**SHERIFFDOM OF SOUTH STRATHCLYDE,
DUMFRIES AND GALLOWAY AT STRANRAER**

[2026] FAI 27

STR-B46-25

DETERMINATION

BY

SHERIFF GARRY A SUTHERLAND

UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC (SCOTLAND) ACT 2016

into the death of

JOHN ALEXANDER HAMILTON

Stranraer 3 June 2026

The sheriff, having considered all the evidence presented at the Inquiry, determines in terms of section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016 that:

1. John Alexander Hamilton was born on 31 July 1963.

2. In terms of section 26(2)(a), his death occurred at 0842 hours on 23 July 2024 at the Stena Ferry Terminal, Cairnryan.

3. In terms of section 26(2)(b), an accident resulting in his death occurred at 0715 hours on 23 July 2024 at the Stena Ferry Terminal, Cairnryan.

4. In terms of section 26(2)(c), the causes of his death determined at a postmortem examination at the Queen Elizabeth University Hospital Mortuary on 30 July 2024 were:

i) consistent with neck injury and drowning;

ii) cardiac enlargement.

5. In terms of section 26(2)(d), the cause of the accident that resulted in the death was that said John Alexander Hamilton became entangled in two lengths of rope known as "tails", each of which, while held by him, one in each hand, were attached to the eyes of two mooring lines. In accordance with the extant Work Instruction, he was holding the tails while escorting the mooring lines to the quay edge at Stena Ferry Terminal at Cairnryan as they were being winched aboard the Superfast VII ferry prior to its departure. While thus entangled, as the mooring lines were being winched aboard, and by then in close proximity to the quay edge, he was lifted from his feet, pulled against the metal structure of the aft mooring arm and struck the starboard hull of said vessel, before detaching from said ropes and falling into the tidal waters of Loch Ryan.

6. In terms of section 26(2)(e), the precautions which (i) could reasonably have been taken, and (ii) had it been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided, would have been

i) The demarcation on the quayside of an area which if entered by a Port Service Operative whilst unmooring, would immediately pause any recovery of mooring lines onto a vessel; and

ii) The person in charge of directing the recovery of mooring lines onto the vessel occupies the pulpit position at the rear of the vessel's aft winching

deck during unmooring operations to provide a complete overview of all Port Service Operatives on the quayside involved.

7. In terms of section 26(2)(f), there were no defects in any system of working which contributed to his death or any accident resulting in his death.

8. In terms of section 26(2)(g), it is of relevance to the circumstances of John Alexander Hamilton's death to formally acknowledge the measures promptly taken by Stena in the aftermath of the accident. It cannot be asserted with confidence given the many factors that create risks to Port Service Operatives when carrying out mooring and unmooring operations that these will eliminate the possibility of a recurrence. Notwithstanding that, by introducing these changes, Stena has taken what could be described as reasonably practicable measures to prevent a recurrence, especially at Cairnryan, as follows:

- The checking by Port Service Operatives of each other's Personal Protection Equipment to ensure all items are being properly worn.
- The length of any tail attached to a mooring line has been shortened to mitigate the risk of entanglement.
- Any mooring line, once lifted off its bollards by two Port Service Operatives, will be aligned for clear retrieval and having signalled the crew to commence heaving, will be let go and its progress monitored across the quay as it is winched back onboard.
- The installation of bars around any snag hazards on the quayside to mitigate the risk of snagging as the mooring lines pass in close proximity to them.

- The application of a defined "no entry" zone for Port Service Operatives while the mooring lines are being retrieved, whereby if for any reason a Port Service Operative requires to enter that area during retrieval, the winch operator will stop the winches.
- The person directly in charge of mooring line retrieval operations on the aft winching deck of the vessel being located whereby he or she has a clear view of Port Service Operators on the quayside to allow them to radio the winch operator to stop the winches if the Port Service Operative does so enter.

Recommendations

Given the comprehensive precautions which Stena put in place to ensure the health and safety of its Port Service Operatives post-accident, there are no recommendations to make under section 26(1)(b). There are no (a) reasonable precautions to be taken; (b) improvements to any system of working to be made; (c) systems of working to be introduced; or (d) other steps that could be taken which might realistically prevent other deaths in similar circumstances.

NOTE

Procedural history

[1] On 26 November 2025, 21, 22, 23 January and 11 March 2026, at Stranraer Sheriff Court a public Inquiry was held into the death of John Alexander Hamilton (hereinafter referred to as "Mr Hamilton"). On the first day of the Inquiry a site visit was conducted

at the Stena Ferry Terminal, Cairnryan. The Crown was represented throughout by Mr Glancy. Stena were represented throughout by Mr Smith KC. The family member Sheila Crosbie was represented throughout by Mr Conway.

[2] Preliminary hearings were held at Stranraer Sheriff Court remotely via the Webex Platform on 14 August, 25 September, 9 October, and 6 November 2025. Mr Glancy, Mr Smith KC and Mr Conway attended each hearing on behalf of those whom they represented.

[3] An application was made at an early stage by the Crown under Rule 4(2)(b) of the Act of Sederunt (Fatal Accident Inquiry) Rules 2017 to regulate the manner in which evidence/information would be led before the Inquiry. That was not opposed by either Mr Smith KC or Mr Conway and so was granted. In terms of that application, it was sought to lead evidence/information by way of statements, documentary productions, label productions, Joint Minutes of Agreement, and the oral evidence of those witnesses who were identified in a schedule accompanying the said application. The witnesses identified to give oral evidence were Sheila Crosbie, Jack McManus, Joseph Johnston, James McGilton, Michael Hughes, Captain Paul Young and Peter Quigley. In due course at the Inquiry, with the exception of Sheila Crosbie, all of those witnesses gave oral evidence. In addition, an expert witness Ms Karen McNeill also gave oral evidence to supplement a written report that had been lodged.

[4] The Inquiry was held in terms of the Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland)Act 2016.

[5] The Inquiry was governed by the Act of Sederunt (Fatal Accident Inquiry) Rules 2017.

[6] In terms of sections 1(3) and (4) of the 2016 Act, the purpose of the Inquiry was to establish the circumstances of the death and consider what steps (if any) might be taken to prevent other deaths in similar circumstances. The purpose of the Inquiry was not to establish civil or criminal liability.

[7] In terms of subsections (1)(a) and (2), in relation to the death to which the Inquiry relates, the sheriff's findings must be as to (a) when and where the death occurred, (b) when and where any accident resulting in the death occurred, (c) the cause or causes of the death, (d) the cause or causes of any accident resulting in the death, (e) any precautions which (i) could reasonably have been taken, and (ii) had they been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided, (f) any defects in any system of working which contributed to the death or any accident resulting in the death, and (g) any other facts which are relevant to the circumstances of the death.

[8] The Inquiry was raised by the Crown as a mandatory Inquiry under section 2(3) of the 2016 Act on the basis that the accident that resulted in the death of Mr Hamilton occurred whilst he was acting in the course of his employment or occupation.

The information/evidence before the inquiry

[9] The following were agreed by the Joint Minute of Agreed Facts:

[9.1] That John Paul Loughery, a Scottish Ambulance Service Paramedic pronounced the life of John Alexander Hamilton extinct at Cairnryan at 0842 hours or thereby on 23 July 2024.

[9.2] That the post mortem examination of said John Alexander Hamilton (hereinafter referred to as the Deceased) took place at the Queen Elizabeth University Hospital, Glasgow Mortuary on 30 July 2024, conducted by Gemma Kemp and Julia Bell, both consultant forensic pathologists.

[9.3] That said pathologists recorded that the Deceased was six feet one inch in height and weighed approximately thirteen stones.

[9.4] That during their examination of the Deceased, they noted that the right first and third ribs were fractured at the side which may have been caused by impact with a hard surface or water. Any other rib fractures were consistent 1 with resuscitation attempts.

[9.5] That the pathologists found a fracture through the body of the sixth cervical vertebrae with no damage to the underlying spinal cord, and opined that this type of injury can be caused by a hyperextension of the neck. They commented that it is recognised that sudden trauma to the cervical spinal cord can be associated with sudden death even without demonstrable injury to the cord. They concluded that the action of being propelled then impacting with the water has caused the neck injury.

[9.6] That there was no frothy fluid in the mouth or airways, but the lungs were slightly crepitant to the touch which, although non-specific, would be in keeping with the inhalation of water. More overt signs of drowning such as hyperinflated lungs or froth in the airways may have been lost due to cardiopulmonary resuscitation attempts.

[9.7] That in terms of natural disease, the heart was enlarged and above the expected weight for a man of his height and weight. A common cause of cardiac enlargement such as this is chronic hypertension (high blood pressure).

[9.8] That in summary, they concluded that John Hamilton was involved in an incident at work whereby ropes lifted him off his feet, when he was on the dock, and he was thrown into the water. The post mortem examination has found a fracture of the cervical spine consistent with a hyperextension neck injury and there were also signs that would be in keeping with water inhalation/drowning. Based on the history provided, it would seem most likely that the initial impact with the water had resulted in the neck injury (including possible spinal cord damage and a degree of immobility) following on from which there had been significant water inhalation/drowning. As Mr Hamilton had a pre-existing enlarged heart, this may have rendered him more likely to succumb to the sequelae of the neck fracture and inhalation of water and is therefore considered to be a potentially contributory factor in the death 2.

[9.9] That the pathologists determined that the cause of death was Primary cause 1a: Consistent with neck injury and drowning Potential contributing causes: 2: Cardiac enlargement.

[9.10] That samples of blood, urine and vitreous humour, taken from the Deceased during the post mortem examination were analysed between 30 July 2024 and 16 August 2024, both dates inclusive, at Aberdeen Royal Infirmary by Doctors Peter David Maskell and Fiona Mary Wyllie, both Forensic Toxicologists, who found no trace of any alcohol or controlled drugs.

[9.11] That on 31 July 2024, at the Department of Neuropathology at Edinburgh University, Professor Colin Smith, Consultant Neuropathologist, examined sections of brain and spinal cord which found no evidence of traumatic brain injury or traumatic spinal cord injury to the Deceased.

[10] All three participating parties lodged inventories of productions. These will be referred to in more detail where appropriate, but broadly speaking those fell into the following categories:

1 – Documents: these consisted of risk assessments, policy and training documents, training records and correspondence.

2 – Reports: these consisted of expert opinion reports.

3 – Photographs: these consisted of still images of the locus or the Superfast VII.

4 – Videos: these consisted of enhanced and slow-motion CCTV footage of the accident that resulted in Mr Hamilton's death and of the operation of the winches aboard Superfast VII when unmooring.

5 – Physical productions: these consisted of the Personal Floatation Device worn by Mr Hamilton at the time of his death.

[11] Written statements of the following persons were lodged: Sheila Crosbie, George McMillan, Iain Clark, Jack McManus, Joseph Johnston, James McGilton and Michael Hughes.

[12] On the afternoon of the first day of the Inquiry a site visit took place at the Stena Ferry Terminal, Cairnryan. This was arranged to coincide with the arrival and subsequent departure of the Superfast VII, the vessel that had been involved in the accident that resulted in Mr Hamilton's death. Following upon it having disgorged its passengers and cargo, an accompanied inspection of the aft winching deck took place. This is the location of the winch apparatus on the vessel relevant to the accident on 23 July 2024. The manner of the operation of the winches was explained by an officer. The positions of the various personnel were inspected, particularly the winch operator's post and the "pulpit" which shall be referred to later. The views of the quayside available from those positions were inspected. The level of ambient noise was experienced. Thereafter the quayside was inspected. The views from bollards one and four which shall both be referred to later were observed. An unmooring operation was then observed. Again, the ambient level of noise was experienced. Throughout the visit

all present wore a personal floatation device with crotch strap, a hard hat and steel toecap footwear supplied at site.

Summary of the information/evidence

Background to the accident

[13] Stena operate a passenger and freight ferry service from Cairnryan to Belfast and have done so since around 2011. Prior to that for many years the service had operated between Stranraer and Belfast. There were two similar vessels operated on that route, the Superfast VII and Superfast VIII. Both vessels always docked at the quay at Cairnryan in the same orientation, namely aft first with the starboard side moored to the quay. An automatic mooring arm system was in place at Cairnryan. It used two such arms. If either of those were inoperable for any reason, neither was used. Generally, when the mooring arms were in operation a limited number of mooring ropes were used to further secure the vessel to bollards on the quayside. On occasions when the arms were inoperable however, a greater number of mooring ropes were used at the discretion of and as directed by the captain of the vessel. Prevailing weather and tidal conditions, amongst other factors, would influence the captain's decisions regarding number and placement of mooring ropes generally.

[14] There were different types of ropes involved in mooring. During the Inquiry, slightly different terminology was used by some witnesses and documents. Those were:

i) The large diameter ropes that ran from the winches on the vessel to the bollards on the quay. These had a large loop on the end for attachment to the bollard called an "eye". These shall be referred to as mooring ropes.

ii) The smaller diameter detachable lines that were attached to the eyes of the mooring ropes. These were used to throw the mooring lines out and onto the quay upon arrival and for that purpose had a weighted knot or similar attached to the end referred to universally in the evidence as a "monkey"s fist". These shall be referred to as messenger lines; and

iii) Other smaller diameter lines that were used for the purpose of safe handling of the mooring ropes shoreside. These were permanently attached to the eye of the mooring line. These shall be referred to as tails.

[15] Mooring operations were carried out shoreside on the quay by a team of Port Services Operatives or PSOs. Mr Hamilton was a PSO with 40 years of service or thereby in that role on 23 July 2024. He had been employed by Stena throughout that time and had previously worked at Stranraer. He was considered to be a very experienced and competent PSO. He was well respected by colleagues and management at Stena.

[16] Mooring and unmooring operations were carried out on ship by teams of seamen of differing levels or ranks under the direction and supervision of an officer or bosun. There was a team at the fore of the ship and a team at the aft where the winches were located.

[17] Apart from one occasion decades ago that did not result in a fatality, there had never previously been an instance of a PSO falling into the water at either of Stena's facilities on Loch Ryan. That one prior instance had been at Stranraer.

[18] Although it shall be considered at a later stage, at this point it is observed that in accordance with its statutory duties, Stena had in place a framework of risk assessments, safe systems of work and training relating to, amongst other things, unmooring operations at Loch Ryan Port or LRP as it is referred to in those documents. To avoid confusion of terminology going forward, LRP shall be the name used for Stena Ferry Terminal, Cairnryan elsewhere in this determination. In July 2024 those cumulatively established at that time that PSOs, such as Mr Hamilton, when conducting unmooring operations of either of the Superfast Vessels, should:

i) At all times during those wear Protective Personal Equipment or PPE that consisted of *inter alia*: a Personal Floatation Device or PFD with a crotch strap properly attached and a hard hat. This was to minimise the risk of drowning or head injury.

ii) Only lift mooring ropes from bollards and thereafter handle them using tails. This was to mitigate the risk of hands or arms being caught and crushed between the mooring line eye and the bollard.

iii) Only lift a mooring rope from a bollard when directed to do so and after the tension had been released from the corresponding winch on the vessel. This was also to mitigate the risk of hands or arms being caught and crushed between the mooring line eye and the bollard.

iv) Pay particular attention to avoiding standing in a loop or bight of any ropes or lines. This was to mitigate the risk of entanglement.

v) Then walk the mooring rope to the edge of the quayside using the tail. This was to mitigate the risk of a) the mooring rope or tail becoming snagged on an obstacle on the quayside; or b) falling into the water and fouling the thrusters or propellers of the vessel.

[19] Mr Hamilton had received training and refresher training in relation to the foregoing. His training records were up to date in July 2024.

The accident

[20] Mr Hamilton commenced his shift on the evening of 22 July 2024 at LRP. His shift was due to end following the 07:30 departure of Superfast VII on 23 July 2024. He was deployed to conduct mooring and unmooring operations at the base of the quayside where the aft of the incoming vessel would be positioned. In that regard he was paired with fellow PSO Michael Hughes. Mr Hughes was also an experienced and well respected PSO. His service with Stena in that role mirrored Mr Hamilton's. They had been close friends throughout their working careers. They had an excellent working relationship. Another team of PSOs was deployed to the end of the quay where the fore of the incoming vessel would be positioned. A quay/PSO manager had general oversight of the two teams of PSOs.

[21] Vessels had arrived and departed on two occasions during Mr Hamilton's shift. Thereafter, Superfast VII arrived at 06:00. Prior to the arrival of Superfast VIII earlier

during that shift, it became apparent that one of the docking arms at LRP was not operable. Accordingly, the decision was taken by its captain at the time to moore it by way of additional mooring ropes. It had moored and unmoored with no difficulties. The mooring arm remained out of operation when the Superfast VII then arrived. The decision was also taken by its captain at the time to moore it by way of additional mooring ropes. At the aft of the vessel the captain's decision was to deploy two mooring ropes to bollard one and one mooring rope to bollard four. The two mooring ropes deployed almost perpendicular to the vessel's hull onto bollard 1, near to the framework of the docking arm, are known as "breast lines". The mooring rope deployed diagonally to the rear of the vessel onto bollard 4 is known as a "stern line".

[22] The weather on the morning of 23 July before the 0730 departure of Superfast VII from LRP to Belfast was warm, dry, sunny and clear. There was little to no wind. Tidal conditions were normal with the tide low. The water level was around 4 meters below the quayside edge. These represented benign conditions for conducting unmooring operations. With their considerable years of experience, neither Mr Hamilton nor Mr Hughes perceived there to be any apparent unusual level of risk to them.

[23] As the Superfast VII prepared for departure, Mr Hamilton adopted a position at bollard one. Mr Hughes adopted a position at bollard four. Accordingly, Mr Hamilton had two mooring ropes to deal with whereas Mr Hughes had one. Whilst standing in those positions, Mr Hughes' view of Mr Hamilton was obscured to a considerable degree by a concrete plinth and steelwork that supported the passenger walkway from the terminal onto the vessel. A CCTV camera attached to that walkway was recording a

view from behind Mr Hughes' position towards Mr Hamilton and the vessel. That camera recorded the tragic events to follow.

[24] Upon a signal to him from the chief officer in charge of operations on the aft winching deck, Jack McManus, the tension of the mooring ropes was slackened by the winch operator onboard the Superfast VII, Mr Johnston. Mr Johnston was an Able-Bodied Seaman at the time. In accordance with the directed practice at the time, both Mr Hamilton and Mr Hughes lifted the mooring ropes from the bollards using the tails. Both Mr Hamilton and Mr Hughes then proceeded to walk the mooring lines held by them towards the edge of the quayside as they were winched in, holding them by the tails. Mr Hamilton used both hands and held in each a tail of a mooring rope. That was not unusual and nothing in Stena's guidance or training at the time directed PSOs not to do so. Neither Mr Hamilton nor Mr Hughes were wearing hard hats. Both were wearing PFDs. It is not clear from the evidence whether the crotch strap for Mr Hamilton's PFD was attached and properly fitted, but it is possible that it was not. Mr Hughes' crotch strap was not fitted. In accordance with the applicable safe system of work both men should have been wearing hard hats. Both men should have been wearing their PFDs properly fitted via crotch strap.

[25] As Mr Hamilton proceeded, he came fully into the view of Mr Hughes (and the CCTV camera) as he cleared the visual obstacle. Nothing he observed at that point caused Mr Hughes concern. As time passed however it became apparent to Mr Hughes that Mr Hamilton was becoming closer to the frame of the docking arm and the edge of the quayside than would normally be the case whilst still holding onto the tails. As this

continued, Mr Hughes heard Mr Hamilton say "haud oan" or words to that effect. He did not shout that. There was no evidence to the effect that Mr Hamilton appeared panicked or distressed. Mr Hamilton's exclamation would not have been audible to Mr Johnston due to the ambient noise at his position on the vessel at the winch operator's station.

[26] With his experience and familiarity with Mr Hamilton, at this stage Mr Hughes perceived an issue. Mr Hamilton was beside the docking arm, and only a few meters from both the docking arm frame and the quayside edge. He was past the point where Mr Hughes had observed him to have released the tail(s) when conducting the same operation during the previous Superfast VIII departure on that shift. Mr Hamilton would normally have released the tails 4 or 5 meters from the edge of the quayside. As Mr Hamilton closed to the edge of the quayside Mr Hughes shouted loudly to stop the winch. At that point Mr Johnston let go of the winch controls in order to stop it. Doing so stopped it as effectively as hitting the emergency stop. The winch did not stop instantly after Mr Johnston did so, running on for two to four seconds after.

[27] As the mooring lines were being winched aboard, Mr McManus was standing in a position towards the centre of that deck to allow him to see the winches and the seamen there. In addition to Mr Johnston those were Mr McGilton and Mr Graham, who were looking inboard and could not see the PSOs on the quayside. The pulpit is a raised area around 1.5 metres above the deck accessed by a short ladder. It is in an elevated position hull-side, towards the rear of the aft winching deck. A person positioned there would have the best possible view of the quayside and the PSOs

stationed at bollards one and four. A person positioned in the pulpit during the unmooring would have a superior, unobscured view of the PSOs on the quayside compared to the winch operator.

[28] Mr Hughes then moved towards Mr Hamilton as quickly as he could. He was unable to reach him prior to Mr Hamilton being lifted bodily from the ground into and against the frame of the mooring arm, apparently by either or both of the tails. As the winch continued to run, Mr Hamilton was pulled against, then over the frame and then up some distance towards the winch port on the hull of Superfast VII before falling into the water. As that was happening, the winch then stopped running and the tails whipped back upwards as Mr Hamilton fell. Although it is not clear, it is likely that Mr Hamilton collided with the hull of the vessel before he fell.

[29] It is appropriate at this stage to refer to the CCTV footage that was available. There were two versions of this, both of which it is understood had been digitally enhanced from the original raw video file given that the camera had been quite some distance from Mr Hamilton's position on the quay. Presumably as a consequence, the definition of the footage was not particularly high. One of the two versions had been further processed to play in slow motion. Whilst the footage was of some assistance in terms of showing the overall mechanics of the accident that caused Mr Hamilton's death, certain details remained unclear. Firstly, it appeared to show that the crotch strap to Mr Hamilton's PFD was not properly attached, but such was the definition of the footage that this could not be discerned for certain. Secondly, for the same reason it cannot be discerned whether Mr Hamilton had become entangled with one or both of

the tails that he held. Given that the footage shows clearly that Mr Hamilton was lifted upward initially rather than his feet or legs being pulled out from underneath him, that might suggest that the entanglement was with his upper body. Thirdly, it cannot be discerned which part of his body or clothing – or indeed his PFD - became so entangled.

[30] As the CCTV footage is time stamped, to a degree it is helpful in demonstrating the short timescale over which this otherwise routine unmooring exercise turned into a fatal accident. There was a matter of only a short few seconds between it becoming truly apparent that Mr Hamilton was in difficulty and his being raised off the quayside. Whilst the court enjoys the benefit of hindsight and can watch a slow motion recording from an unobscured and ideal viewpoint of the tragic event, it must be borne in mind that Mr Hughes and Mr Johnston i) saw this unfold in real time; and ii) given the routine nature of the operation and benign conditions, had no reason to anticipate such an accident may occur. Until 23 July 2024 such an occurrence was almost without precedent.

[31] The hull of the vessel was approximately 2 metres from the edge of the quayside. Due to the tidal phase, the surface of the waters of Loch Ryan were approximately 4 metres below the edge of the quayside. As he had been lifted initially towards the winch port before falling, the height of Mr Hamilton's fall would accordingly have been more than 4 metres. Mr Hamilton's PFD inflated automatically as it should have upon contact with water. It did not however rotate him onto and keep him on his back with his head above water as it should have, thereby maintaining a patent airway. Prior to

any assistance arriving, Mr Hamilton was floating face down in the water for a time. He was unconscious.

[32] In an impulsive act of bravery, Mr Hughes immediately entered the water, with no regard for his own safety via a ladder on the quay. His PFD inflated automatically as it should upon contact with the water. Despite his own heavy waterlogged garments, he swam to Mr Hamilton. He was unable to rouse him to consciousness. He turned Mr Hamilton so that his head was above water and a patent airway was established, but he struggled to maintain that. A life ring was thrown into the water near the two men. Unable to deliver any form of effective CPR or indeed maintain his position, Mr Hughes dragged Mr Hamilton through the water to the vicinity of the ladder at the quayside. Due to the low tide and the weight of their waterlogged garments Mr Hughes could not do anything other than hold onto the bottom of the ladder and await assistance whilst struggling to maintain a patent airway for Mr Hamilton. Iain Clark descended the ladder and assisted Mr Hughes in trying to keep Mr Hamilton's head above water.

[33] A fast rescue boat was dispatched from the Superfast VII. After approximately 15 minutes in the water, Mr Hamilton was retrieved aboard that. He was taken ashore at a beach area at LRP. CPR was administered. It was not successful. Emergency services that had been called arrived at the scene from Stranraer.

[34] One of the members of the emergency services was Mr Loughery, a Scottish Ambulance Service paramedic. All efforts at CPR having failed, he pronounced the life of Mr Hamilton extinct at 0842 hours or thereby.

The aftermath

[35] Following Mr Hamilton's death a post mortem examination was carried out. The details and conclusions of that are to be found in the terms of the Joint Minute that has been referred to earlier. Of note however is the conclusion that the failure by Mr Hamilton to wear a hard hat as part of his PPE did not contribute towards his death.

[36] Stena carried out an immediate review of their mooring and unmooring procedures at LRP following upon the accident that resulted in Mr Hamilton's death. As a consequence, the following changes were made to operations:

i) A "no go zone" was identified and demarked on the quay with thick white paint between the bollards and the quay edge. This serves two purposes: a) to identify for PSOs an area that they must not enter when conducting operations; and b) to identify for winch operators, but also other seamen and officers on the relevant vessel, a point at which the winches must be immediately stopped if a PSO strays beyond it.

ii) A rounded metal railing has been erected around the docking arm and frame to mitigate the risk of mooring ropes or tails becoming snagged upon them.

iii) Proud bolts and other protrusions on the quay that could potentially become snagging points for mooring ropes or tails have been removed or ground down to mitigate that risk.

iv) Tail lengths have been shortened to mitigate the risk of entanglement.

v) PSOs must only handle one mooring rope or tail at a time when unmooring.

vi) PSOs must act in pairs when handling a mooring rope or tail at a time when unmooring.

vii) PSOs must only remove the loop of the mooring rope from the bollard when unmooring. They should not handle it beyond that and must no longer walk the mooring rope to the edge of the quay using the tail.

viii) All PSOs must now have as part of their essential PPE a whistle to allow them to alert colleagues both shoreside and on the vessel to difficulties.

ix) The officer supervising winch operations at the aft of the vessel must at all times be stationed on the pulpit and maintain a view of the PSOs on the quayside during unmooring operations.

x) All PSOs must wear full PPE which must be correctly and fully fitted whilst conducting unmooring operations. Further, they must ensure that all other PSOs in their team do so.

Documentary productions and expert witnesses

[37] It is appropriate to give further details to those productions that fell into the first category mentioned earlier, namely Documents: these consisted of risk assessments, policy and training documents, training records and correspondence. Key amongst those were productions that were assessments, safe systems of work, training of PSOs and other ship-based Stena employees that were in place before and after the accident

that resulted in Mr Hamilton's death. These shall be referred to as the pre-accident documents and the post-accident documents respectively.

[38] The relevant chronology of the dated pre-accident documents is as follows:

Crown Production Number	Production Description	Date of Production
9	Safe System of Work Mooring Operations dated 7 May 2021	07/05/2021
8	Mooring Operations version 4	01/01/2022
4	RA211392 Person in Water	26/05/2023
24	Stena Health, Safety and Environmental Policy	-/11/2023
27	Stena Line Risk Assessment Mooring Operations	07/01/2024
26	Training Record John Hamilton	07/01/2024
2	Loch Ryan Port Risk Assessment Report	24/07/2024

[39] In addition several relevant pre-accident documents were undated. Copies of all of those bear to have been produced by Stena to the Health and Safety Executive on 6 August 2024 as part of its investigations. Each of the following documents has a certificate to that effect signed by a Victoria Hughes. It is likely that many of these documents were in existence at the time of the accident that resulted in Mr Hamilton's death on 23 July 2024 and I was not invited to find to the contrary.

Crown Production Number	Production Description
1	Port and Terminals Safety Brief wearing lifejackets

3	Port and Terminals Safety Brief Personal Protection Equipment
5	Port and Terminals Safety Brief Mooring In
6	Port and Terminals Safety Brief Mooring Out
7	Port Services Operative Manual
10	Mooring Operations (Cairnryan)

[40] The relevant chronology of the dated post-accident documents is as follows:

Stena Production Number	Production Description	Date of Production
5	Mooring operations safe system of work	30/07/2024
4	Risk assessment 211392 person in water	26/08/2024
6	Mooring operations standard Operating procedure document PR-1527	03/12/2024
10	Risk assessment 251828 Superfast VII mooring operations	24/05/2025
8	Risk assessment 252850 mooring operations	07/08/2025
7	Mooring operations Cairnryan Port Specific operating procedure Document PR-2285	08/08/2025

[41] In addition, the following relevant post-accident document is undated, but it is not advanced that it existed at the time of the accident and I was not invited to find to the contrary:

Stena Production Number	Production Description

9	Stena Line Lochryan Port – port and terminal emergency preparedness and response plan

[42] Witness Peter Quigley of Stena spoke generally to these documents, their application and implementation at LRP. Witness Captain Paul Young was an expert witness. He spoke to these documents as part of his overall assessment of the manner in which unmooring operations had been carried out at LRP pre and post-accident, particularly in relation to the safety of PSOs. Ms Karen McNeill was an expert witness and gave her evidence from a similar perspective to Captain Young, but she reached different conclusions to him.

[43] With regard to the pre-accident documents, it can be fairly summarised by stating that cumulatively these identified the risks posed to PSOs during mooring and unmooring operations both generally and specifically at LRP presented by 1) entanglement with mooring lines (or tails); and 2) falling into the water from the quayside. Consequently, PSOs were required and trained: 1) to pay attention to and avoid both loops and bights of ropes to mitigate the risk of entanglement; and 2) to always wear *inter alia* a PFD, properly attached through use of its crotch strap, to mitigate the risk of drowning.

[44] It can also be fairly stated that the combined risk of a PSO being dragged into the water and drowning due to becoming entangled in mooring lines (or tails) was not identified as requiring any additional mitigation measures from those referred to above. That only occurred after the accident that led to the death of Mr Hamilton. At that point the various further measures identified earlier were put in place swiftly by Stena as can

be seen from the post-accident documents. There is however another relevant element to the evidence that was not touched upon by any of the representatives in court in their final submissions.

[45] It is not a matter of dispute that the safe system of work in place at the time of the accident, Crown Production 9, required PSOs such as Mr Hamilton to walk the mooring line to the edge of the quay by holding its tail as it was winched aboard during unmooring. Mr Hamilton can clearly be seen to do this, albeit holding 2 mooring lines via their tails, during the CCTV footage of the accident. Captain Young explained why a PSO would previously have been required to do that. Particularly at the aft of a vessel, its thrusters or propellers would likely be under power as it was unmooring. If a mooring line were allowed to simply be hauled aboard by the relevant winch unguided by a PSO, there was a risk that it may fall into the water and become fouled on a thruster or propeller. The identification of this risk can be seen at page 5 paragraph 7.4 of Crown Production 9, which states:

> "..Always walk the rope to the quay edge using the tail (three feet from quay edge) taking the most direct route. Never allow the rope to fall into water as this could foul the vessels thrusts"

Furthermore, Captain Young explained that walking the mooring line to the quay edge using the tail in this manner minimised the risk that it may become snagged on an obstacle on the quayside such as the frame to the automatic mooring arm. Quite apart from the possibility of damage being occasioned by either of these risks to the vessel or quayside, there was also a risk of injury to either PSOs or seamen aboard the vessel. The "snapback" from a mooring line under tension from a straining winch failing could

cause serious injury or even death to a person caught in its line of movement. Snapback of a mooring line under tension, for whatever reason, was a risk that was identified throughout the documentation. Captain Young identified that as a well-known risk for all involved in mooring operations of large vessels with potentially fatal consequences.

[46] Although it was not explored to any degree in submissions, it can be seen that the measures adopted by Stena immediately after the fatal accident involved the mitigation of the likelihood of a PSO becoming entangled and dragged into the water by increasing the risks of a mooring line becoming fouled on a vessel's thrusters or propellers or snagged on an obstacle on the quayside. Clearly Stena were aware of this due to the steps subsequently taken of installing a rounded metal railing around the perimeter of the automatic mooring arm frame and removing/grinding down large securing bolts. The mooring arm frame and the proud bolts were obvious obstacles in the path of a mooring rope that had been removed from bollard one and was being winched back aboard unguided – which is now the procedure. Whilst that addresses the risk of snagging on the quayside, there is an obvious tension in the provisions of Stena Production 7. It provides for the new procedure of the PSOs not guiding the mooring line via the tail to the edge of the quay as before, but at page 6 it directs that PSOs must also ensure: "no ropes or heaving lines will be dropped into the water within the vicinity of vessel's propellers, jets or bow thrusts". It is difficult to see how that tension is resolved by the PSO. By following the post-accident safe system of work, he will have no ability to control whether any lines will drop into the water within the vicinity of the vessel's propellers, jets or bow thrusts once the tail has been released

outwith the no entry zone. Regardless, it is clear that there was a logical risk-based reason why PSOs did not previously have a clearly demarked "no entry zone" on the quayside to observe. It was not simply an oversight or omission during the risk assessment process.

[47] As one would expect given his position with Stena and his overall responsibility for the safety of, *inter alia*, PSOs at LRP, Mr Quigley gave evidence to the effect that the pre-accident documentation met the legal requirements incumbent upon Stena under the Health and Safety at Work legislation. Further, he gave evidence to the effect that it, together with all of the associated procedures and training, adequately addressed those risks to PSOs that could have been identified at that time. Effectively his position was that the circumstances that gave rise the accident that resulted in Mr Hamilton's death on 23 July 2024, cumulatively, could not have been predicted and so the risk assessments, safe systems of work and training etc that were in place at the time were adequate. In doing so he acknowledged that the circumstances of the accident highlighted previously unforeseen risks, and that measures were then swiftly put in place to mitigate against those in the future.

[48] Captain Young, who had become involved through the Health and Safety Executive and gave evidence as a Crown witness, whilst more critical of Stena reached broadly the same conclusions. Coming as he did from a seafaring background unlike Ms McNeill, Captain Young was better able to expand upon his reasoning for reaching those conclusions. I formed the impression that he had a masterful grasp of the many

factors at play on 23 July 2024 that cumulatively resulted in the accident occurring, and that accident being fatal.

[49] No less helpful to the court however was the evidence of Ms McNeill, which primarily consisted of her comprehensive written report lodged by Mr Conway. At this stage I would wish to observe that the numerous high-quality images that she incorporated into her report were of great assistance to the Inquiry and were of such utility that they became the reference point for all witnesses who gave evidence in court. Whilst Ms McNeill did not have the benefit of a seafaring background like Captain Young, her expertise in the areas of health and safety and engineering matters relating to safe systems of work, risk assessments, provision of work equipment, protective equipment and occupational health was evident. Ms McNeill incorporated and commented upon the pre-accident and post-accident documents in her report. In doing so she concluded that the pre-accident documents should have identified and mitigated certain of the risks that ultimately manifested themselves in the factors that cumulatively resulted in the fatal accident occurring. Where her evidence differed to that of Captain Young, I preferred his evidence due to his greater overall experience arising from his seafaring background.

[50] It is appropriate at this stage to identify, based upon all of the information/evidence before the Inquiry what those factors were that resulted in the accident and the death of Mr Hamilton. In chronological order that they arose, they were are follows:

i) Due to the automatic mooring arms being out of commission, the captain of the Superfast VII elected to use two breast and one stern line to moore the vessel in the aft area. It was directed that the two breast lines both be deployed to bollard one. As a result, when unmooring, Mr Hamilton was alone at bollard one and many metres away from Mr Hughes who was at bollard four.

ii) As a consequence of i), and due to there being no direction in the applicable safe system of work at the time to the contrary, Mr Hamilton removed both mooring lines alone from bollard one when the tension was released by the winch operator.

iii) As a consequence of ii), and in accordance with the safe system of work applicable at the time, Mr Hamilton walked both mooring lines, holding them by their tails, towards the quayside to avoid them becoming snagged on, *inter alia*¸ the mooring arm frame or falling into the water to potentially foul on the propellers or thrusters.

iv) Although there is no industry standard length for such tails, those attached to the two breast mooring lines of Superfast VII on 23 July 2024 were excessively long for their purpose, being at least 1.5 metres, almost 5 feet, in length. The safe system of work in place at the time directed that the PSOs got no closer than 3ft to the edge of the quayside. This excessive length increased, albeit to an indeterminable degree, the risk of Mr Hamilton becoming entangled in them.

v) That by handling a tail in each hand as he did instead of focusing on one at a time, the risk to Mr Hamilton of becoming entangled in them increased, albeit to an indeterminable degree.

vi) That by handling a tail in each hand as he did, Mr Hamilton would have been prevented from giving any hand signals – the approved method of communication by PSOs in the pre-accident documents. Other than shouting (which notably he did not do), he had no other means at his disposal to communicate any difficulty to colleagues onshore or on the Superfast VII.

vii) The high ambient noise level both at the quayside and on the aft winching deck of Superfast VII would to an indeterminable degree mask any attempt at verbal communication by either Mr Hamilton or Mr Hughes with the winch operator.

viii) Although the exact manner in which Mr Hamilton became entangled cannot be determined, it would only have become apparent, or should have become apparent, to the winch operator as he drew close to the edge of the quayside. The view of Mr Hamilton from the winch operator's position became less clear the closer he came to the edge of the quayside, reducing the likelihood of him swiftly identifying that Mr Hamilton was in difficulty.

ix) Due to his having to monitor the progress of both Mr Hamilton and Mr Hughes, and due to bollards one and four being at opposite ends of his field of view, the winch operator would have to alternate his attention

between Mr Hamilton and Mr Hughes as he winched in the mooring lines. That would cause a delay in the winch operator apprehending if either PSO encountered any difficulties and so his reacting appropriately to same.

x) Other than the winch operator, none of the other shipside seamen or officer on the Superfast VII aft winching deck were situated in such a manner as to allow them to directly observe either or both Mr Hamilton or Mr Hughes as they conducted unmooring operations or intervene in the event of a difficulty.

xi) Neither activating the emergency stop button nor letting go of the operating lever on the controls caused the winch to the 2 breast lines on the Superfast VII to stop instantly. It runs on for a period between 2 and 4 seconds prior to coming to a complete stop. During that time the lines and so Mr Hamilton, entangled in either or both, continued to be hauled aboard.

xii) Due to the tide being low at LRP at the time of the unmooring operations, any PSO falling into the water would drop further than they would at a higher tide. Consequently, there would be a more violent impact with the water. Further, logically, immediate rescue attempts by shoreside colleagues would be slower, more difficult and more hazardous than if the tide had been higher.

xiii) On the balance of probabilities, it appears that Mr Hamilton's PFD was not properly fitted in that the crotch strap was not affixed and tightened. This

may have contributed to the PFD failing to act as designed in keeping his head above water and thereby maintaining a patent airway.

[51] It can be seen that there are 2 stages to consider from the foregoing factors: those that caused or contributed to the accident occurring and those that caused or contributed to that accident being fatal to Mr Hamilton. Factors i) to x) relate to the accident occurring in the first place. They created the environment where it became possible. On the evidence before the court, it appears that none of them in isolation would have resulted in the accident. All were, to a greater or lesser degree under the control of Stena. Of those over which Stena held a greater degree of control, it is notable that those have been the focus of changes to safe systems of work in the post-accident documents. Factors xi) to xiii) relate to that accident then resulting in Mr Hamilton's death. Not all of these were under the control of Stena to any degree. Again, where they are it is notable that those have been the focus of changes to safe systems of work in the post-accident documents.

Positions

[52] Whilst Mr Glancy, Mr Smith KC and Mr Conway were by and large in agreement as to the information/evidence before the court regarding the accident, the cause of Mr Hamilton's death and the aftermath, their positions differed in relation to:

1 in terms of section 26(2)(e) the precautions which (i) could reasonably have been taken, and (ii) had it been taken, might realistically have resulted in the death, or any accident resulting in the death, being avoided;

2 in terms of section 26(1)(b) whether the court should make recommendations in relation to (a) reasonable precautions to be taken; (b) improvements to any system of working to be made; (c) systems of working to be introduced; or (d) other steps that could be taken which might realistically prevent other deaths in similar circumstances; and

3 in terms of section 26(2)(f), whether there were defects in any system of working which contributed to his death or any accident resulting in his death.

In relation to 1 and 2, those differences arose primarily due to them inviting the court to make different findings on the information/evidence as to whether there were reasonable precautions that could have been taken and if so, whether those should form recommendations given the extent of the changes Stena made after the fatal accident. In relation to 3, those differences arose primarily due to them inviting the court to make different findings in relation to the adequacy of the risk assessments and safe systems of work in the pre-accident documents.

Reasonable precautions

[53] Mr Glancy and Mr Conway submitted that I should make findings in relation the identification of reasonable precautions. Mr Smith KC invited me not to do so. Agents and counsel agreed that that the test to apply is that laid out in *Sutherland* v *Lord Advocate* 2017 SLT 333, namely:

> "[31] In determining whether the death might have been avoided by a reasonable precaution, the appropriate test has been described as that of a '*lively possibility*'. Such a description is entirely apt and is consistent with the language of 6(1)(c). According the provision its ordinary meaning, certainty or probability are not relevant considerations in determining whether the death might have been avoided. Further, given the nature of the process as I have described it, in considering whether a precaution is reasonable, foreseeability has no part to play. The question falls to be determined with the benefit of hindsight, and a finding that the death might have been avoided by the application of a reasonable precaution carries no implication that the failure to take the reasonable precaution was negligent or unreasonable. Whether or not a precaution was reasonable does not depend on foreseeability of risk, or whether at the time the precaution could or should have been recognised."

[54] Applying that to factors i) to xiii), on the information/evidence before the court there are two complementary reasonable precautions that could have been taken that would meet the test. Firstly, the demarcation on the quayside of an area which if entered by a Port Service Operative whilst unmooring, would immediately pause any recovery of mooring lines onto a vessel. There is a lively possibility that this would have negated factors i) to x), as regardless of Mr Hamilton becoming entangled on a tail or tails, winching would have ceased within a short few seconds of his entering into the demarked area. Even factoring in the time that the winch would have run on after the operator stopped it and allowing for a tardy, distracted or simply inobservant winch operator, it is difficult to conceive that the winch would not have stopped before Mr Hamilton was lifted off the quayside and against the mooring arm frame. There is a lively possibility that an accident such as that which resulted in Mr Hamilton's death would thereby be avoided.

[55] It is difficult to conceive of a point of failure with this precaution other than said potentially tardy, distracted or simply inobservant winch operator. As is often the case,

the human element in the system is the potential weak point. The risk of that could be mitigated by a further reasonable precaution, that the person in charge of directing the recovery of mooring lines onto the vessel occupies the pulpit position at the rear of the vessel's aft winching deck during unmooring operations to provide a complete overview of all Port Service Operatives on the quayside involved. A second pair of eyes with the best viewpoint available from the winching deck of the PSOs on the quayside is a logical supplementary precaution. As soon as they saw Mr Hamilton entering the demarked area, they would have radioed the winch operator. Even if the winch operator was slow to react, there is a lively possibility that this further reasonable precaution would have avoided the accident resulting in the death occurring.

Recommendations

[56] Thereafter, the next stage to address where agents and counsel were not aligned is whether the court should make recommendations in relation to (a) reasonable precautions to be taken; (b) improvements to any system of working to be made; (c) systems of working to be introduced; or (d) other steps that could be taken which might realistically prevent other deaths in similar circumstances. Mr Glancy and Mr Smith KC submitted that I should not make any recommendations. Mr Conway invited me to do so. As has already been discussed, following upon the accident that resulted in Mr Hamilton's death, several measures were put in place promptly by Stena. These include the two reasonable precautions identified by the court, but also a number of other comprehensive measures. Notwithstanding the court's observations regarding

the scope for tension between one of those measures and the potential increase of the identified risk of a mooring line or tail either becoming snagged or fouling a propeller or thruster, implementation of those undoubtedly would reduce the risk of a similar accident involving a PSO such as Mr Hamilton occurring again in the future. That being so, there are no recommendations to make under section 26(1)(b).

Defects in systems

[57] Finally agents and counsel were not aligned on:

> 3 in terms of section 26(2)(f), whether there were defects in any system of working which contributed to his death or any accident resulting in his death.

Mr Conway deviated from Mr Glancy and Mr Smith KC on this point in inviting me to find that there were such defects. Simply put, Mr Conway's position is that the risk assessments in the pre-accident documents were defective. The post-accident documents, served to underscore that in the risks identified and measures implemented to mitigate those. In supplementary submissions Mr Conway observed that Sheriff D R G Keir in the *Determination under the Inquiries into Fatal Accidents and Sudden Deaths Etc (Scotland) Act 2016 into the death of Carlos Hernon Correo Palacio* [2025] FAI 22 found that the failure to provide suitable and sufficient risk assessments was *inter alia* a defect in the system. I was invited to follow the same approach.

[58] Mr Glancy's position in this regard was relatively straightforward. Mr Smith KC's position went into more detail and invited me to not to follow the same path as

Sheriff Keir as, he submitted, it was not correct as a matter of law. To address the issue however, I need not express any view upon that. A risk assessment is not an end in itself. It informs the preparation of a safe system of work. It is the safe system of work and the training, implementation and monitoring of which that then seeks to create a work environment for employees (and members of the public) where the identified risks have been mitigated insofar as possible. Risk assessments are regularly reviewed both due to passage of time and in light of any relevant developments. Those reviews, in turn, can lead to appropriate changes to the relevant safe system of work.

[59] Mr Conway identified in his submissions suggested defects in the risk assessments in the pre-accident documents. As I have summarised earlier in this determination at paras [43] and [44], the risks of a PSO becoming entangled or falling into the water were identified in those documents. I have found that it was the combination of those different risks, or more accurately the need to take any further mitigating steps to address that combination, that was not identified. What was missing in those documents was a measure or measures to address that possibility. Although it is logically anterior, the two reasonable precautions that I have identified would have done so. Unlike the defects identified by Sheriff Keir in his Determination pertaining to omissions, in this instance the absence of the two reasonable precautions previously was not simply an omission. As I have detailed at paras [45] and [46], the practice of the PSO walking the mooring lines via the tails to the edge of the quayside was, itself, a mitigating measure in relation to separate identified risks. Those risks were according to Captain Young well known. In this respect his seafaring background was clearly

beneficial. On the evidence before the court, even with the benefit of hindsight, I do not find that it i) it was defective to identify those risks; and ii) to take steps to mitigate them.

[60] I make the same finding in relation to what I have referred to as the supplementary precaution. The evidence of Mr McManus was that he and other officers positioned themselves in such a manner as to allow them to be close to and observe the seamen on the winching deck. There were identified, and I would say obvious, risks to them working in such proximity to large, powerful winches and coiling mooring lines. This is supported by the pre-accident documents. Mr McManus' evidence, which coincided with what could be seen at the site visit, was that adopting a position in the pulpit was not ideal for his observing and supervising the seamen when the mooring lines were being winched aboard. Again, therefore this was not simply an omission.

[61] Mr Conway's proposition can be tested by inverting it. There was no evidence of an injury or death at LRP arising from a i) mooring line or tail becoming snagged; ii) a mooring line or tail fouling a propellor or thruster; or iii) an accident caused by failure of a winch or a seaman becoming entangled on the winching deck. If the risk assessments and safe systems of work in the pre-accident documents had provided for the two identified reasonable precautions, and then such an accident did occur instead of the one that resulted in Mr Hamilton's death, would it be argued that those risk assessments and safe systems of work were defective? The reality is that the risk assessments and safe systems of work, based on the information available at the time were logical. Whilst it is understandable that Mr Conway criticises these omissions,

they are consequences of measures previously taken to mitigate other identified risks. What further steps Stena may or may not require to take to mitigate any increase in those other risks arising from the implementation of the reasonable precautions is outwith the scope of this Inquiry.

Any other factors relevant to the circumstances of the death

[62] Agents and counsel's positions were more aligned in relation the applicability of section 26(2)(g). It is of relevance to the circumstances of Mr Hamilton's death to formally acknowledge the measures promptly taken by Stena in the aftermath of the accident. It cannot be asserted with confidence given the many factors that create risks to Port Service Operatives when carrying out mooring and unmooring operations that these will eliminate the possibility of a recurrence. Notwithstanding that, by introducing these changes, Stena has taken what could be described as reasonably practicable measures to prevent a recurrence, especially at Cairnryan, as follows:

- The checking by PSOs of each other's PPE to ensure all items are being properly worn.
- The length of any tail attached to a mooring line has been shortened to mitigate the risk of entanglement.
- Any mooring line, once lifted off its bollards by two PSOs, will be aligned for clear retrieval and having signalled the crew to commence heaving, will be let go and its progress monitored across the quay as it is winched back onboard.

- The installation of bars around any snag hazards on the quayside to mitigate the risk of snagging as the mooring lines pass in close proximity to them.
- The application of a defined "no entry" zone for PSOs while the mooring lines are being retrieved, whereby if for any reason a PSO requires to enter that area during retrieval, the winch operator will stop the winches.
- The person directly in charge of mooring line retrieval operations on the aft winching deck of the vessel being located whereby he or she has a clear view of PSOs on the quayside to allow them to radio the winch operator to stop the winches if the PSO does so enter.

Conclusion

[63] I would wish to record the court's thanks to Mr Glancy, Mr Smith KC and Mr Conway for the exemplary manner in which they conducted themselves throughout the Inquiry. Their thorough preparations and skilful submissions were of great assistance.

[64] All the information/evidence before the court was to the effect that Mr Hamilton was well loved by his friends and family, well respected by his colleagues and employers and an experienced and able PSO. Neither he nor any of his colleagues either onshore or on the Superfast VII perceived any unusual danger to him on 23 July 2024. An unfortunate combination of a number of contributing factors led to the tragic accident that resulted in his death. Neither he nor any of his colleagues were at fault.

Even the selfless efforts of his colleague and friend of many years, Mr Hughes, could not avert it. Stena learned lessons from the accident, implementing immediate and comprehensive measures to seek to ensure that something similar does not happen again. In many respects Stena has pre-empted the outcome of this Inquiry in doing so, doubtless to ensure that no time was lost in taking steps to ensure the safety of its employees. I would hope that Mr Hamilton's family and friends, who have my deepest condolences, can take some measure of comfort from that and some satisfaction from knowing that this thorough Inquiry has scrutinised those measures carefully.