ACCIDENT REPORT

Red Ensign Group

Isle of Man Ship Registry
A Member of the Red Ensign Group

Report on the investigation of

the fatal man overboard from

the Isle of Man registered bulk carrier

World Prize

3.5 nautical miles east-south-east of

Rönnskär, Sweden

on 14 October 2025

MAIB
MARINE ACCIDENT INVESTIGATION BRANCH

VERY SERIOUS MARINE CASUALTY REPORT NO 16/2026 JULY 2026

Extract from

The Isle of Man Merchant Shipping

(Accident Reporting and Investigation)

Regulations 2001 – Regulation 4:

The fundamental purpose of investigating a casualty, an accident, or an incident under these Regulations is to determine its circumstances and the causes with the aim of improving the safety of life at sea and the avoidance of accidents in the future. It is not the purpose to apportion liability, nor, except so far as is necessary to achieve the fundamental purpose, to apportion blame.

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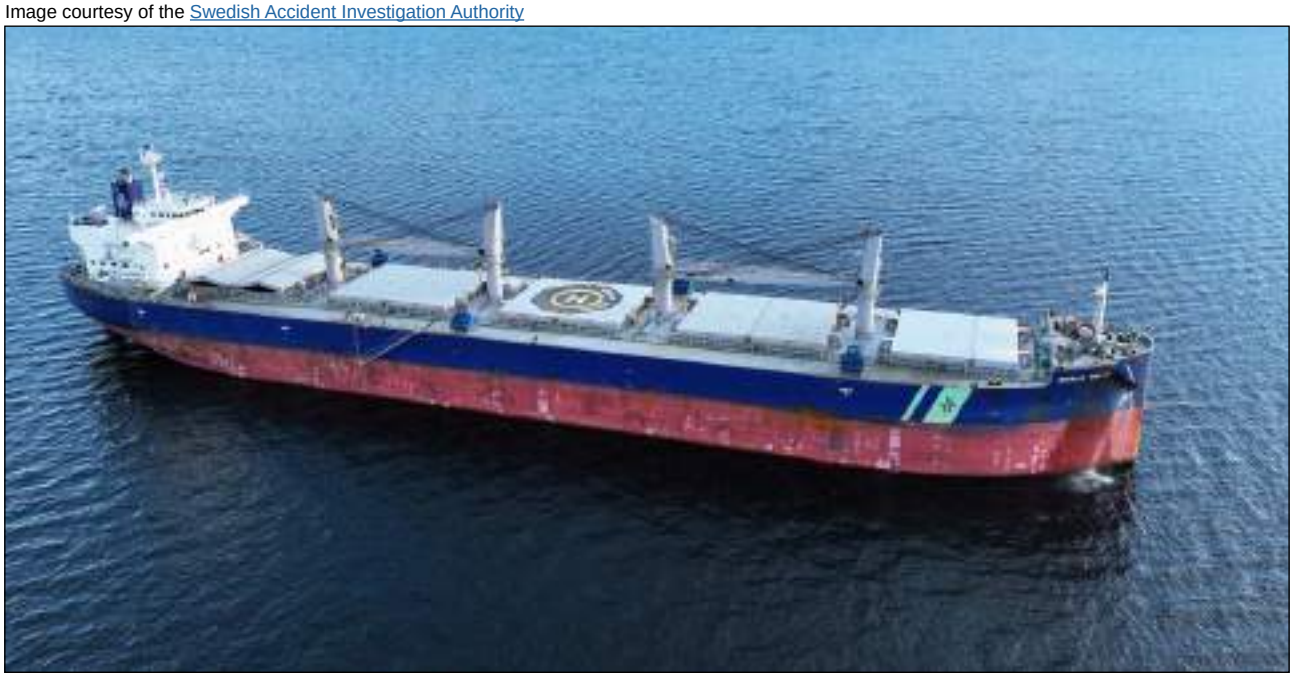
Image courtesy of the Swedish Accident Investigation Authority



World Prize

GLOSSARY OF ABBREVIATIONS AND ACRONYMS

2/O	-	second officer
3/O	-	third officer
AB	-	able seaman
C/O	-	chief officer
COSWP	-	Code of Safe Working Practices for Merchant Seafarers
DOC	-	Document of Compliance
ISM Code	-	International Management Code for the Safe Operation of Ships and for Pollution Prevention
ISO	-	International Organization for Standardization
LARP	-	Look, Act, Report and Prevent
MAIB	-	Marine Accident Investigation Branch
MLC	-	Maritime Labour Convention, 2006, as amended
MOB	-	man overboard
OS	-	ordinary seaman
PFD	-	personal flotation device
PPE	-	personal protective equipment
REG	-	Red Ensign Group
SAR	-	search and rescue
SHK	-	Swedish Accident Investigation Authority
SMA	-	Swedish Maritime Administration
SMS	-	safety management system
SOLAS	-	International Convention for the Safety of Life at Sea, 1974
Synergy Maritime	-	Synergy Maritime Private Limited
UTC	-	universal time coordinated

TIMES: all times used in this report are UTC +2 unless otherwise stated.

SYNOPSIS

At 0840 on 14 October 2025, the bosun on the Isle of Man registered bulk carrier *World Prize* died when he fell from the main deck while the crew were preparing the pilot ladder following the vessel's departure from Rönnskär, Sweden.

The Swedish pilot boat *Pilot 753 SE* was a short distance away, waiting to collect two pilots from *World Prize*. The pilot boat's crew saw the bosun fall to the water and tried to recover him, but he sank beneath the surface during their attempt. He was recovered from the seabed the following day.

The investigation found that the unsafe procedure used when rigging the pilot ladder had become normalised practice, placing the crew at serious risk of injury. Crew members working near the unguarded deck edge on *World Prize* were not equipped with the appropriate personal protective equipment to prevent them from falling, arrest any fall, or support them in the water, and nobody in the vicinity of the pilot ladder acted to interrupt the work. It was also evident that *World Prize* was not equipped with sufficient handheld radios for use by the crew.

The investigation also identified that permits to work on *World Prize* were largely completed as a compliance exercise to satisfy oversight requirements, rather than being used as a practical mechanism to manage risk and ensure safe operations.

The deckhand on *Pilot 753 SE* had not been trained on the new man overboard recovery system on board the boat, reducing the capability of the crew to recover an unconscious person from the water.

Following the accident, the managers of *World Prize*, Synergy Maritime Private Limited, completed an internal investigation and introduced measures to prevent a recurrence. These included crew training and modifications to provide suitable anchor points for safety harnesses when rigging the pilot embarkation equipment. The pilot ladder davits were reinstated and the deck near the pilot embarkation stations was marked to highlight the fall hazard. *World Prize* was also provided with personal flotation devices compatible with the safety harnesses carried on board and additional handheld radios for use by the crew. The company also issued a fleetwide safety alert with an accompanying video to emphasise the lessons identified in its investigation.

The operators of *Pilot 753 SE*, the Swedish Maritime Administration (Sjöfartsverket), removed all the superseded equipment from its vessels and amended its digital training and maintenance management system to include all crew in manoverboard drills.

The Isle of Man Ship Registry published a Manx Shipping Notice to require Isle of Man registered ships to carry the latest version of the UK Code of Safe Working Practices for Merchant Seafarers.

In view of the actions already taken, no recommendations have been made.

SECTION 1 – FACTUAL INFORMATION

1.1 PARTICULARS OF *WORLD PRIZE*, *PILOT 753 SE* AND ACCIDENT

SHIP PARTICULARS		
Vessel's name	*World Prize*	*Pilot 753 SE*
Flag	Isle of Man	Sweden
Classification society	DNV Group AS	RINA S.p.A.
IMO number	9860403	Not applicable
Type	Bulk carrier	Pilot boat
Registered owner	BW Dry Cargo Pte. Ltd	Sjöfartsverket
Manager(s)	Synergy Maritime Pvt. Ltd	Sjöfartsverket
Construction	Steel	Steel
Year of build	2021	1979
Length overall	199.99m	16.45m
Gross tonnage	34,762	25
Minimum safe manning	15	2
Authorised cargo	Dry bulk	Not applicable

VOYAGE PARTICULARS		
Port of departure	Rönnskär, Sweden	Näsgrundet, Sweden
Port of arrival	Klaipėda, Lithuania	Näsgrundet, Sweden
Type of voyage	International	Coastal
Cargo information	Copper concentrate	Not applicable
Manning	19	2

MARINE CASUALTY INFORMATION		
Date and time	14 October 2025 at 0840	
Type of marine casualty or incident	Very Serious Marine Casualty	Not applicable
Location of incident	3.5nm east-south-east of Rönnskär, Sweden	
Place on board	Main deck	Not applicable
Injuries/fatalities	1 fatality	None
Damage/environmental impact	None	None
Ship operation	On passage	On passage
Voyage segment	Mid-water	Not applicable
External & internal environment	Wind north-westerly force 3; sea state 3; good visibility; seawater temperature 6°C	
Persons on board	21 (19 crew and 2 pilots)	2

1.2 BACKGROUND

The investigation into the circumstances of the accident was conducted by the Marine Accident Investigation Branch (MAIB) on behalf of the Isle of Man Ship Registry. The Isle of Man is a member of the Red Ensign Group (REG) and the investigation was completed in accordance with the memorandum of understanding between the MAIB and the REG member administrations.

The investigation was directly supported by the Swedish Accident Investigation Authority (SHK[1]), which gathered the initial evidence on *World Prize* and the attendant pilot vessel *Pilot 753 SE*.

1.3 NARRATIVE

The Isle of Man registered bulk carrier *World Prize* was berthed at the Boliden Rönnskär smelter facility on the north-western coast of the Gulf of Bothnia **(Figure 1)**. The vessel had been alongside since 11 October 2025.

At 0751 on 14 October 2025, *World Prize* departed its berth intending to proceed to anchor off the port and await instructions. On the bridge was the master, the third officer (3/O), a deckhand and two pilots. Pilot 1 was conning the vessel with pilot 2 observing. With the assistance of two tugs *World Prize* swung in the port and joined its intended departure track.

The chief officer (C/O), bosun and an ordinary seaman (OS) were stationed on the forecastle of *World Prize* during its manoeuvre from the berth. The second officer (2/O) was on the aft mooring deck with two able seamen (AB1 and AB2).

Image courtesy of Google Maps

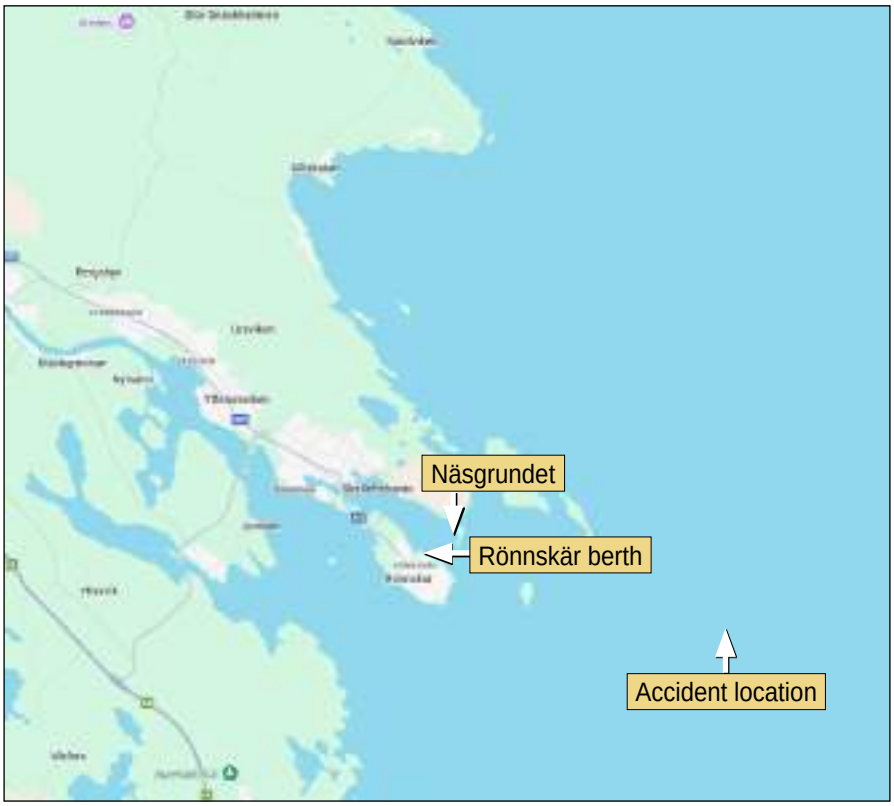


Figure 1: Location of accident

[1] Statens haverikommission.

At 0754, pilot vessel *Pilot 753 SE* departed its berth at nearby Näsgrundet to recover the pilots once *World Prize* was clear of the port. At 0813, the two tugs were released from *World Prize* and the master told the 2/O to take their team and rig the starboard combination ladder to enable the pilots to disembark.

With the tugs gone the C/O, bosun and OS made their way aft from the forecastle and met the 2/O and their team, who had started to rig the combination ladder at the pilot embarkation station on the starboard side of the main deck. The C/O dismissed the 2/O to take their rest period and held a toolbox meeting to brief the bosun, OS and ABs on the intended work. AB1 and AB2 signed the preprepared permit to work and then continued the work they had started with the 2/O.

At 0824, the master used their handheld radio to call the team working on deck and told them that the pilots would be departing in 15 minutes. The pilot ladder was rigged through the forwardmost of three pilot embarkation stations on the main deck **(Figure 2)**. The safety chains protecting the opening were removed. The bosun then used the remote control for the accommodation ladder winch to deploy the accommodation ladder down the side of *World Prize*. AB1 and AB2 made their way along the accommodation ladder, installing the stanchions on either side of the ladder and threading the guard lines loosely through the loops on the stanchions.

Images courtesy of the Swedish Accident Investigation Authority

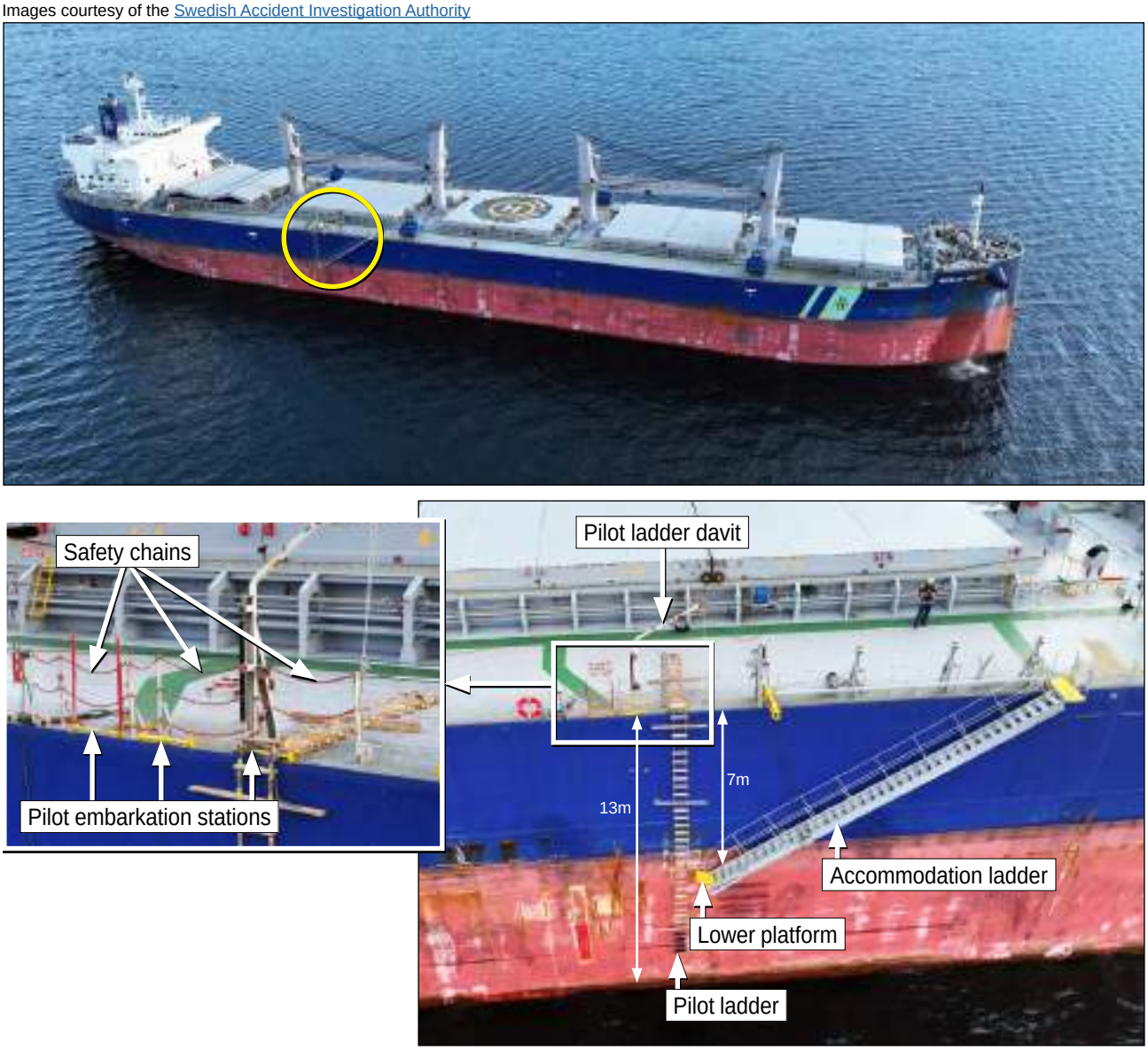


Figure 2: *World Prize* deck and combination ladder arrangement

At 0832, the master called the C/O on their handheld radio and told them to get the ladder rigged early as the pilots were soon to depart. At 0835, the two pilots left the bridge and went to the main deck, escorted by the 3/O. *Pilot 753 SE* was about 65m off the starboard quarter of *World Prize*, waiting to be called in for the pilot transfer.

With the accommodation ladder now deployed, the team on the deck manually lowered the pilot ladder down the side of the ship. AB1 was on the accommodation ladder, adjusting its lower platform using tools brought to them by AB2.

The pilots arrived on the deck to wait for an instruction from the deck crew to disembark the vessel. As the pilot ladder was lowered, one of its spreader bars caught on the accommodation ladder. At the top of the pilot ladder the C/O, bosun and OS lifted and lowered the pilot ladder to free it from the accommodation ladder. The bosun's right leg was positioned between the rungs of the pilot ladder **(Figure 3)**. The bosun and C/O leant over the side of the ship, shouting instructions to AB1 who was about 7m below them on the accommodation ladder platform.

Image courtesy of the Swedish Accident Investigation Authority

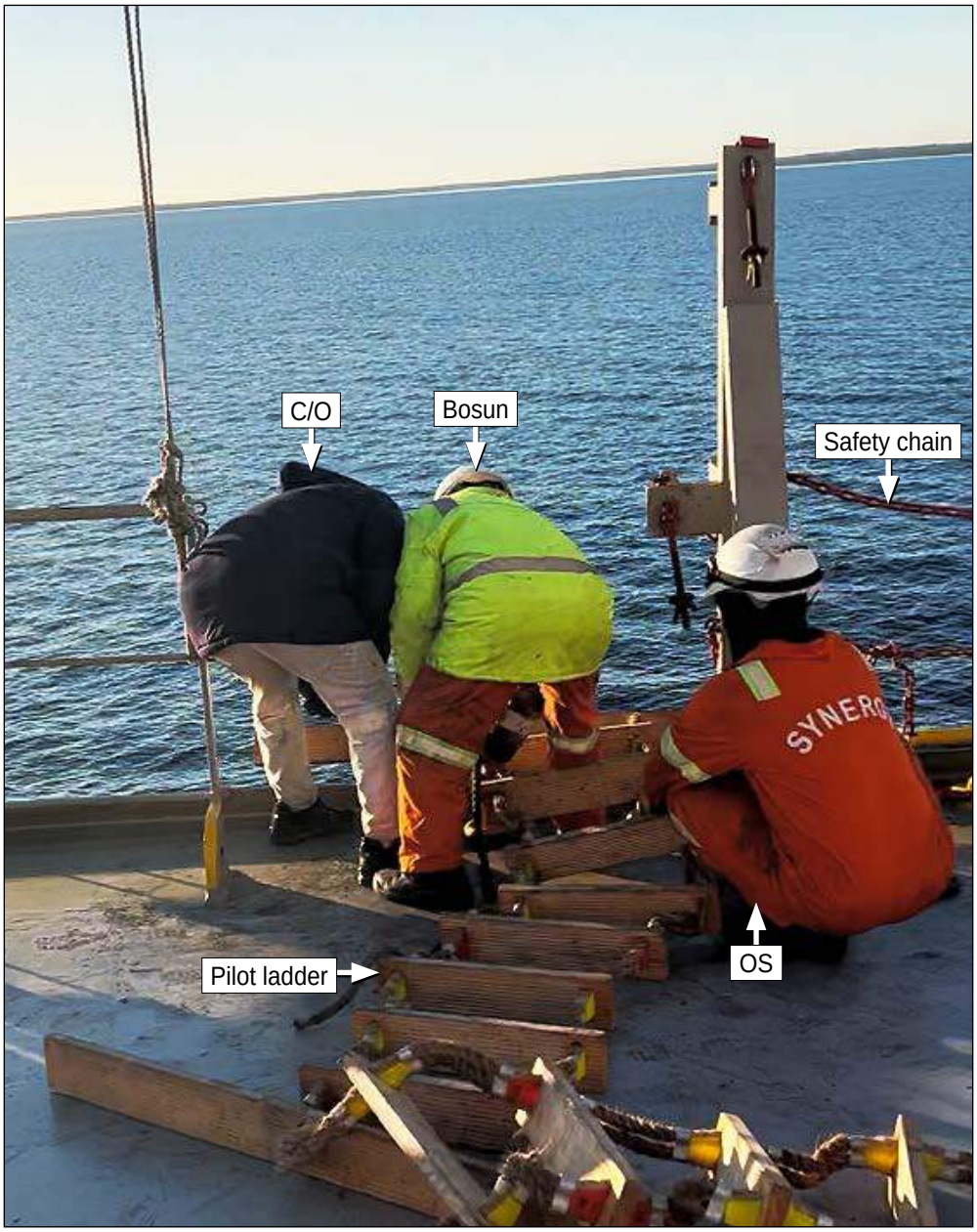


Figure 3: Crew positions immediately before the accident

The 3/O took the remote control for the accommodation ladder and began relaying information from the deck teams to the bridge on their handheld radio. The 3/O adjusted the position of the accommodation ladder, guided by instructions from the C/O.

At 0840, the bosun straightened up, appeared to lose his balance and fell headfirst through the unguarded opening at the top of the pilot ladder. The bosun glanced off AB1's left shoulder as he fell, before striking the lower platform of the accommodation ladder and falling into the sea.

On board *Pilot 753 SE*, which was now 25m off the beam of *World Prize*, the crew saw the bosun fall and the skipper immediately turned the boat to starboard to recover the bosun from the water. On board *World Prize*, the 3/O alerted the bridge to the man overboard (MOB) and launched a nearby lifebuoy. The master used their handheld radio to instruct the C/O to prepare to launch *World Prize*'s rescue boat.

The deckhand on *Pilot 753 SE* took a lifebuoy from the boat's aft deck, and a boathook from a rack on the starboard external walkway. The deckhand stationed themself at the port bow as *Pilot 753 SE* approached the bosun, who was floating just below the surface in an upright position with his arms outstretched. The freeboard was about 0.9m at the gap in *Pilot 753 SE*'s railings at the bow. The bosun was being kept afloat by air trapped in his jacket. As *Pilot 753 SE* came closer it became clear to the deckhand that the bosun was slowly sinking. At approximately 0842, the deckhand managed to catch the bosun with the boathook.

Pilot 753 SE's skipper joined the deckhand on the forward deck. The two crew lay on the deck and reached down to try and lift the unconscious bosun on board. They were unable to place the lifebuoy completely over the bosun's head and arms, so attempted to tie a rope to one of his arms. The bosun slipped from the rope and sank beneath the water's surface.

On *World Prize*, pilot 1 used their personal mobile phone to contact the Swedish rescue services. Pilot 2 returned to the bridge, where they were joined by pilot 1 on completion of their phone call. Pilot 2 took the con to allow *World Prize*'s master to manage the launch of the rescue boat, while pilot 1 continued to liaise with the Swedish rescue services and *Pilot 753 SE*'s skipper by VHF radio.

Within a minute of pilot 1's call, the Swedish rescue services broadcast a "Mayday Relay" on VHF channel 16 requesting the support of vessels in the area. At 0848, the skipper of *Pilot 753 SE* informed *World Prize* that they had been unable to recover the bosun but were continuing to search.

By 0914, the search and rescue (SAR) effort was underway. The crew of *World Prize* launched the vessel's rescue boat and local vessels responding to the "Mayday Relay" call from the Swedish rescue service joined the SAR effort. The Swedish rescue service activated a SAR helicopter, which arrived on scene at 0930 to assist.

The search did not locate the bosun. At 1100, the SAR efforts were terminated. The bosun's body was recovered from the seabed by police divers the following day.

1.4 ENVIRONMENTAL CONDITIONS

The weather was good with light winds and a smooth sea. The seawater temperature was 6°C.

1.5 *WORLD PRIZE*

1.5.1 General

World Prize was a geared bulk carrier built in 2021. It had five cargo holds serviced by four deck cranes and was registered in Douglas, Isle of Man. The vessel's crew and technical management was undertaken by Synergy Maritime Private Limited (Synergy Maritime).

On the day of the accident, *World Prize* had completed discharge of a cargo of copper concentrate at the Boliden Rönnskär smelter facility. On departure, the vessel was proceeding to anchor to await orders. *World Prize* subsequently departed for Klaipėda, Lithuania.

1.5.2 Pilot embarkation arrangement

When *World Prize* was loaded with a freeboard of less than 9m pilots accessed and left the vessel directly via one of two pilot ladders, one on each side of the main deck. When the freeboard was greater than 9m the pilot ladder was paired with the accommodation ladder in an arrangement called a combination ladder. The pilot was able to descend the accommodation ladder then move from its lower platform onto the pilot ladder to descend the rest of the way to transfer onto the waiting pilot boat. The deck of *World Prize* had three pilot ladder stations on each side that allowed the pilot ladder to be rigged in different locations, depending on the angle of the accommodation ladder. Removable safety chains were fitted next to the pilot embarkation stations, in the gaps between the solid guardrails installed along the edge of the deck **(**see **Figure 2)**.

On 14 October 2025, *World Prize* was in ballast and had a freeboard of approximately 13m in way of the pilot embarkation arrangements, requiring the use of the combination ladder. For pilots to disembark to *Pilot 753 SE* the bottom of the pilot ladder needed to be about 2m above the waterline.

1.5.3 Crew

There were 19 crew on board *World Prize*, all of whom were appropriately certified for their position. Thirteen of the crew, including the master and bosun, had joined the vessel in Antwerp on 28 September 2025.

The bosun, Antonio Competente[2], was a 51-year-old Filipino national. He had previously worked on *World Prize* and joined for the second time on 28 September 2025. The bosun held an STCW[3] II/5 Able Seafarer Deck Certificate of Proficiency since October 2015.

The bosun generally worked from 0700 to 1700 with an hour for lunch. He would work outside these hours when *World Prize* arrived or departed from port.

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[2] The initial police report indicated the bosun's name as *Competente Villorente, Antonio*. His passport indicated that Villorente was his middle name.

[3] International Convention on Standards of Training, Certification and Watchkeeping for Seafarers, 1978 as amended.

The bosun undertook a medical examination on 1 August 2025. The report of the examination recorded that the bosun was taking various medication for blood pressure, high blood lipids and an underlying cardiac condition. He held a medical fitness certificate that was valid until 6 August 2026.

At the time of the accident the bosun was wearing overalls, safety shoes, gloves, a helmet and a high-visibility jacket. He carried a handheld radio. The bosun's helmet remained on his head during the fall and was recovered, undamaged, following the accident. The bosun was not wearing a personal flotation device (PFD) or safety harness.

A postmortem examination was carried out by the Swedish National Board of Forensic Medicine[4] in Umeå. The pathologist's report did not identify the presence of alcohol or drugs. It noted the presence of significant injuries to the bosun's face and torso, concluding that:

> *The findings in the respiratory tract and lungs indicate that death was caused by drowning. The moderate injuries are not considered to have been immediately fatal, but the head injuries in particular, with the possibility of affecting consciousness, may have contributed to Competente Villorente drowning.* [sic]

1.6 *WORLD PRIZE* SAFETY MANAGEMENT

1.6.1 Company safety management

Synergy Maritime was part of the wider Synergy Marine Group of companies. It undertook the technical and crew management of over 140 vessels of different types.

Synergy Maritime held a Document of Compliance (DOC) issued on 29 March 2023 by Class NK[5] on behalf of the Isle of Man. The DOC was valid until 2 April 2027 and certified that the company's safety management system (SMS) had been audited and complied with the requirements of the International Management Code for the Safe Operation of Ships and for Pollution Prevention (ISM Code). *World Prize* operated under the Synergy Maritime SMS.

Synergy Maritime maintained a stop work policy, empowering crew members to stop work should they witness an unsafe act. This policy was supported by 'LARP', a company programme that expected crew to *Look, Act, Report and Prevent* unsafe conditions and acts. Posters were displayed around *World Prize* to remind crew members of their authority to stop work if appropriate.

The Synergy Maritime SMS included a series of operational procedures that outlined how activities were to be carried out on vessels within the fleet. These procedures detailed the requirements for completing risk assessments and permits to work for specific tasks and also set out the personal protective equipment (PPE) to be used.

In 2019, Synergy Maritime undertook a safety campaign on gangway operations. This campaign included the rigging of the combination ladders on its vessels. The content of the safety campaign was aligned with the SMS requirements and included the need for the completion of a permit to work, a briefing for the involved crew members, PPE requirements, and supervision of the activity.

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[4] Rättsmedicinalverket.

[5] Nippon Kaiji Kyokai.

1.6.2 Safety management system audits

World Prize held a safety management certificate issued on 3 March 2022 by DNV Group AS on behalf of the Isle of Man. The certificate was valid until 3 March 2027. An intermediate audit was conducted on 27 December 2024. The auditor reviewed a finding from a previous audit on board that had identified an instance where the enclosed space entry procedure was not followed and the permit to work for an entry had been completed incorrectly. The SMS was found to comply with the requirements of the ISM Code and the safety management certificate was endorsed.

Internal audits were carried out on *World Prize* in May 2024 and April 2025. In both cases the procedures for working at height were examined and recorded without comment. The April 2025 audit was completed over 3 days and a number of training activities were completed while the auditor was on board. The training was delivered to the majority of the crew in an extraordinary safety meeting on 17 April 2025 and included briefings on:

- *…The importance of using PPE as per matrix as per job specification.*
- *Procedures of raising LARP…importance of keeping a safe working environment and authority to stop work in case of a hazardous atmosphere during the operation…* [sic]

The April 2025 audit report recorded that crew were *given proper training and awareness for creating a safe working atmosphere on ship*. It also stated that training in the rigging of the pilot ladder had been completed.

Of the crew who undertook the training on 17 April 2025, only the second engineer was on board at the time of the accident.

1.6.3 Safety officer inspections

The Isle of Man Merchant Shipping (Maritime Labour Convention) Regulations 2013 required the designated safety officer to undertake routine inspections of the vessel and its operations. The results of these inspections were reported and discussed at the on board safety committee. The May 2024 internal audit raised a nonconformity noting that, although records of the safety officer's inspections were being maintained, physical inspections of the relevant areas were not being completed. There was no similar finding at the April 2025 internal audit.

1.6.4 Safety committee meetings

The crew on board *World Prize* attended a monthly safety committee meeting that followed a set agenda covering 20 items. These discussion areas included a review of any safety observations and LARP actions for the period since the previous meeting.

The minutes of the July 2025 safety committee meeting recorded that the vessel required *walkie talkie for shipboard operation*, including the ship's requisition reference number. This matter was reiterated in the minutes of the August 2025 meeting; it was not mentioned in the September 2025 meeting. The requisition for handheld radios remained unfulfilled at the time of the accident.

The minutes of the individual safety committee meetings indicated discussion of a wide range of individual topics, with some meetings recording more than 40 discrete items. With the exception of one meeting, which lasted 1.5 hours, the safety committee meetings during 2025 each recorded a duration of one hour.

1.6.5 Risk assessment for working overside

The Synergy Maritime SMS contained a hazard identification and risk assessment procedure for *World Prize* that identified working overside as a hazardous activity and listed nine separate hazard areas. **Table 1** summarises two of the vessel's documented hazard areas and their associated control measures.

Hazard	Control measures
Communications	*Crew going for overside rigging for pilot boarding arrangements to carry walkie talkie along with enough manpower and be in constant communication with the wheel house.*
Personal protective equipment	*Adequate PPE including floatation devices, safety harness to be used. Briefing of personnel involved at the job to highlight the dangers and precautions required.*

Table 1: *World Prize* working overside risk assessment extract

1.6.6 Permit to work – work at height procedure

The Synergy Maritime SMS contained a permit to work procedure for working at height. The procedure defined the risks present when working near dangerous edges as:

> *… platforms and walkways without permanent railings or areas near collapsible/ removable railings over which a person may fall.*

The procedure required a permit to work for working at height to be completed where the potential fall was more than 1.5m. It also stated that it was mandatory for crew to use a self-retractable reel with a shock absorber as a fall arrest device when rigging the gangway or combination ladder.

Anyone working overside or within 2m of an unguarded deck edge, such as while rigging a pilot ladder, was required to *wear a work vest/lifejacket over appropriate fall prevention equipment*.

The procedure set out specific requirements for the management of the rigging of the combination ladder, stating that:

> *All team members involved in the rigging of the combination/ accommodation ladder shall discuss risk assessment for rigging the combination ladder. An experienced crewmember that is suitably attired with a buoyancy aid, and appropriate fall prevention equipment…with portable radio should be allowed to work on the shipside at the accommodation ladder. A responsible person with enough helping hands should always monitor the safety aspects of rigging from*

the main deck itself. He shall carry a radio with him also and be in continuous contact with the bridge. The person helping on the main deck when working in the vicinity of the accommodation ladder platform and open ship side railing, should also wear a safety harness secured from a safe point along with a life vest.

The procedure also required that a:

Certificate of Training for Work at Height […] *must be completed for each personnel prior carrying out Work at height or within 14 days of joining whichever earliest. The training should be ship and fall prevention equipment specific.* [sic]

The work at height procedure set out considerations for the selection of anchor points for fall prevention equipment to be attached to. These included assessment of:

- *Strength of the anchor point*
- *Location of the anchor point – Choose the anchor point as elevated as possible above the user's height.*
- *Easy accessibility*

Further, that:

As far as possible the anchor point shall be chosen vertically above the lanyard or self-retractable reel.

Ensure as much as possible vertical alignment of anchor points to avoid pendulum swing effect after a fall takes place.

If required, a rail (horizontal line) can be rigged to provide a long continuous dynamic anchor point.

Handrails are NOT safe structural anchorages.

The permit to work for work at height required the responsible officer to confirm the suitability of the anchor point.

The permit to work procedure was supplemented by a PPE matrix setting out the equipment required for certain tasks. For work at height the matrix indicated that a harness, safety line and fall arrest device were required, with the addition of a PFD when working at the ship's side. Synergy Maritime reinforced these requirements with a series of posters that illustrated the PPE to be worn when working at height or overside. These posters were displayed on board *World Prize*.

1.7 *WORLD PRIZE* PERMIT TO WORK – RIGGING THE COMBINATION LADDER

On 13 October 2025, a work planning meeting was held on board *World Prize* to discuss the following day's activities. During the meeting, a work planning sheet was completed that included the task of rigging the combination ladder. The planning sheet indicated that the C/O was the person conducting the task and that the work team comprised the bosun, ABs and OS. The planning sheet stated that the activity was low risk and that a permit to work was not required.

1.7.1 Permit to work as examined by the Swedish Accident Investigation Authority

Although the planning sheet did not require a permit to work for the rigging of the combination ladder, a working at height permit to work form[6] was completed for the departure of *World Prize* from Rönnskär on 14 October 2025. This permit was presented to the SHK inspectors who boarded *World Prize* on 15 October 2025.

The permit to work recorded the work location as the starboard combination ladder and the completed permit was valid from 0700 to 1200 on 14 October 2025.

Section 1 of the permit to work comprised a checklist of 17 measures to be ticked off by the master or responsible officer as either in place or not applicable. Four of the measures were ticked as not applicable to the rigging of the combination ladder. The remaining 13 were ticked 'yes' to confirm that:

- the risk assessment had been reviewed for adequacy;
- the participants had completed training for a working at height certificate;
- a safety net had been rigged;
- a safety harness, fall arrest device and lifejacket were in use;
- the anchor points for the fall arrest devices were of adequate strength;
- proper arrangements were in place for communication between the work team and the responsible person in attendance at the work site.

Section 2 of the permit listed four items to be checked by the person in charge of the work team. The items included an acknowledgement that section 1 of the permit had been completed as necessary, and that the person in charge of the work team was aware of their responsibility to *stop the work immediately in the event of change from agreed safe criteria*. All four items were marked with a tick in the 'yes' column.

Section 4 of the permit listed eight additional measures for rigging a gangway or combination ladder that included the use of an appropriate and approved flotation aid; the use of a safety harness and fall arrest device; and sufficient crew, a supervisor, a winch operator and a deck rating to be available. All eight measures had a tick in the 'yes' column.

Section 5 of the permit listed two ABs as the personnel involved in working at height, and they had both signed it. The person supervising the team at the work location was indicated as being the 2/O. The permit was signed by the 2/O and C/O and approved by the master, who indicated they were satisfied with the safety precautions in place. The date written alongside each of the three signatures was 14 October 2025 and the time was 0700.

Section 6 of the permit confirming the permit's completion or cancellation remained blank.

[6] Synergy Maritime SMS form PTW 03.

1.7.2 Permit to work as examined by the Marine Accident Investigation Branch

After the accident, *World Prize* departed the anchorage at Rönnskär for Klaipėda, Lithuania, where MAIB inspectors boarded the vessel on 23 October 2025. The same permit to work described in section 1.7.1 was presented to the MAIB inspectors for examination. The entries on the permit now stated that:

- the work location was the port/starboard combination ladder;
- the permit was valid from 0800 on 14 October 2025;
- the 2/O, C/O and master had signed the permit at 0800 on 14 October 2025;
- the work had been signed off as completed in two stages on 14 October 2025: the starboard combination ladder at 0900 and the port side combination ladder at 1200.

A comparison of the permit to work entries is provided in **Figure 4**.

Images courtesy of the Swedish Accident Investigation Authority and MAIB

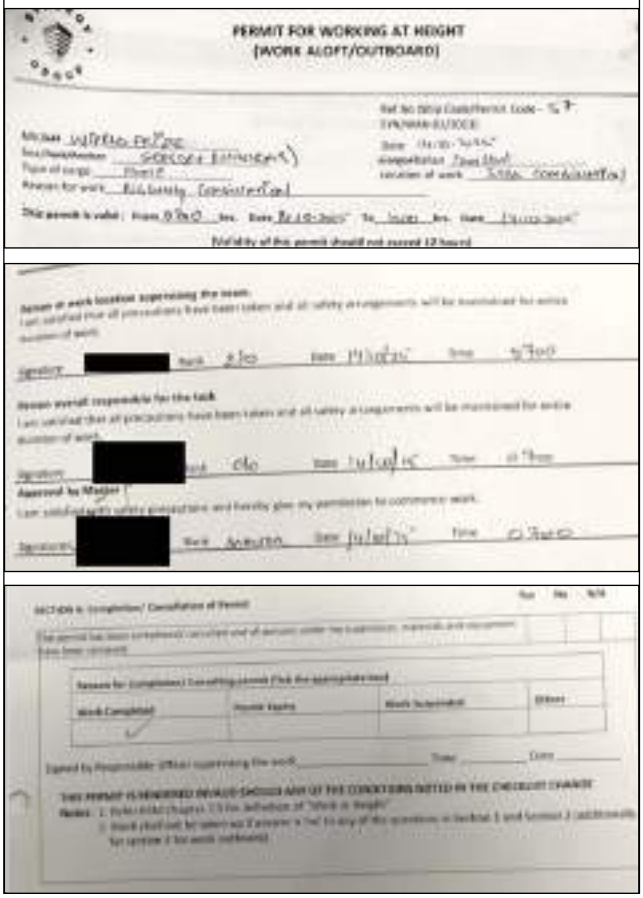
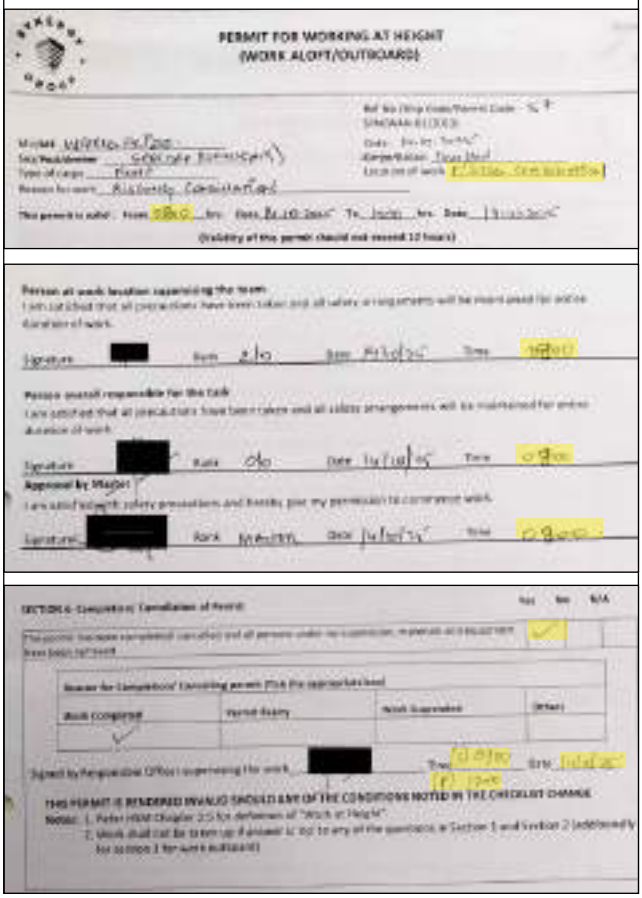
Permit to work presented to SHK inspectors on 15 October 2025	Permit to work presented to MAIB inspectors on 23 October 2025
	

Figure 4: Comparison of entries on permit to work presented to SHK on 15 October 2025 and MAIB on 23 October 2025, respectively

1.8 *WORLD PRIZE* SAFETY EQUIPMENT

1.8.1 Fall arrest devices

World Prize was provided with two appropriately certified fall arrest devices incorporating a tensioned lifeline, designed to allow the normal movements of a worker and to automatically lock in the event of a sudden motion to prevent a fall.

Two different connection methods used to anchor the fall arrest devices when rigging the combination ladders were demonstrated to MAIB inspectors by *World Prize*'s crew during the investigation. One method showed the fall arrest device attached to a deck guardrail, the other led the line around the corners of the vertical beam to which it was attached **(Figure 5)**.

The pilot embarkation stations on the deck of *World Prize* had no designated anchor points nearby for securing a fall arrest device to be used by crew when rigging the accommodation ladder.

1.8.2 Communication equipment

World Prize had five operational handheld radios for on board communication. The two ABs on the accommodation ladder platform did not have radios and communication with them was conducted verbally from the deck-edge.

1.8.3 Pilot ladder lifting arrangement

A davit with a marked safe working load of 1kN was provided at each of *World Prize*'s pilot embarkation stations. The davits had reportedly fallen into disrepair and were not used on board to aid in the deployment of the pilot ladder. Instead, the crew lowered and raised the pilot ladder manually.

The pilot ladders had a total length of 15m and weighed approximately 120kg. At the time of the accident, 11m of the starboard ladder was deployed down the side of *World Prize*. The hanging weight was about 90kg.

1.8.4 Marking of hazardous areas

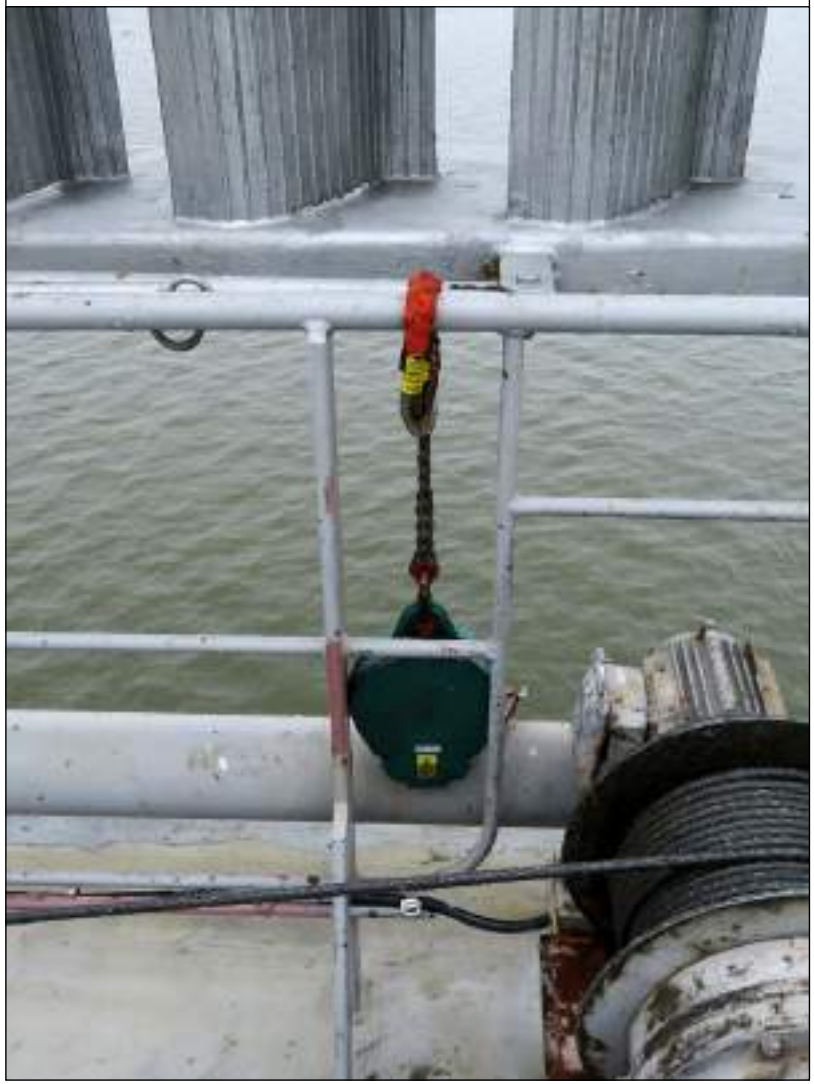
The work at height procedure contained in the SMS required that *all dangerous edges around the ship's normal working areas must be identified and marked clearly with high-visibility paint*.

The presence of a fall hazard when safety chains at the pilot embarkation stations were removed was partially marked on the deck in way of the pilot ladder access points. The markings did not encompass the extent of the openings in the ship's guardrails, nor the 2m limit of the hazardous area identified in the SMS **(Figure 6)**.

1.8.5 Personal flotation devices

World Prize was equipped with PFDs for the crew to use while working where there was a risk of unintentionally entering the water. Each PFD comprised a waistcoat fitted with buoyant solid foam across the chest sections and in a collar around the neck. The label indicated that the PFD was designed to provide 70N of buoyancy but *not designed to turn an unconscious wearer face up in the water*.

Attachment to handrail



Attachment to vertical beam

Figure 5: Demonstrated anchor points for fall arrest devices

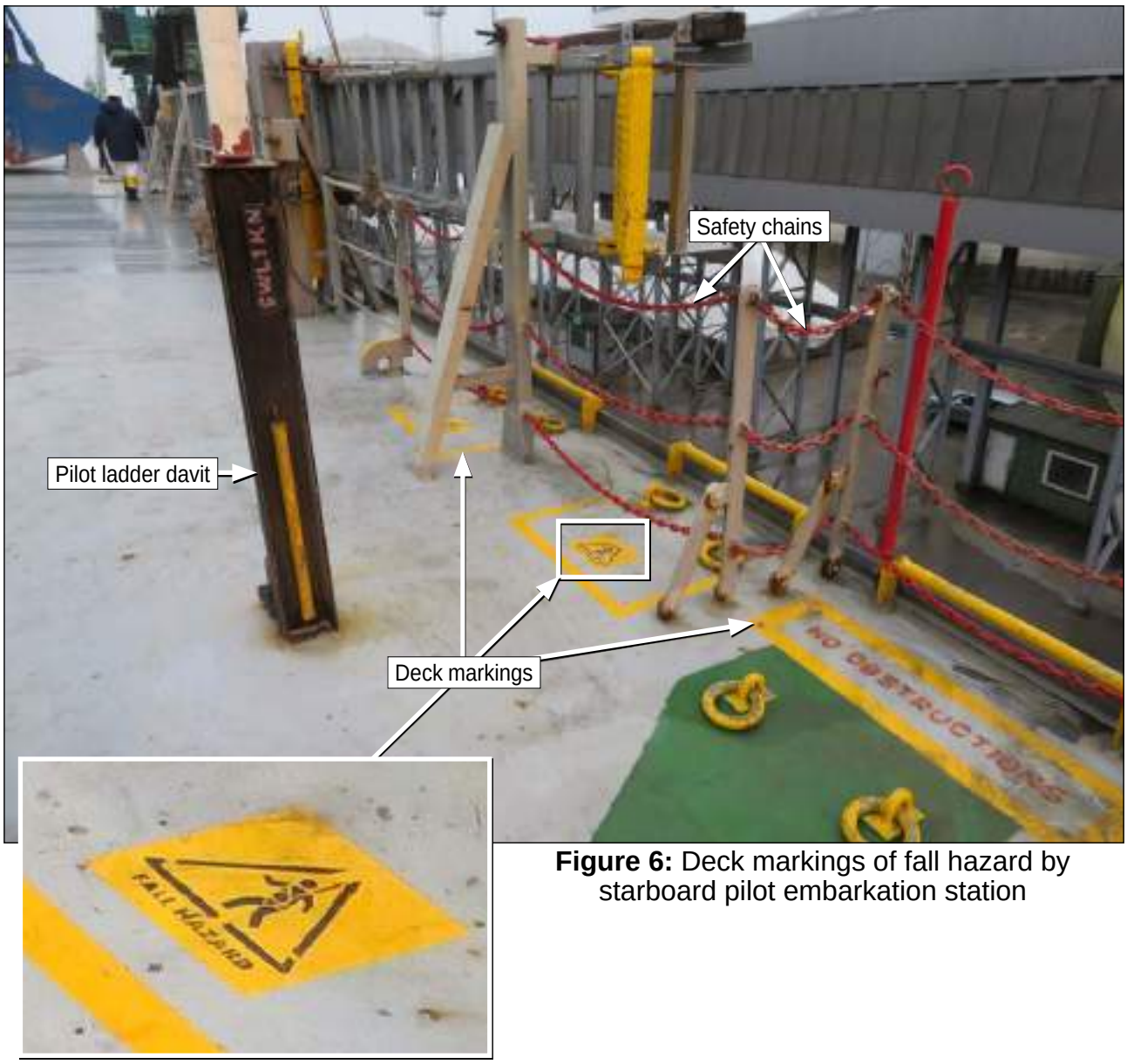


Figure 6: Deck markings of fall hazard by starboard pilot embarkation station

1.8.6 Safety harnesses

The safety harnesses on board *World Prize* were labelled as meeting European Standard EN 361:2002 – Personal protective equipment against falls from a height. Full body harnesses.

The safety harnesses incorporated a dorsal connection point that, when worn together, would sit behind the rear panel of the waistcoat-type PFDs provided.

1.9 USE OF PERSONAL PROTECTIVE EQUIPMENT

1.9.1 Rönnskär arrival

World Prize arrived at Rönnskär on 11 October 2025. A permit to work at height was completed for the rigging of the port accommodation ladder adjacent to the accommodation block. The safety measures indicated on the permit were identical to those contained on the permit to work completed on 14 October 2025. The permit included the use of a safety harness and fall arrest device.

During *World Prize*'s arrival at Rönnskär a photograph captured the crew apparently preparing the accommodation ladder for use. One crew member was standing on the accommodation ladder, with no apparent safety harness or fall arrest device **(Figure 7)**.

Image courtesy of the Swedish Accident Investigation Authority

Figure 7: *World Prize* crew preparing accommodation ladder for use on arrival at Rönnskär on 11 October 2025

1.9.2 Rönnskär departure

The investigation reviewed the arrangements in place for the rigging of the combination ladders against the permit to work as originally completed (see section 1.7.1). The discrepancies included:

- Safety harnesses and fall arrest devices were not in use at the time of the accident on the starboard combination ladder.
- No safety net was rigged.
- The responsible person at the work site was dismissed during the rigging of the starboard combination ladder and was not present for the rigging of the port combination ladder.
- No records were available to show that the people rigging the combination ladders had completed the training required by the SMS.
- The ABs working on the accommodation ladder were not equipped with handheld radios to enable them to communicate with the responsible person at the work site.

The crew were not wearing the safety harnesses and fall prevention equipment required by the work at height procedure while working near the fall hazard presented by the removal of the safety chains.

1.10 SWEDISH MARITIME ADMINISTRATION

1.10.1 General

The Swedish Maritime Administration (SMA)[7] provided pilot transfer services along the Swedish coast. The operation was divided into nine geographical areas with 20 pilot stations in total. The SMA was responsible for approximately 70 pilot boats, including *Pilot 753 SE*, and employed about 190 crew.

Pilot 753 SE provided pilot transfer services for the port of Skelleftehamn, including the terminal at Rönnskär. In January 2025, *Pilot 753 SE* was inspected by RINA S.p.A. surveyor on behalf of the SMA. The boat was issued with a document of compliance indicating compliance with the requirements of the Swedish Ship Safety Act 2003:364. The document of compliance was valid for 5 years, conditional on the completion of a successful intermediate inspection during the period of validity.

1.10.2 *Pilot 753 SE* recovery systems

Pilot 753 SE was fitted with two independent systems for recovery: a rescue sling; and a newly installed ARHoop, manufactured by AR Safety AS, Norway. The SMA was in the process of replacing rescue slings with the ARHoop on all of its pilot boats.

The rescue sling comprised a rope sling on the end of pole sections that needed to be assembled before use. The ARHoop was a single system with a flexible hoop on one end of a guide tube connected to a lifting rope. Both the rescue sling and the ARHoop were intended to be used with a manually operated recovery davit that could be mounted on either side of the forward deck of *Pilot 753 SE* to recover a person from the water. The rescue sling was stowed in front of the wheelhouse and the ARHoop was stored in a protective cover port side aft of the wheelhouse **(Figure 8)**.

Pilot 753 SE was also equipped with two lifebuoys fitted forward and aft on the port side and two boathooks stowed on the starboard side.

Following the accident SHK attended a trial of the ARHoop system on *Pilot 753 SE*, during which two trained crew members used it to recover a mannequin representing an unconscious person from the water. A post-accident inspection by SHK of the rescue sling on board *Pilot 753 SE* found that its pole sections were difficult to assemble.

[7] Sjöfartsverket.

Images courtesy of the Swedish Accident Investigation Authority

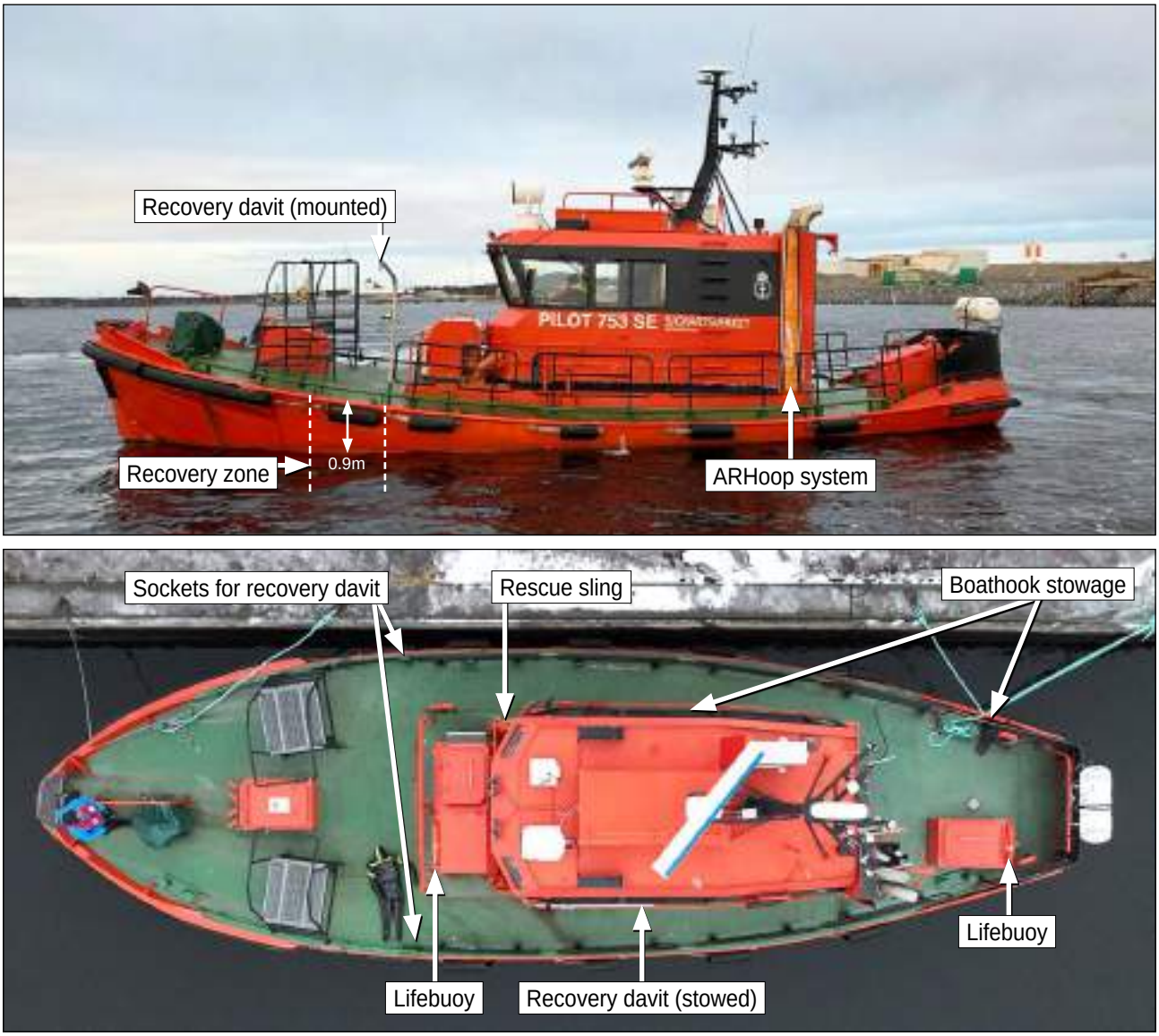


Figure 8: *Pilot 753 SE* recovery equipment

1.10.3 Crew

On 14 October 2025 *Pilot 753 SE* was operating with a skipper and deckhand. Both crew had undertaken training in first aid, high-speed craft operation and basic safety and held valid medical fitness certificates.

The skipper had been permanently employed as a boatman for more than 25 years. The SMA introduced a revised operational procedure for recovery of a person from the water in the spring of 2025. The skipper had undertaken four MOB recovery drills on *Pilot 753 SE* since the new procedure was introduced.

The deckhand had been retired for several years following a career as a boatman spanning more than four decades. They worked for the SMA as a substitute deckhand for 3 days to 5 days per month.

The crew training records were maintained in the SMA's digital training and maintenance management system. The deckhand was not included in the system and had not participated in any drills since retiring. The deckhand had not trained with the ARHoop recovery system and had previously used boathooks when recovering items from the water on board *Pilot 753 SE*.

1.10.4 Safety management review

At the beginning of 2024, the SMA established a new role tasked to conduct a review of the pilot boats it operated. The objective was to improve, coordinate, and standardise safety management at all the pilot stations. Among others, priority areas included the development of training activities; safety drills; and the provision of standardised equipment and methods, particularly for MOB situations.

The SMA's review of MOB equipment identified that the rescue sling should be replaced with a simpler arrangement that could be deployed promptly to recover a person from the water. This resulted in the start of a phased introduction of the ARHoop system.

The review also identified a need to increase the frequency of MOB drills, and to ensure that these were carried out at individual rather than pilot station level. From April 2025, all crew members were required to practice MOB procedures every month.

The SMA used a digital training and maintenance management system that generated a work list for each crew member at the start of every duty period. The work list would set out any training the crew member needed to complete. Temporary crew members did not have access to the system and did not have an individual work list to manage their activity.

1.11 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. The reaction to sudden immersion in cold water is a reflex response and does not require a person to be conscious for it to occur.

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. This in turn leads to progressive incapacitation that impedes the ability to swim.

1.12 REGULATION AND GUIDANCE

1.12.1 International Management Code for the Safe Operation of Ships and for Pollution Prevention

Chapter IX of the International Convention for the Safety of Life at Sea (SOLAS), 1974 applied the requirements of the ISM Code to cargo ships with a gross tonnage of more than 500gt on international voyages.

The Isle of Man Merchant Shipping (ISM Code) Regulations 1998 brought into effect the requirements of the ISM Code, setting out the mandatory framework for vessel safety management.

The ISM Code required that the objectives of the company included the need to assess all identified risks to its ships, personnel and the environment and establish appropriate safeguards.

The functional requirements of the ISM Code included the need for an SMS to include instructions and procedures to ensure safe operation of ships in compliance with relevant international and flag state legislation. The ISM Code further required the company to establish procedures, plans and instructions, including checklists as appropriate, for key shipboard operations concerning the safety of personnel.

A company's SMS was required to ensure compliance with mandatory rules and regulations; and to take into account applicable codes, guidelines and standards recommended by the administration.

1.12.2 The Maritime Labour Convention, 2006

Regulation 4.3 of Title 4 of the Maritime Labour Convention (MLC), 2006, as amended required shipowners to make provision for seafarers to work in a safe and hygienic environment.

To support ships registered in the Isle of Man to comply with the MLC requirements, the Isle of Man Ship Registry published Maritime Labour Notice 4.3(A)[8] setting out its health and safety guidelines. The notice detailed the measures necessary to prevent accidents and included the responsibility of safety officers to ensure, as far as possible, *that safety instructions and guidance are followed*. The guidelines also reflected the requirements for the use of PPE on board.

1.12.3 Code of Safe Working Practices for Merchant Seafarers

The Code of Safe Working Practices for Merchant Seafarers (COSWP), published by the UK Maritime and Coastguard Agency, was developed to standardise safety procedures for UK merchant seafarers. The Code had undergone frequent revisions since its first publication in 1974.

The Isle of Man Merchant Shipping (Code of Safe Working Practices) Regulations 1989 required Isle of Man registered ships to carry the COSWP for the guidance of the crew on board and specifically identified the version of the COSWP published in 1991. The Isle of Man administration had not issued a Manx Shipping Notice for any subsequent updates to the COSWP. The crew on board *World Prize* had access to the 2025 version of the COSWP.

The COSWP provided best practice guidance for health and safety on board ships. The Code's contents were not mandatory, although the COSWP noted the requirement contained in the ISM Code for applicable codes to be taken into account and identified itself as one such code. The COSWP contents included:

- Managing occupational health and safety (chapter 1)
- Personal protective equipment (chapter 8)
- Permit to work systems (chapter 14)
- Work at height (chapter 17)

[8] MLN 4.3(A) (Rev.2) – Health & Safety Policies & Programmes, issued 23 December 2024.

Extracts from the guidance included in chapters 1, 8, 14 and 17 of the COSWP 2025 edition are shown in **Table 2**.

COSWP 2025 section	Guidance
1.1	Every person on board has a responsibility for their own occupational health and safety and that of others, including • complying with instructions, safety procedures and any other measures in place for their own or others' safety Your organisation should: • create a culture where everyone takes responsibility for a safe working environment, and seafarers are enabled to speak up about any safety concerns.
1.2.1	The following elements contribute to a safe working culture: • risk awareness • clearly defined expectations • good communications • good planning • accountability • clear leadership • good safety culture • effective knowledge management.
1.2.2	Seafarers should feel confident to stop work if they feel unsafe; this is known as 'stop work authority'.
1.2.4	Leading the team by example is a combination of two things: being seen to comply with the safety procedures, and working as a key part of the team.
1.2.5	Good planning is essential in ensuring occupational health and safety at work. You can only control risks adequately by ensuring that everyone involved is aware,…
1.2.6	Effective risk assessments should: • correctly and accurately identify all hazards • identify who may be harmed and how • determine the likelihood of harm arising • quantify the severity of the harm • identify and disregard inconsequential risks • record the significant findings • provide the basis for implementing or improving control measures • provide a basis for regular review and updating.

COSWP 2025 section	Guidance
1.2.6	Give a toolbox talk before any work is carried out that involves more than one person and where there is significant risk to persons or assets.
1.2.7	… it is important that: • there are well-defined rules and guidelines, which are clearly understood • responsibilities are clearly defined for everyone on board and ashore
1.2.8	A good safety culture is one where safety is an integral part of everything that is planned, discussed, done and documented. Everyone in the company should think about safety and new ways of improving it as a matter of course. They should be on the alert for any unsafe acts or unsafe conditions; look out for each other; intervene to prevent accidents and incidents; actively share good ideas; and always seek to improve.
8.1.1	PPE must be assessed to ensure it effectively reduces the risk to a safe level. If you cannot reduce the risk to a safe level even with relevant PPE then the activity must not be carried out.
8.1.6	Your organisation should • assess the equipment required to ensure that it is suitable and effective for the task in question, and meets the appropriate standards of design and manufacture
8.2	Seafarers must wear the protective equipment or clothing supplied when carrying out a task for which it is provided, and follow the instructions for use.
8.9.1	All personnel who are working at height (i.e. in any position from which there is a risk of falling) should wear a safety harness (or belt with shock absorber) attached to a lifeline.
8.11.1	Provide a lifebuoy with sufficient line where seafarers are working overside or in an exposed position where there is a risk of falling or being washed overboard… wear a working lifejacket, a personal flotation device or a buoyancy aid, as appropriate. Where necessary, provide thermal protective clothing to reduce the risks of cold shock.
14.2.1	A permit to work provides an organised and predefined safety procedure. It does not in itself make the job safe but ensures that you follow measures for safe working.

COSWP 2025 section	Guidance
17.2	Your organisation should • ensure that work at height, where it is necessary, is properly planned, appropriately supervised and done as safely as is reasonably practicable
17.2.2	Personnel working at height where there is a risk of falling should wear a safety harness with a lifeline or other arresting device at all times.

Table 2: Guidance extracts from the COSWP, 2025 edition

1.13 PREVIOUS ACCIDENTS

1.13.1 *Finnhawk* and *Humber Saturn* – fall from a pilot ladder

On 8 January 2023, a pilot fell from a pilot ladder, probably after suffering a cardiac arrest event, while boarding the Finland registered roll-on/roll-off cargo vessel *Finnhawk* from the UK registered pilot vessel *Humber Saturn* (MAIB report 2/2026[9]). The pilot struck the deck of *Humber Saturn* before falling into the water and losing consciousness.

The pilot was quickly recovered onto *Humber Saturn*'s semi-submerged MOB recovery platform, which could not be raised. He remained semi-immersed in cold water for over 40 minutes until he could be transferred to a lifeboat. The pilot was then evacuated to hospital but was later pronounced deceased.

The investigation found, among other safety issues, that the pilot's chance of survival was significantly reduced by his immersion in cold seawater immediately after the fall and by his partial immersion on *Humber Saturn*'s defective lowered recovery platform for over 40 minutes.

1.13.2 *Elandra Baltic* – fall overboard

On 13 April 2020, the Republic of the Marshall Islands registered chemical/oil products tanker *Elandra Baltic* was preparing for arrival at Fos-sur-Mer, France to discharge a cargo of diesel.

The bosun and an AB were rigging the pilot ladder in readiness to embark a pilot. After lowering the accommodation ladder over the side, they noticed that the lower platform was not parallel to the water and needed adjusting. The AB went down the ladder to secure the platform. He fell overboard and was not recovered.

The investigation by the Republic of the Marshall Islands Maritime Administrator[10] identified that the AB was not using the PPE required by the company's SMS for working overside; the supervision of the activity was ineffective; and there was a lack of communication between the work party and the responsible officer.

[9] MAIB report 2/2026: Finnhawk and Humber Saturn

[10] Republic of the Marshall Islands Maritime Administrator investigation report: Elandra Baltic

The report also identified that the stop-work authority that crew members held to correct an unsafe condition was not exercised by any of the crew observing the work to rig the ladder.

1.13.3 *Navios Amitie* – fall overboard

On 5 February 2020, the bosun on the Malta registered bulk carrier *Navios Amitie* fell into the sea while rigging a combination ladder. It was dark and the vessel was making way to the pilot station off the port of Çanakkale, Turkey. The bosun was not recovered.

The Transport Malta Marine Safety Investigation Unit report[11] concluded that the bosun lost his balance while lashing the accommodation ladder to the vertical pilot ladder and fell into the sea. He was neither wearing a safety harness nor a lifejacket. The investigation also identified that no formal risk assessment and no permit to work had been completed.

Additionally, the onboard SMS procedure prohibited working overside while the vessel was underway. The report identified that this requirement was incompatible with normal ship operations, as crew members were required to rig a combination ladder during arrival and departure from port. Consequently, the crew could not reasonably comply with the procedure as written.

1.13.4 *Singapore Express* – fall from a pilot ladder

On 27 February 2018, the Hong Kong registered container ship *Singapore Express* departed Lisbon, Portugal with a pilot on board. On completion of the pilotage, a pilot boat came alongside *Singapore Express* to embark the pilot. During the transfer the pilot fell into the sea.

The crew of the pilot boat attempted to recover the pilot, and were at one point able to take hold of his jacket and lifejacket, but could not lift him from the water. More than 100 minutes after falling into the sea, the pilot was recovered unconscious from the sea but was later declared deceased.

An investigation was carried out by Portugal's Marine Accident Investigation Office[12]. The investigation report[13] identified that no emergency procedures for the recovery of persons from the water existed on board the pilot boat. It concluded that the lack of emergency procedures exacerbated the delay in recovering the pilot from the sea. The investigation also found that the pilot vessel's recovery davit was unfit for purpose, requiring the person in the water to be able to assist in their own recovery. The cold seawater temperature was judged to have limited the pilot's physical ability to help himself.

[11] Transport Malta Marine Safety Investigation Unit report 04/2021: Navios Amitie

[12] Gabinete de Investigação de Acidentes Marítimos (GAMA).

[13] Copies of this report can be requested by email to iam@gama.mm.gov.pt

1.13.5 *Nabucco* – fall overboard

On 26 June 2017, the Luxembourg registered chemical oil tanker *Nabucco* was berthed in Saltend, England. *Nabucco* had two means of access established: a gangway to enable access at low water and an accommodation ladder for when the tide was higher. When the tide turned during the night, the accommodation ladder needed to be stowed and the gangway prepared for use.

The C/O was working alone on the platform of the accommodation ladder when he fell into the water between the vessel and the quay. Despite an intensive search, the C/O's body was not recovered until 5 July 2017.

The investigation by the Luxembourg Administration of Technical Investigations[14] concluded that the C/O was not wearing a lifejacket and a safety harness while performing the task of stowing the accommodation ladder, which was not in accordance with the existing procedure. The report highlighted that the operator's procedures detailing the requirements for the use of PPE while working on deck were adequate. The investigation also found that:

> *Safety procedures defined in the operator's SMS were not adhered to by the crew at different levels of responsibility, impeding the safety on board the Nabucco and weakening the safety culture.*

1.13.6 *Madinah* – fall overboard

On 2 July 2015, the Hong Kong registered container ship *Madinah* was preparing for arrival at the port of Lyttelton, New Zealand. The preparations involved the bosun and a deck trainee rigging the port accommodation ladder.

Both the bosun and the deck trainee were wearing safety harnesses. The bosun sent the deck trainee to fetch PFDs, which were required to be worn for any task outside the ship's railing. When the trainee returned, the bosun had already swung the accommodation ladder over the side, clipped his safety harness to a plastic-coated wire and walked along the accommodation ladder to lift the handrails into place. In doing so he lost his balance and fell from the ladder. The wire to which he had clipped his safety harness failed and he fell into the sea. Despite an extensive search the bosun was not recovered.

The investigation by New Zealand's Transport Accident Investigation Commission[15] concluded that the bosun's chances of survival would have significantly increased had he been wearing a PFD. The investigation also concluded that the design of the wire rope and its method of attachment to the ship were not fit for the purpose for a safety harness.

1.13.7 *Cape Splendor* – fall overboard

On 6 October 2014, the Singapore registered bulk carrier *Cape Splendor* was at anchor off Port Headland, Australia. During the lunch break *Cape Splendor*'s bosun descended the ship's accommodation ladder, intending to fish from the lower

[14] Luxembourg Administration of Technical Investigations: Nabucco report

[15] New Zealand Transport Accident Investigation Commission report MO-2015-02: Madinah

platform. An AB joined him to assist. Neither crew member was using a PFD or fall prevention equipment. At about 1250, the bosun lost his balance and fell into the sea. An extensive air and sea search followed but the bosun was not found.

Following the accident investigators from the Australian Transport Safety Bureau witnessed the ship's crew rigging the ladder in a manner that was contrary to its SMS procedures documenting the risks and risk controls to prevent falls from height when working over the side of the ship. The investigation report[16] stated that:

> *Accordingly, it appeared that company safety circulars and training to support those SMS procedures had not resulted in the crew learning lessons for safe work over the side – nor had such lessons been learned from the accident on 6 October.*
>
> *Other evidence, including interviews with crew and permit to work records, indicated that the ladder was routinely rigged in a similar way. The crew's usual practices show that they did not appreciate the importance of fall prevention when working over the side.*

The report concluded that:

> *Cape Splendor's safety management system (SMS) procedures for working over the side of the ship were not effectively implemented. As a result, the ship's crew routinely did not take all the required safety precautions when working over the side. Further, they did not consider that any such precautions were necessary if going over the side when not working.*

[16] Australian Transport Safety Bureau report 314-MO-2014-011: Cape Splendor

SECTION 2 – ANALYSIS

2.1 AIM

The purpose of the analysis is to determine the contributory causes and circumstances of the accident as a basis for making recommendations to prevent similar accidents occurring in the future.

2.2 OVERVIEW

World Prize's bosun died when he fell from the deck while assisting in the rigging of the starboard combination ladder. This section of the report discusses the factors contributing to this accident, including the circumstances of the fall, the provision and use of safety equipment, the supervision and assurance of operations and the safety climate on board *World Prize*. It also examines the ability of *Pilot 735 SE* to recover persons from the water.

2.3 THE ACCIDENT

2.3.1 The fall from the deck

The C/O and bosun were working close to *World Prize*'s unguarded deck edge while rigging the starboard pilot ladder and were communicating with the two ABs on the lower platform. It is not absolutely clear why the bosun fell, but it is most likely he overbalanced while attempting to either communicate with the two ABs on the accommodation ladder or to assess the height of the pilot ladder above the water.

With no means of restraint or arrest, the bosun fell to the water, striking the AB and then the lower platform at the bottom of the accommodation ladder during his descent. The circumstances leading up to the bosun's fall shared many similarities with the fatal accidents on board *Navios Amitie* and *Nabucco*.

The bosun fell from the deck of *World Prize* while working near an unguarded opening.

2.3.2 Survivability

It is almost certain that the bosun's injuries to his head and torso resulted from him striking the lower platform of the accommodation ladder as he fell to the water. These injuries were not life-threatening in themselves, although may have rendered him unconscious, and it was almost certain that he was alive when he entered the water.

The bosun's helmet remained in position throughout the fall. The locations of the bosun's injuries, together with the absence of damage to the helmet shell, make it unlikely that the helmet struck the accommodation ladder platform during the fall. It is therefore unlikely that the use of the helmet influenced the outcome of the accident.

The bosun was not wearing any clothing that would protect him from the temperature of the water he entered. The fall into the water almost certainly initiated an immediate cold water response in his body, regardless of whether he was conscious at the time.

The initial physiological response to cold water immersion likely caused the bosun to involuntarily inhale seawater upon entry. He was seen to be floating face down in the water a short time after the fall, making it unlikely that sufficient time had passed to make cold incapacitation a factor in the accident.

The postmortem report recorded no indication of any cardiac arrest. It is therefore unlikely that either the bosun's medication or the underlying conditions they were treating influenced the outcome of the accident. Without wearing a PFD to support him in the water, the injured bosun's prospect of survival was significantly diminished.

The bosun's injuries likely rendered him unable to help himself once he had entered the water. Without a PFD to support him in the water, and likely experiencing a cold water response, the bosun was unable to maintain his airway clear of the water and therefore drowned.

2.4 PROCEDURES FOR WORKING ON OR NEAR THE SHIP'S SIDE

2.4.1 Working near an unguarded deck edge

The work to rig the combination ladder on *World Prize* required the removal of the safety chains that spanned the gap in the solid guardrails running along the side of the main deck when a pilot embarkation station was in use **(**see **Figure 2)**.

The pilot ladder davit located *World Prize*'s deck was not fit for use. Crew members had therefore likely become normalised to lowering and recovering the pilot ladder manually, handling its suspended weight. This created a tendency for the ladder to pull them towards the deck edge, exposing them to an increased risk of falling. The additional risk arising from the removal of the pilot ladder davit from service had not been identified.

The SMS on board *World Prize* identified that working near to an unguarded deck edge constituted a hazard that required both the completion of a permit to work and the use of specific PPE to mitigate the risk presented. It specifically required anyone working on the accommodation ladder and in the vicinity of the open shipside railing to wear both a safety harness secured to a safe anchor point, and a PFD. The area designated in the SMS as being a hazardous area was not wholly marked to highlight to the crew that they were at risk. None of the crew working near the fall hazard presented by the open gaps in the guardrails on *World Prize* were using the PPE required by the SMS.

The investigation showed that the risk mitigations set out in the SMS were not applied when rigging the accommodation ladder during the vessel's arrival at Rönnskär or when rigging of the combination ladder at the time of the accident.

The unsafe methods used while rigging the combination ladder and when conducting work in a hazardous area had likely become normalised practice, placing the crew at serious risk of injury.

2.4.2 Communication

The procedure for rigging the combination ladder on *World Prize* required a crew member working shipside at the accommodation ladder to carry a handheld radio for communication.

A shortage of handheld radios for the operation of *World Prize* was raised at the on board safety committee meetings in July 2025 and August 2025. The lack of communication equipment for the work team meant that it was only possible to talk directly to the crew on the accommodation ladder by leaning over the side of the vessel. Doing so from the top of the pilot ladder, where the safety chains had been removed, placed crew members at risk of falling.

The report of the fatal accident on board *Elandra Baltic* similarly demonstrated how poor communication between crew members working on an accommodation ladder and the responsible officer on deck could lead to ineffective supervision of activities on the ladder.

A lack of sufficient handheld radios for use by the crew contributed to them working close to an unguarded deck edge, increasing the risk of falling.

2.4.3 Fall arrest and fall prevention

The SMS procedure for working over the side of the vessel required personnel to use a safety harness and a fall arrest device. The procedure provided guidance on the selection of a suitable anchor point to which a fall arrest device could be secured. However, the two demonstrated methods for the connection of the fall arrest devices at the pilot boarding stations did not meet the guidance contained in the SMS procedure, nor did they allow the free movement of the personnel working on the accommodation ladder.

With no attachment points above the accommodation ladders that met the guidance criteria in the vessel's SMS, it is unlikely that fall arrest devices were used when rigging the combination ladders on *World Prize*. The investigation report on the failure of a bosun's fall arrest device when he fell from an accommodation ladder on board *Madinah* also highlighted the need for appropriate anchor points.

The evidence that crew working on *World Prize*'s accommodation ladder did not use fall arrest devices during the vessel's arrival at Rönnskär or at the time of the accident supports the likelihood that this equipment was not routinely used when rigging the combination ladder. Similarly, it is likely that crew working on deck near the fall hazard created by the removal of the safety chains at the deck edge did not routinely use the required fall prevention equipment.

Crew members working near an area of unguarded deck edge were not equipped with the appropriate PPE to prevent them falling or arrest their fall should they do so.

2.4.4 Personal flotation devices

World Prize was equipped with PFDs for the crew to use when working in areas where there was a risk of falling into the water.

The waistcoat-type PFDs provided were incompatible with the dorsal connection point of the safety harnesses used on board. This meant that their configuration would be unlikely to meet the certified performance standard if worn together.

The PFD's buoyant solid foam was intended to provide additional buoyancy to help a conscious wearer remain afloat while awaiting recovery. They were not designed to rotate an unconscious person face up in the water. The use of such PFDs did not

account for the possibility that a crew member may not be able to assist themselves should they enter the water, making them almost entirely dependent on rapid recovery for survival.

The PFDs provided to crew members were incompatible with the safety harnesses used on board and could not support them to keep their face out of the water should they enter the water when unconscious, placing them at significant risk when working on the ship's side.

2.5 SUPERVISION

2.5.1 Permit to work

The COSWP stated that a permit to work provided an organised and predefined safety procedure, noting that each permit to work should be relevant and as accurate as possible for the task being undertaken.

The rigging of *World Prize*'s combination ladder on 14 October 2025 was a planned activity that met the SMS requirements for the use of a permit to work. A review of the completed permit to work would indicate that the work to rig the combination ladder had been completed in full compliance with all of the SMS requirements intended to reduce the risks to the crew. However, many of the required safeguards were not implemented at the work site. The lack of safeguards replicated the observed activity to rig the accommodation ladder during the ship's arrival at Rönnskär.

The scant regard for the permit to work requirements continued after the accident, with the amendment to the completed permit to work to incorporate the rigging of the port combination ladder after the port side ladders had already been rigged and used. This reinforces the likely existence of an on board culture in which the administration of safety was divorced from its effective management.

The risk mitigations in the permit to work were not strictly adhered to, and the form's completion and subsequent amendment were possibly undertaken to demonstrate compliance, placing the crew at risk.

2.5.2 Local supervision

The operation to rig the combination ladder was initially planned to be undertaken by two ABs under the supervision of the 2/O. This plan changed with the arrival of the C/O and the bosun once the forward tug had been released. The change of plan did not elicit a review of the permit to work, despite the work being the subject of a toolbox talk once the team had gathered on the main deck. The lines of responsibility and communication were unclear. As the work to prepare the accommodation ladder progressed, the C/O became the de facto supervising officer at the work site due to his seniority.

The updated schedule for the pilots' departure likely gave the perception that the rigging of the ladder needed to be completed quickly. The new urgency to the task possibly contributed to both the C/O and the bosun becoming directly involved in the activity to adjust the height of the pilot ladder.

There was a blurring of the distinction between supervisory and operational roles, diminishing oversight and increasing the potential for the risks of working near a fall hazard going unrecognised.

The local supervision of the rigging of the pilot ladder was ineffective in ensuring it was conducted in a safe manner, placing the crew at significant risk.

2.5.3 Stop work

A clear stop work policy was in place on board *World Prize*. It was displayed on posters throughout the ship and formed a standing agenda item in the vessel's monthly safety committee meetings.

None of the crew invoked the stop work policy on the day of the accident, despite the activity to rig the combination ladder exhibiting numerous departures from the safe working practices set out in the SMS procedures for working at height. Locally, it is possible that the difference in seniority between the C/O and bosun and the more junior crew engaged in the work reduced the likelihood that any concerns would be raised. It is therefore possible that this contributed to the lack of challenge to the actions of the C/O and bosun.

Immediately before the accident the two pilots were near the pilot embarkation station on *World Prize*'s deck, waiting for the crew's invitation to disembark. It was the crew's responsibility to prepare the combination ladder for use and the pilots were not directly engaged in the activity, limiting their opportunity to identify unsafe practices and intervene.

The investigation report on the two fatalities on board *Elandra Baltic* underlined the need for crew members to have the confidence to exercise their authority to stop work when they observe an unsafe condition.

The presence of personnel observing the activity at the unguarded deck opening on *World Prize* did not result in an intervention to stop the unsafe work, exposing the crew to a risk of falling.

2.6 SAFETY CLIMATE

Synergy Maritime maintained an SMS that encompassed a suite of measures to reduce the risks present in the operation of *World Prize*. The SMS procedures required documented evidence of compliance, and examination of the records formed part of the periodic internal and external verifications of the operation of the system.

The records maintained on *World Prize* did not accurately reflect the activities carried out. This had been identified in the nonconformity raised for safety officer inspections during the internal ISM audit in May 2024, and was noted during the intermediate audit to endorse the safety management certificate in December 2024.

Similar to the working practices identified in the *Cape Splendor* investigation report, it is likely that the observed practices on *World Prize* reflected the way the combination ladders were routinely rigged. Repeated exposure to the risks without incident probably led to the normalisation of the unsafe practices. This reduced the perceived risk of the activity and undermined compliance with the required SMS procedures.

The records completed at the time of the accident for the rigging of the combination ladder indicated that the prescribed controls and procedures had been followed. However, important work-related elements of the documentation were, in practice, incorrect, modified, or had been applied retrospectively. The manner of the work undertaken to rig the combination ladder was at odds with the requirements of the SMS and acceptance of the way it was conducted was apparent at all levels on board *World Prize*.

Similarly, the safety meeting minutes documented discussions over an extensive range of topics. It is difficult to reconcile the scope of the discussions recorded with the limited duration of the meetings stated in the minutes.

The evidence of the inappropriate documenting of safety critical activities identified in the investigation places doubt over the records of other activities maintained on board *World Prize*. It is possible that the records maintained, and presented during routine audits, also contained erroneous entries.

Inappropriate recording of safety critical activities was evident over a period encompassing different crews on board, suggesting that it was a behaviour embedded in the working practices on *World Prize* and not solely with those on board at the time of the accident.

A safety climate is shaped by the way safety policies are applied in practice, how leaders balance safety against operational demands, and the extent to which personnel feel able to challenge unsafe situations.

The evidence indicates that the safety climate on board *World Prize* resulted in an emphasis on the documentation of compliance rather than the effective management of risk.

2.7 THE MAN OVERBOARD RECOVERY ATTEMPT

Pilot 753 SE was a short distance off the beam of *World Prize* when the bosun fell. The boat's two crew were alert to the activity on board *World Prize* and saw the fall, immediately closing to attempt to recover the bosun from the water. The bosun from *World Prize* was not wearing a PFD so the crew of *Pilot 753 SE* had little time to plan how the recovery should be carried out.

Faced with an urgent situation and minimal time for deliberation, the actions of the crew of *Pilot 753 SE* were almost certainly driven solely by procedures embedded through training. The deckhand on *Pilot 753 SE* had not been trained in the recovery procedure using the ARHoop system and did not consider using it. The deckhand was familiar with using a boathook to retrieve objects from the water, and it was this equipment they took to the bow of the vessel to attempt to recover the bosun.

The crew members were unable to bring the bosun on board using the boathook and lifebuoy brought by the deckhand so had to improvise, attempting to secure the unconscious bosun in position while they sought another solution for his recovery. The high freeboard of *Pilot 753 SE* at the bow made recovery of the bosun problematic, and both crew members had to lie on the deck to reach the bosun. Despite their best efforts, the attempt to secure the bosun was unsuccessful.

A later trial of the ARHoop system installed on *Pilot 753 SE* with SHK in attendance demonstrated its capability to recover an unconscious person from the water. However, because the ARHoop system was not used at the outset of the response, the crew had to replan the recovery under conditions in which the bosun was already in danger.

Pilot vessels regularly carry out personnel transfers at sea, making it foreseeable that someone could fall overboard. This risk necessitates appropriate equipment and training to mitigate it effectively. The requirement for vessels engaged in such operations to be able to recover a person from the water promptly was highlighted in the investigation report on the fatal accident involving *Singapore Express*. That report concluded that a lack of emergency procedures exacerbated the delay in recovering the pilot, who had fallen into the sea during a transfer.

The value in being able to recover a person from the water quickly was further highlighted in the investigation report on the fatal accident involving *Finnhawk* and *Humber Saturn*, which concluded that the pilot's chance of survival was significantly reduced by his prolonged immersion in cold water.

The possibility of a successful recovery of the bosun by the crew on board *Pilot 753 SE* might have increased had the ARHoop system installed on board been used.

The SMA had identified the need for crew members to practice MOB recovery, but it relied on individual access to the digital training and maintenance management system to be allocated the training task. Temporary crew members, such as the deckhand on *Pilot 753 SE*, were not included in and did not have access to the system. Consequently, they were never scheduled to undertake training for recovering persons from the water and the deckhand had not been trained in the use of the ARHoop system.

The absence of a system to monitor and manage the training of temporary crew members had not been identified within the SMA despite the ongoing development of training activities and safety drills focusing on MOB situations.

The suitability and lack of familiarity with equipment and training in MOB procedures on board *Pilot 753 SE* reduced the capability of the crew to recover an unconscious person from the water.

2.8 REGULATION

The ISM Code required that applicable codes and guidelines be taken into account in the development of an SMS. From a health and safety perspective, the Isle of Man Merchant Shipping (Code of Safe Working Practices) Regulations 1989 made reference to the UK COSWP to promote safe working practices on Isle of Man vessels.

Although the crew on board *World Prize* had access to the most recent version of the publication, the governing Isle of Man legislation explicitly required the carriage of the 1991 edition. This was both outdated and no longer available.

The Isle of Man legislation set a carriage requirement for an edition of COSWP that was no longer available, potentially placing seafarers at risk from hazards that more recent versions were intended to manage.

SECTION 3 – CONCLUSIONS

3.1 SAFETY ISSUES DIRECTLY CONTRIBUTING TO THE ACCIDENT THAT HAVE BEEN ADDRESSED OR RESULTED IN RECOMMENDATIONS

1. The bosun fell from the deck of *World Prize* while working near an unguarded opening. [2.3.1]

2. The bosun's injuries likely rendered him unable to help himself once he had entered the water. Without a PFD to support him, and likely experiencing a cold water response, the bosun was unable to maintain his airway clear of the water and therefore drowned. [2.3.2]

3. The unsafe methods used while rigging the combination ladder and when conducting work in a hazardous area had likely become normalised practice, placing the crew at serious risk of injury. [2.4.1]

4. A lack of sufficient handheld radios for the use by the crew contributed to them working close to an unguarded deck edge, increasing the risk of falling. [2.4.2]

5. Crew members working near an area of unguarded deck edge were not equipped with the appropriate PPE to prevent them falling or arrest any fall should they do so. [2.4.3]

6. The risk mitigations in the permit to work were not strictly adhered to, and the form's completion and subsequent amendment were possibly undertaken to demonstrate compliance, placing the crew at risk. [2.5.1]

7. The local supervision of the rigging of the pilot ladder was ineffective in ensuring it was conducted in a safe manner, placing the crew at significant risk. [2.5.2]

8. The presence of personnel observing the activity at the unguarded deck opening on *World Prize* did not result in an intervention to stop the unsafe work, exposing the crew to a risk of falling. [2.5.3]

9. The evidence indicates that the safety climate on board *World Prize* resulted in an emphasis on the documentation of compliance rather than the effective management of risk. [2.6]

3.2 SAFETY ISSUES NOT DIRECTLY CONTRIBUTING TO THE ACCIDENT THAT HAVE BEEN ADDRESSED OR RESULTED IN RECOMMENDATIONS

1. Crew members were not provided with PFDs compatible with the safety harnesses used on board, or that could support them should they enter the water when unconscious, placing them at significant risk when working on the ship's side. [2.4.4]

2. The suitability and lack of familiarity with equipment and training in MOB procedures on board *Pilot 753 SE* reduced the capability of the crew to recover an unconscious person from the water. [2.7]

3. The Isle of Man legislation set a carriage requirement for an edition of the code of safe working practices for merchant seafarers that was no longer available, potentially placing seafarers at risk from hazards that more recent versions were intended to manage. [2.8]

SECTION 4 – ACTION TAKEN

4.1 ACTIONS TAKEN BY OTHER ORGANISATIONS

Synergy Maritime Private Limited has conducted an internal investigation into the accident on board *World Prize*. As a result it has:

- Delivered a programme of training and crew counselling on board *World Prize*.
- Distributed a Fleet Alert and accompanying training video on the circumstances of the accident and the safety lessons identified in the internal investigation.
- Reinforced the stop work authority in its fleet and refocused safety training on behavioural matters to include operational and supervisory responsibilities and scenario-based training.
- Completed engineering modifications on *World Prize* to provide tested anchor points for fall restraint and fall arrest devices when rigging the combination ladders.
- Maintained the pilot ladder davits on board *World Prize* and placed them back into service.
- Reviewed the provision of PPE in its fleet.
- Replaced the PFDs on *World Prize* with units compatible with the safety harnesses on board.
- Provided additional handheld radios to *World Prize*.
- Re-marked the deck of *World Prize* next to the pilot embarkation stations to highlight the extent of the hazardous area when the safety chains are removed.

The **Swedish Maritime Administration** has:

- Reviewed the MOB equipment on its vessels and removed all superseded equipment.
- Amended the digital training and maintenance management system to include all crew, both permanent and temporary, in MOB drills including the recovery method for an unconscious casualty.
- Published a training video to support the conduct of MOB recovery on its vessels[17].

The **Isle of Man Ship Registry** has:

Published Manx Shipping Notice 077 in accordance with regulation 1(3) of the Merchant Shipping (Code of Safe Working Practices) Regulations 1989 so that references to ‘Code’ in those Regulations refer to the latest version of the UK COSWP.

[17] SMA training video

SECTION 5 – RECOMMENDATIONS

In view of the actions already taken, no recommendations have been made.

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