suboptimal and suitable only for supervised access by trained seafarers with the individuals wearing lifejackets (as conducted by the PSC inspectors). It would not be considered suitable for guests or for unsupervised access. Had the vessels been moored in a way that the landing stages were accessible from the stern of the vessels (bows WEST) then VICTOR HUGO's aft gangway could have been used in conjunction with the fixed steps to provide safe access during the day. Each vessel had an assigned Nightwatchman (Guardian) and it would have required both to adjust the single Ship's gangway at each stage as the tide rose or fell.

4.2.2 In strong wind conditions, where a vessel is held by the wind at a significant distance from the berth, and / or if the vessel is surging in the berth, use of the vertical ladders would be difficult and could become unsafe. An alternative means of access would be a much safer option.

4.2.3 The *Granville* and *Victor Hugo* carry portable ladders for use at berths where fixed access arrangements are not provided or are unsuitable. The use of this equipment where the vessel is subject to significant movement at the berth puts personnel using it at significant risk. It is one of

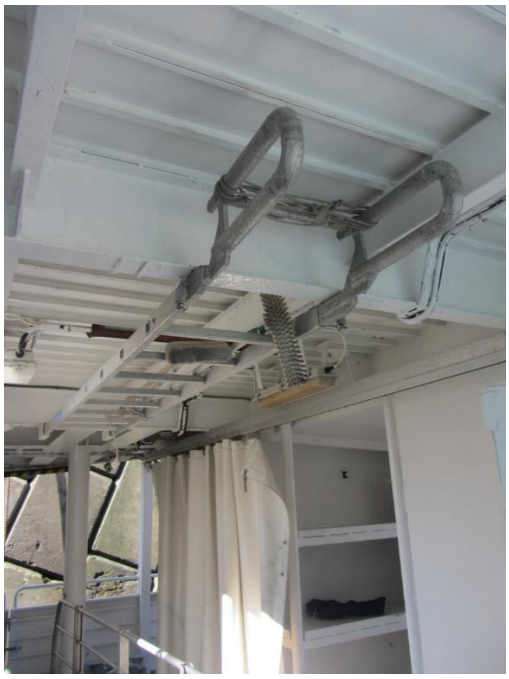
these ladders that was used to access the *Victor Hugo* from the quayside when the master and crew member returned aboard their vessel.

4.2.4 In his statement to the States of Jersey Police, the master of the Victor Hugo commented that upon return to the vessel the means of access from the *Victor Hugo* to the Victoria Pier was "not very safe." Once weather conditions had become inclement, it may not have been possible to put in place an alternative safe means of access to the shore. Noting the forecast weather conditions for the overnight period, measures should have been considered beforehand to ensure the maintenance of a safe means of access to the vessels. Given the weather conditions experienced in the overnight period, a safe means of access would need constant monitoring.

4.2.5 Victoria Pier is provided with two "landing stages" incorporated into the pier to facilitate boarding vessels at different tidal heights. Use of the landing stages significantly limits the height to which persons are exposed to vertical ladders when accessing vessels. It is also possible that gangways could be rigged between a vessel and the landing stages, but these would need constant monitoring and adjustment to the changing tidal height, as noted in the port state control report extract included in 4.2.1.

4.2.6 During the overnight period of 22-23 July 2023 the predicted tidal range for St Helier was 7.2m. Use of the Victoria Pier landing stages would have required the position of the moored vessels, the mooring lines and the gangway to the shore to be constantly monitored and adjusted as necessary.

4.2.7 Early in the morning of 22 July 2023 an email was sent from St Helier VTS to the vessels *Victor Hugo, Granville* their operating company and other vessels using the port, advising of "ideal berthing positions" on the Victoria Pier. This was accompanied by a photograph clearly showing the desired arrangement. The "ideal berthing position" meant that the landing stages were not accessible for the *Victor Hugo and Granville* due to the need for another vessel to access the area and work cargo in the overnight period. This arrangement therefore limited the means by which safe access could be provided between *Victor Hugo* and the shore.



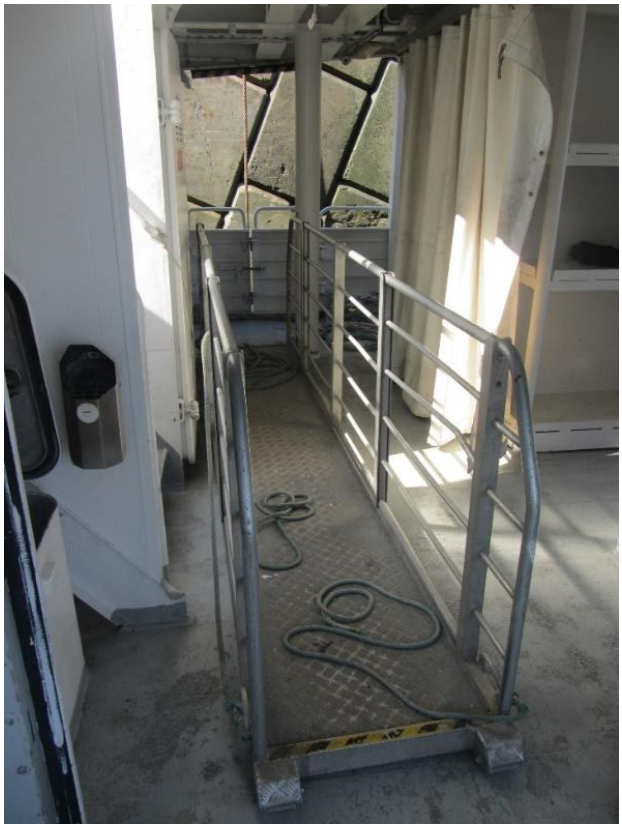
Vessels ladder used to access the shore when shore facilities are unable to be used.

4.3 Means of access between vessels

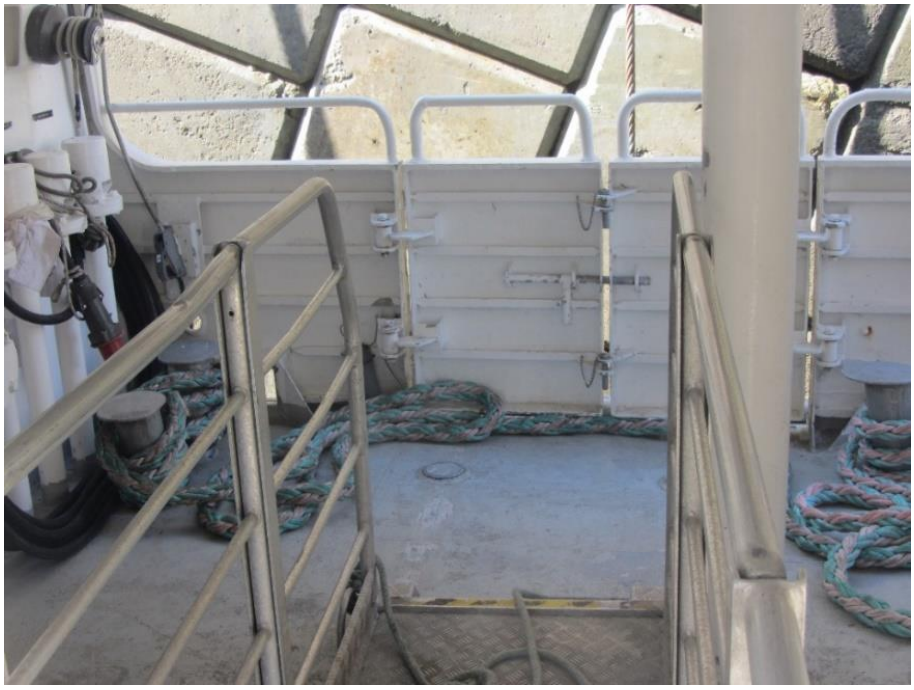
4.3.1 *Victor Hugo* is provided with an aluminium gangway. When rigged and deployed correctly this equipment can provide a safe means of access to another vessel of similar size, deck height and configuration. The gangway could also be used as a safe means of access to the shore, dependent upon the height of the quay relative to the vessels deck. The gangway is located on the aft part of the vessel immediately behind the passenger accommodation. Gates are provided in the vessel's bulwarks to enable the gangway to be rigged directly from the deck level.

4.3.2 Although (due to the weight of the gangway) it is not a single person operation, a small number of crew members could deploy the gangway. If there is movement between vessel and quayside, or between vessels the movement between gangway and vessel structure creates noise. If vessel motion is extreme, it is also possible that the gangways and / or vessel structures could be damaged. Statements from crew members suggest that this noise, which causes disturbance to those staying aboard the vessels overnight was the reason why the gangway was not rigged between the vessels on the night of the accident.

4.3.3 In a statement made by the master of the *Victor Hugo,* the means of access from the *Victor Hugo* to the *Granville* "was dangerous to pass but it was possible with caution. It can be done when both boats stay aligned for a couple of seconds." Considering this assessment, it is unclear why he chose to transfer between the vessels himself without a gangway. In any case, this act set a poor example to other crew members of his vessel and the *Granville.*



Aluminium gangway



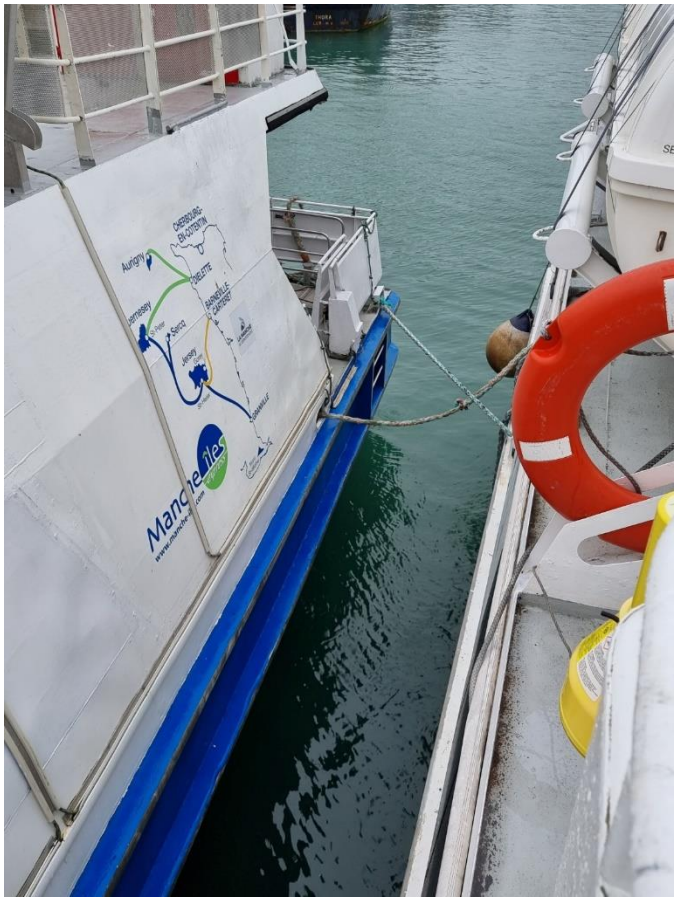
Gates in bulwarks for the gangway to interface with another vessel or the shore

4.4 Mooring Arrangements

4.4.1 The *Victor Hugo* was made fast alongside the Victoria Pier. The *Granville* was secured to the *Victor Hugo* with two long mooring lines forward (spring and fore line) and "two short lines crossed on the back" according to the master's statement.

4.4.2 Supplementary mooring lines were not taken from the *Granville* to the Victoria Pier. When questioned, the *Victor Hugo's* master expressed the opinion that rigging these lines would not have made significant difference to the motion of the vessels. However, when rafting small vessels from an alongside berth, it is good practice to rig shore-lines from the outboard vessel to restrict movement and balance the loads between all mooring lines. This becomes especially important in periods of strong winds. It is possible that if shore lines from the *Granville* had been rigged in addition to the lines securing both vessels together, overall movement of the two vessels might have been reduced and therefore it would have been easier (and quieter) for a gangway to the rigged and maintained between the vessels.

4.4.3 It is not clear to what extent monitoring of the vessels' mooring arrangements and safe means of access was undertaken by the vessels' crews during the overnight period.



Arrangement of the vessels stern mooring at the time of the port state control inspection on 23 July 2023

4.5 Effects of Alcohol

4.5.1 Statements to the States of Jersey Police from the crew claim that alcohol was being consumed by some of those present aboard the *Granville.* If this occurred this was in contravention with the company policy, which according to the *Victor Hugo's* master states that no alcohol may be consumed by any crew member aboard the vessel. It is understood that the company allows for crew members to consume alcohol when ashore and off duty, but that they must remain at all times below the French drink driving limit.

4.5.2 The post-mortem of the deceased crew member recorded that the secondary cause of death was acute alcohol intoxication (see 2.13).

4.5.3 In the hours leading up to the accident, it is probable that the deceased crew member consumed alcohol whilst socialising with colleagues aboard the *Granville.*

4.5.4 Alcohol intoxication is likely to have compromised the crew members judgement and his ability to successfully transfer between the vessels notwithstanding the lack of a safe means of access between the vessels.

4.6 Crew Accommodation

4.6.1 Neither the *Granville* nor the *Victor Hugo* was provided with crew sleeping accommodation. The company provided hotel accommodation ashore when the vessels were required to be away from their home ports overnight. However, a practice had developed whereby it was financially beneficial for crew members to stay aboard their vessel overnight rather than use the hotel provided. Crew members sleeping aboard the vessels used portable beds that are arranged in the clear areas between seats in the passenger cabin. On the night of the accident hotel accommodation had been arranged for *Victor Hugo's* master and some crew members, the remainder opting to stay aboard their vessel.

4.6.2 The provision of suitable crew accommodation is a requirement of the Maritime Labour Convention 2006, with which *Granville* and *Victor Hugo* are required to comply unless exempted by their Flag State. The sleeping arrangements described above would not meet the requirements of the Maritime Labour Convention.

4.6.3 The Maritime Labour Convention 2006 has not been extended to Jersey by the UK. The associated requirements could not be enforced on the *Granville* or the *Victor Hugo* by the Jersey authorities, hence the port state control officers could only raise these issues as recommendations.

4.7 Maritime Regulations in force in Jersey

4.7.1 A review of the applicable maritime safety regulations in Jersey was undertaken as part of this investigation.

4.7.2 Provisions are contained within the Jersey Shipping Law 2002 for the inspection of ships (including foreign ships) in Jersey waters. It is under these provisions that the port state control inspection of the vessel was undertaken following the accident.

4.7.3 The targeted nature of the port state control inspection addressed matters pertinent to the accident. It should be noted that these areas also broadly reflect the limit of enforcement of specific maritime regulations regarding the safety of foreign vessels, notwithstanding the ability for inspectors (under the Shipping Law 2002) to deal appropriately with vessels deemed "dangerously unsafe" and to serve prohibition notices where "activities involve or will involve the risk of serious personal injury to a person, whether on board the ship or not."

4.7.4 As noted in 4.6.3, Jersey authorities are currently unable to enforce the requirements of the Maritime Labour Convention of foreign vessels operating in Jersey waters.

4.7.5 Review of maritime safety regulations suggest that the powers of enforcement relating to masters or seafarers suspected to be under the influence of drugs or alcohol when operating on foreign vessels in Jersey ports are limited.

4.7.6 The Harbours (Jersey) Regulations 1962 require that "*the master of every vessel moored alongside a quay shall provide a device, of a type approved by the Harbour Master, for enabling persons to board and leave the vessel with safety, and shall ensure that the same is adequately lighted between sunset and sunrise.*" Although there isn't a formal approval process for the means of access arrangements put in place by individual ships, Ports of Jersey publishes a Code of Safety for Docks and Outlying Harbours which is available from the Jersey Harbours website. This document contains requirements for the safe access to ships and makes reference to UK publications (including Marine Guidance Note 533 and the Code of Safe Working Practices for Merchant Seafarers).

Guidance provided by St Helier VTS regarding the berthing of vessels referred to in para 4.2.7 didn't remove the master's responsibility to provide safe access as required in the regulations cited above. Following the email received from St Helier VTS, no further dialogue was held between either the masters of the Victor Hugo, Granville or their operating company and St Helier VTS about how the vessels would arrange a safe means of access to the shore due to the landing stages being not accessible. The reason given for this by the company was that they didn't want to disrupt operations on Victoria Pier, and that vertical ladders were provided at the pier for access (as previously described).

4.7.7 Access to maritime regulations and associated guidance is available through the Jersey Government and the Ports of Jersey Websites. Although some regulations associated with shipping are easy to access via the websites, the sourcing of the specific regulations associated with this investigation was found to be cumbersome.

5. Actions undertaken by the company following the accident

5.1 The company responded quickly to the initial findings made by Jersey Port State Control Officers. In a letter to the harbour master dated 31 July 2023 the following actions were put in place:

(a) All crew members without exception would be required to be accommodated ashore when vessels spend the night in Jersey.

(b) Revised and re-emphasised procedures regarding safe means of access between vessels and vessel / shore.

6. Conclusions

6.1 There was no effective, safe means of access provided between the *Victor Hugo* and the *Granville.* This was the primary cause of the accident.

6.2 Strong winds were experienced in the harbour area, resulting in movement between the vessels. This made the transfer of persons between them without a safe means of access in place especially difficult and hazardous. The weather conditions and the associated movement of the vessel also made the access between *Victor Hugo* and the shore hazardous.

6.3 The risks associated with safe access between the *Victor Hugo* and the *Granville,* and the *Victor Hugo* and the shore were insufficiently assessed by the masters of the vessels. Mitigating measures put in place to enable safe access were inadequate.

6.4 The deceased crew member was found to be subject to acute alcohol intoxication. Notwithstanding the lack of safe access between the vessels, the intoxication would have impaired both his judgement and ability to enable a successful transfer between the vessels.

6.5 The arrangements for crew members sleeping aboard the vessels at the time of the accident were inappropriate.

7. Recommendations

7.1 Notwithstanding the actions already taken, the vessels' operating company is recommended to undertake a review of the safe means of access provisions for its vessels when operating in Jersey to ensure that they are effective under all weather and tidal conditions and compliant with the associated regulations.

7.2 The vessels' operating company is recommended to review the means by which it promulgates and enforces the alcohol policy for crew members of its vessels.

7.3 The Government of Jersey and Ports of Jersey may wish to review the means by which maritime regulations and associated guidance are promulgated, to ensure that all applicable regulations and guidance are easily and readily accessible by those who need or are required to use them.

7.4 Noting the limited nature of enforcement powers available to the Jersey maritime authorities, The Government of Jersey may wish to review the regulations and associated enforcement powers applicable to foreign vessels entering its ports.

Derrick A Thorrington
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Jersey Maritime Administration
7th September 2024