

Marine Safety Investigation Report

VERY SERIOUS MARINE CASUALTY | June 2025

The Bahamas
Maritime Authority

Margaritaville at Sea Islander

Fall from height on 10 October 2024

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What happened

A crew member onboard a Bahamas flagged passenger vessel fell from height on to a lashing platform between two lifeboats while the vessel was alongside. Nearby crew members heard the fall and a medical response immediately followed.

Despite best efforts by the shipboard and shoreside medical personnel, the victim passed away at a local hospital.

Why it happened

The victim remained in the vicinity of the lifeboats lashing platform on completion of an abandon ship drill for an unknown, but non-operational reason.

The victim, and others at risk of falling during the drill, was not wearing equipment to protect from a fall. Hard hats and harnesses were available at lifeboat stations but they were not routinely used. Like other crew exposed to the same risk, he wore more comfortable headgear to mitigate the effects of the hot weather.

What we can learn

Signs and symbols placed in operational areas for protective equipment donning should be backed by policies and procedures so as to not leave their required use areas open to interpretation by crew.

Operational areas on board ships may still contain hazards even when not active or in use. Crew members should be aware of the risks associated with their environment, inclusive of ongoing, or recently completed tasks.

Communication around medical emergencies should help response teams to know what equipment is appropriate for the scenario they are responding to – specifically in knowing which type of stretcher is appropriate for the location of the response.

Narrative

All times in this report are local time (UTC-5)

On 10 October 2024, The Bahamas flagged passenger vessel, Margaritaville at Sea Islander, was berthed in Cozumel, Mexico, starboard side alongside, undergoing an exchange of passengers and crew. Also on the agenda for the day was a routine drill of launching and recovering the port side lifeboats and rescue boat.

At 09:20, a pre-drill briefing was carried out on the bridge. Crew members were tasked with their duties and assigned designated boats to be launched and recovered during the drill. These were: port side rescue boat, lifeboats 2, 4 and 14. Two able bodied seafarers (AB's) were assigned per lifeboat, and the two assistant bosuns were responsible for the rescue boat. The bosun had on scene oversight of the drill and was tasked with roaming the deck while monitoring communications between the lifeboat teams.

The meeting was then dismissed into a general emergency and abandon ship drill.

Lifeboats 2, 4, and 14 were successfully lowered to just beyond the embarkation deck. Lifeboats 4 and 14 were then recovered into the stowed position. AB 2 was alone on the lashing platform between lifeboats 2 and 4, as his partner AB 1 did not yet arrive. Nevertheless, AB 2 successfully lashed lifeboat 4 and left the lashing platform, proceeding forward to help with the rescue boat launching.

Moments later, the rescue boat was lowered to the waterline while lifeboat 2 was still awaiting recovery.

At 10:42, AB 1 walked onto Deck 3 port side aft near lifeboat 16, and walked forward towards lifeboat 2.



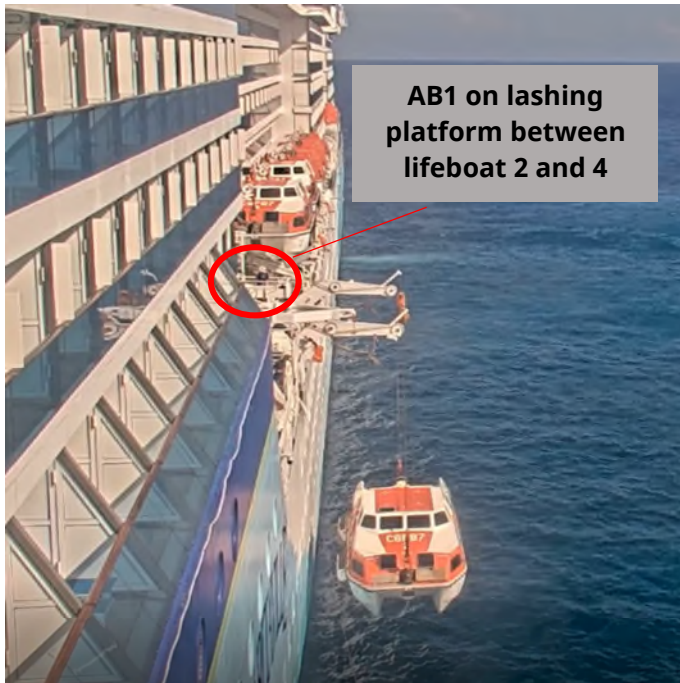
AB1 on Deck 3 port side passing lifeboats 16, 14, 12 and 10 – proceeding forward

At 10:45, AB 1 spoke with AB 2, and other nearby crew members. He was wearing a company issued coverall, work boots and his own sun hat. AB 1 then prepared to climb the ladder leading to the lashing platform of lifeboats 2 and 4.



AB 1 preparing to go up ladder leading to lashing platform between lifeboat 2 and 4

AB 1 proceeded up the ladder and was seen on the lashing platform between lifeboat 2 and 4, just before the rescue boat team began recovery of the rescue boat.



AB 1 on lashing platform (left) immediately followed by rescue boat being recovered (right)

Lifeboat 2 was then recovered, stowed and lashed. The bosun made a final walkthrough to confirm the boats used in this drill were secured. He gave the order for dismissal from stations at around 10:50. He then informed the bridge that all boats were secured for sea. The bosun did not notice anyone remaining on the lashing platforms during his final walkthrough.

AB 1 remained on the lashing platform alone after the bosun dismissed all crew members from the drill. Other crew were around the Deck 3 area.

The two assistant bosuns were having a casual conversation on Deck 3, between the rescue boat and lifeboat 2. At 11:01 they began walking towards the aft.



Two assistant bosuns conversing (left) and walking aft at 11:01 (right)

At 11:03 the assistant bosuns were walking pass lifeboat 6 when they heard someone exclaim “ADUH¹” –, followed by what they believed was a landing onto a platform behind them.

¹ “ouch” in Indonesian language

They turned around (now facing forward) and ran towards the ladder leading to the lashing platform between lifeboats 2 and 4. Assistant bosun 1 then partially climbed the ladder and saw AB 1 laying face up, with the back of his head on the edge of the opening which leads to the lashing platform. Both assistant bosuns also noticed blood was dripping onto Deck 3 from the lashing platform.

AB 1 was still showing signs of consciousness.

Assistant bosun 1, holding onto the ladder with one hand immediately radioed the bridge to inform that an accident occurred by lifeboat 4.

Assistant bosun 2 ran aft towards the bosun who was still on deck, in order to get help. The bosun and other crew members arrived at the scene and congregated at the base of the ladder leading to the platform. An ordinary seafarer (OS) climbed up the ladder followed by assistant bosun 1, in order to monitor AB 1.

Hearing the communication over a radio in his cabin, the first officer immediately ran out to lifeboat 4 to assess the situation. He was informed by the OS and assistant bosun 1 that AB 1 had a wound between the eyebrows but was still conscious. Climbing the ladder to the lashing platform and viewing AB 1 himself, the first officer used his radio to inform the bridge of a medical emergency near lifeboat 4. The officer of the watch (OOW) on the bridge then called the duty nurse.

The OS and assistant bosun 1 informed the first officer that the victim was no longer showing signs of consciousness.

The deck safety officer arrived on scene from the bridge at 11:07 and went up the platform to check if the victim was still breathing.

The duty nurse and doctor (medical response team) arrived on scene around 11:08 and went up the platform with an Automated External Defibrillator (AED), first response bag and medical oxygen cylinder. The medical response team having been briefed by the deck safety officer and told "he is not breathing" by other crew, confirmed there was no carotid pulse and the victim was not breathing.

The deck safety officer called the bridge to announce Code Alpha at around 11:12.

The medical response team initiated Advanced Cardiac Life Support (ACLS) protocols but due to the restrictive nature of the lashing platform, the decision was made to lower the victim onto Deck 3.

The stretcher team had not yet arrived on scene from the first Code Alpha, prompting a second Code Alpha announcement at around 11:15. The stretcher team arrived shortly after, but with a scoop stretcher. The deck safety officer went to a nearby locker to obtain a Neil-Robertson stretcher.

When the Neil-Robertson stretcher arrived, the medical response team with assistance from nearby crew transferred the victim into the stretcher and lowered him onto Deck 3. Now having a greater area to work and reinforced with additional nurses and doctors the medical response team continued to administer cardiopulmonary resuscitation (CPR) and trauma care to the victim.

The staff captain requested a shoreside ambulance at 11:18 and local paramedics boarded the vessel 40 minutes later. They retrieved the victim and disembarked at 12:13, in transit to the local hospital - Amerimed Hospital Cozumel. The hospital informed the vessel that the victim passed away at 12:39.

Vessel and Crew

Margaritaville at Sea Islander was built in Helsinki, Finland, and delivered on 04 July 2000. It had been under the management of Anglo-Eastern Cruise Management Inc since July 2021. The vessel cruised between Tampa Bay, Key West Florida, and Cozumel, Progreso Mexico.



The victim had a valid medical certificate, with no known pre-existing conditions. He was a smoker, citing 8 cigarettes a day on his medical form, and had been on board since 02 June 2024 with six years' experience as an AB.

In his emergency duties, he was the designated person in charge of lifeboat 7, responsible for directing crew to the emergency station and preparing the boat for passenger evacuation.

The victim, along with other crew members involved in the drill that day, signed a safety training record confirming they attended and understood the procedure of preparing and lowering the lifeboats. The safety training included a complete walkthrough by the deck safety officer and verification of the steps required when launching the lifeboats.

Legislation and guidance

The Bahamas Maritime Authority's Marine Notice 36: Management of Occupational Health & Safety describes the general duties of employers and employees in relation to health and safety, in line with Merchant Shipping (Health and Safety – General Duties) Regulations 1984.

Marine Notice 36 does not provide specific guidance on working safely onboard ships but states that the shipowner shall comply fully with the International Labour Organization's Code of Practice "Accident prevention on board ship at sea and in port" or other recognised Codes of Practice including the United Kingdom's Maritime & Coastguard Agency "Code of Safe Working Practices for Merchant Seafarers".

The Bahamas Maritime Authority's Marine Notice 82 – Lifeboat safety is aimed at ships fitted with survival craft and rescue boats with specific launching appliances and highlights important factors for lifeboat safety.

Previous similar cases

M/V Jonathan Star (2023) Panama

Master of the vessel was checking safety equipment on an open-type lifeboat and slipped on the steps when coming down from a vertical ladder onto the floor of the boat deck. He was airlifted off the vessel but declared dead a few days later.

GISIS Reference: C1000442

<https://gisis.imo.org/Members/MCIR/Occurrence.aspx?Reference=C1000442&Form=InvestigationDocument>

Curacao Pearl (2022) Bahamas

Whilst testing the watertight integrity of cargo holds' hatches, a member of the crew, who was working alone in the hold, fell approximately eight metres to his death.

www.bahamasmaritime.com/wp-content/uploads/2023/03/BMA-Curacao-Pearl-report-final.pdf

Tropical Star (2019) Bahamas

A crew member sustained fatal injuries after falling whilst descending a crane's external ladder. The ladder was identified as for use as an emergency exit only but provided the fastest access to the crane cab, so was regularly used.

www.bahamasmaritime.com/wp-content/uploads/2020/10/BMA-Investigation-Report-Crew-fatality-onboard-the-Tropical-Star.pdf

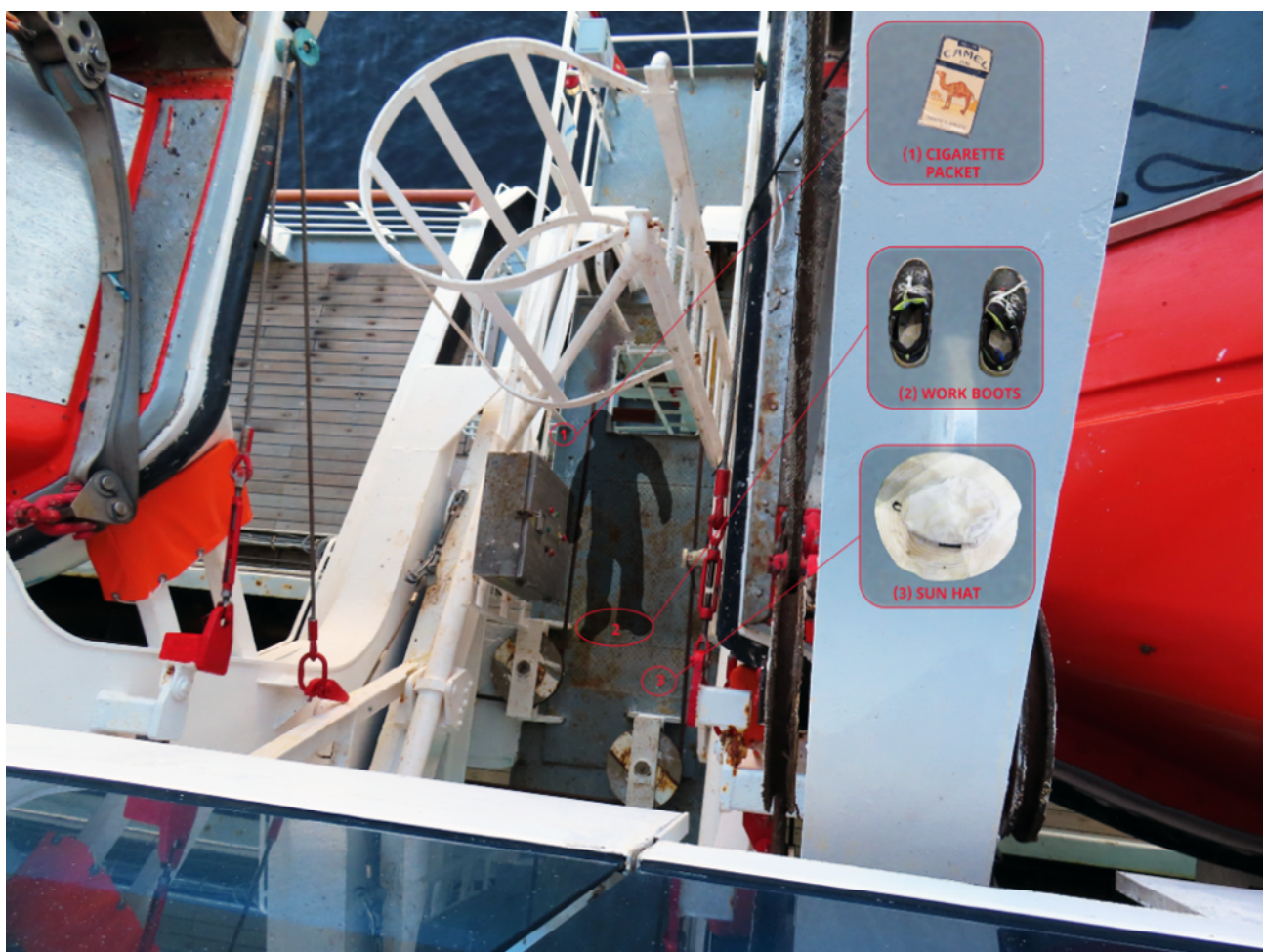
Analysis

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

A post-mortem indicated that the cause of death was hypovolemic shock as a result of a right kidney puncture and deep abdominal trauma due to the fall.

Overview of Scene

The victim fell from an undetermined height² onto the lashing platform. He sustained a cut on his forehead approximately 60-70mm wide. He was wearing a company issued coverall and work boots, along with a sun hat. The image below depicts an overhead view of the casualty and what was seen by first responders.



Position of victim (face up) on the lashing platform between lifeboat 2 and 4

- ① A pack of cigarettes was found, in line with his head near a railing. The cigarette packet was partially opened, with seven cigarettes inside. No lighter was recovered from the scene.
- ② The victim's work boots were found in fair condition. His coveralls remained on his body during transport to the hospital and therefore were not available for inspection.

² The fall could not have occurred from a height of more than 3.4m (the height of the ladder fixed with a safety cage). If he was at this height prior to falling, he would have been captured on the bridge wing's CCTV camera.

- ③ The sun hat the victim was wearing was found near his feet, having fallen off during his fall. The hat was used specifically for the weather that day (31°C) and was not appropriate personal protective equipment (PPE) for working on the lashing platform and the preceding drill.

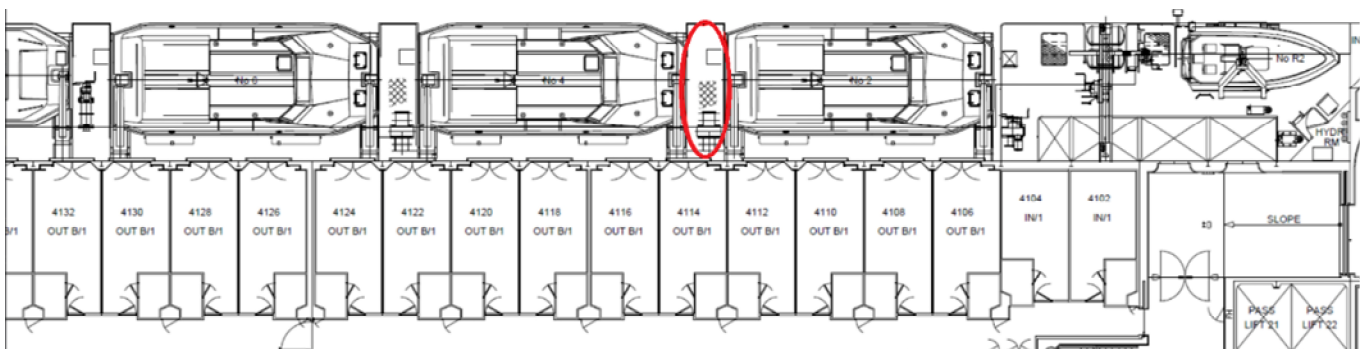
A more detailed look at the three items mentioned are shown in [Appendix 1](#).

With numerous points of elevation on the platform and the position his body was found, it could not be determined from which specific point on the platform the victim fell. Once lifeboat 2 was stowed, the bridge wing's CCTV camera no longer had a line of sight to the lashing platform.

There was no operational reason for the victim to remain on the platform. The lifeboats were secured, and the drill was complete. It is likely that the victim remained on the platform after the drill with the intention of smoking a cigarette.

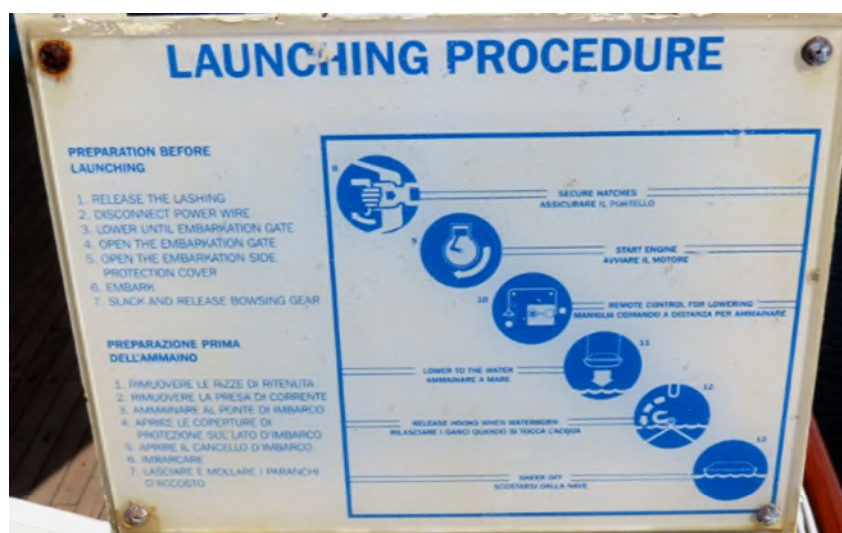
Platform, procedures and practice

The lashing platforms are used to lash and secure two separate ends of different lifeboats. A team on a lashing platform will cover the aft end of one lifeboat, and the bow of another lifeboat.



Circled in red, lashing platform between lifeboats 2 and 4 where the casualty occurred

All crew members involved in the launching and recovery of lifeboats complete and sign a safety familiarisation, that is overseen by the deck safety officer. The company also has lifeboat procedures readily available in document form on the vessel, and generic placards placed on bulkheads and lashing platforms in between lifeboats. The written procedures and placards illustrate the launching of lifeboats, but do not address recovery.



Example of lifeboat launching procedure on lashing platforms and bulkheads

Crew members have specific responsibilities during emergencies. During routine launching and recovery of the lifeboats, the assigned crew interchange responsibilities and adapt as required.

The lifeboat preparatory work for launching and recovery procedures on board the vessel follows a buddy system. Teams of at least two crew members are assigned per boat, where one team member would be responsible for climbing at height, while another will be beneath as support where required. These teams work to disconnect and reconnect lashings and the lifeboat charging cable. An example of this system in use is shown in [Appendix 2](#).

Personal protective equipment (PPE) were stowed at lifeboat, rescue boat and life-raft stations, containing hard hats and safety harnesses for the crew members to perform their launching and recovery duties.



Example of signage and PPE by lifeboat and rescue boats stations

Signage near the stations indicated the areas guarded by rail required hard hats and safety gloves. The ladder leading to the lashing platform above the stations is between the railings. However, on the lashing platform where the casualty occurred, there were no PPE symbols present. The placement of PPE signs, or lack thereof, allows for interpretation the gear may only be required for work on the rescue boat, within the life raft area, or over the side. The signs do not clearly indicate PPE gear is required on the lashing platform located aloft.

Review of CCTV footage identified that a majority of the crew were not wearing hard hats during the drill – opting instead to wear head gear that would mitigate the heat and humidity as the temperature was 31°C. The review also identified that wearing of harnesses for accessing the platforms was not in practice at the time. The bosun who had on scene oversight of the drill, was the only crew member seen with a hard hat on.

Medical Response

The initial response by nearby crew proved effective - having the on duty medical response team on scene within a few minutes of the casualty occurring, and four minutes before a Code Alpha was announced by the bridge.

The duty nurse who initially received the call from the bridge was told to respond to “Deck 3 port side” and along with the accompanying doctor, was only aware of having to work on a confined vertical lashing platform after arriving at the scene. The stretcher team – arriving after the second Code Alpha announcement, brought a scoop stretcher, also unaware that the victim required vertical lowering from the confined lashing platform onto Deck 3, prompting the deck safety officer to go retrieve the appropriate Neil-Robertson stretcher. Generic versions of the two different stretchers are shown in [Appendix 3](#).

Some of the communication language throughout the medical response included phrases such as “Deck 3 port side” and “near lifeboat number 4”. There is a significant difference in useable space and ability to transport a casualty between a relatively larger deck area, and a confined lashing platform.



Work area on lashing platform (left) and Deck 3 (right) where the casualty was lowered

Communication around a medical response should be as precise as possible and updated as more information becomes available for medical emergency responders.

In this instance, the medical response timing may not have had an impact on the outcome.

Fall from height – a continuing industry-wide problem

As well as the significant injuries seen from falls from height on board Bahamian ships, falls from height are still common in the global merchant fleet.

The 2024 submission of *Lessons Learned and Safety Issues Identified from the Analysis of Marine Safety Investigation Reports* submitted to the IMO's sub-committee on Implementation of IMO Instruments included detail on InterManager's analysis of fall accidents on board ships. The data used was verified information from fall accidents on board ships between 1 January 2012 and 1 May 2024.

The submission stated that:

- the trend for fall accidents from, or onboard, ships for the past five-year period has remained consistent between 44 and 52 accidents per year
- the majority of casualties resulting from these accidents involved just a single person
- of the 18 accidents recorded between 1 January and 1 May 2024 within the GISIS marine casualties and incidents module, 15 individual ships were captured, 7 of which accidents were from a fall onboard or from the ship, representing 46%
- accidents caused by a fall are more frequent where the fall occurs within the ship, compared to those where the fall occurs into the sea, such as a person overboard situation
- the location of the fall accidents reported remained consistent between two review periods therefore appearing that the industry is experiencing a similar frequency of fall accidents in similar locations year after year.
- where it is mentioned in the accident investigation report, seafarers directly involved in undertaking the majority of activities which involve working aloft or working over the ship's side, experience the highest number of accidents at 55%

The *Annual overview of marine casualties and incidents 2024* published by the European Maritime Safety Agency (EMSA) presents statistics on marine casualties and incidents involving ships flagged with EU Member States, occurrences within EU Member States' territorial seas or internal waters and involved substantial interest of EU Member States. Its findings include:

- from 2014 to 2023, a total of 650 lives were lost in 444 marine casualties, with a decreasing trend observed over the period.
- in 2023, 89.7% of the victims were crew members whereas the average of fatalities of crew members for the period 2014 to 2023 was 86.9%.
- the primary causes of fatalities in 2023 were 'slipping / stumbling and fall' for occurrences with persons

- from 2014 to 2023, the predominant events causing injuries were 'slipping / stumbling and fall' for occurrences with persons

Conclusions

A postmortem indicated that the victim died from hypovolemic shock as a result of a right kidney puncture and deep abdominal trauma due to the fall.

The victim remained on a lashing platform between lifeboats 2 and 4, after concluding his duties during a lifeboat drill and fell from height. With different points of elevation on the platform and the position his body was found, the origin of his fall could not be determined.

Review of CCTV during the initial drill indicates crew members, inclusive of the victim, opted to wear headgear that would help mitigate the heat. Safety harnesses and hard hats were provided near the lifeboat stations but were not in use during the drill. The bosun was the only crew member seen with a hard hat on.

From the time the Code Alpha was announced by the bridge, the shipboard medical response team and safety officers responded quickly to assess the scene, provide Advanced Cardiovascular Life Support (ACLS), and trauma care to the victim before he disembarked via ambulance to the local hospital.

Fall from heights onboard ships remain a consistent source of injuries and fatalities for seafarers throughout the global merchant fleet.

Recommendations

The investigation found that on the day of the casualty, a majority of the crew, including the victim, were not wearing hard hats or harnesses. They preferred to wear gear more comfortable for the heat and humidity. The supervisor was the only crew member seen with a hard hat on. During recreation of the drill as shown in [Appendix 2](#), the crew were able to effectively carry out their duties with the prescribed PPE donned.

The investigation also found that while the victim remained on the lashing platform after the drill for an unknown, non-operational reason, the sign postings in the casualty area were not effective in communicating required protection for crew when working aloft

Therefore, it is recommended that **Anglo-Eastern Management:**

- Take action to ensure safeguards in place for crew are effective and appropriate across varying conditions they are required to work in
- Ensure supervisors have robust support systems to enforce appropriate gear requirements

As previously highlighted in Curacao Pearl (2023), **The Bahamas Maritime Authority** is recommended to:

- Consider conducting a concentrated inspection campaign to highlight and address the risks of falling from height on Bahamian ships.

Vessel particulars	
Vessel name	Margaritaville at Sea Islander
Vessel type	Passenger
Flag / IMO number	Bahamas / 9187796
Registered owner	MV Cruises I Vesselco Ltd
Manager	Anglo-Eastern Cruise Management Inc.
Classification Society	Registro Italiano Navale
Built	Helsinki, Finland, 2000
Length / breadth / moulded depth	262.7m / 32.2m / 13.60m
Gross / net tonnage	85861/53578
Minimum safe manning	65 (1341-2680 passengers on board) / 23 (0 passengers on board)

Voyage Particulars	
Departure port	Tampa Bay, Florida
Arrival port	Cozumel, Mexico
Distance / duration	N/A
Crew / passengers	813 / 878

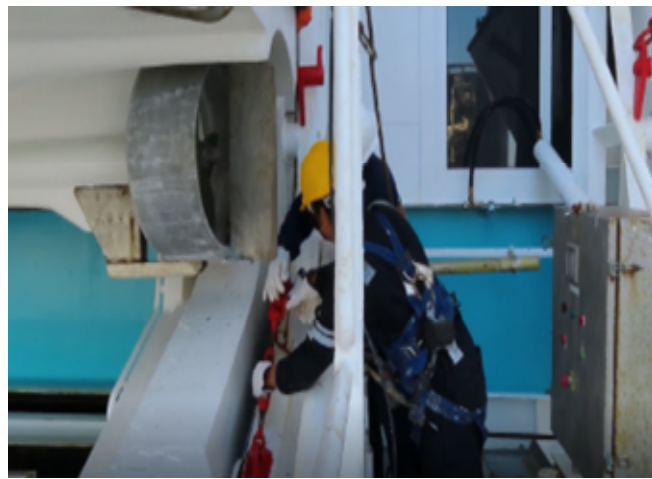
Marine Casualty Information	
Severity of casualty	Very Serious Marine Casualty
Date / time	10 October 2024 / 11:03
Geographical location	Cozumel, Mexico. 22° 28.8'N 086° 58.5'W
Place onboard	Lashing platform between Lifeboat 2 & 4
Injuries / fatalities	1 Fatality
Damage / environmental impact	None
Ship operation	Embarking/disembarking passengers and crew
Stage of passage	Alongside
External environment	Wind: NE force 3. Clear skies. Air temperature 31°C

Appendices

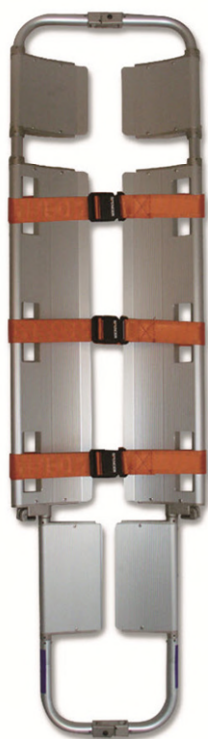
Appendix 1 – Expanded view of personal effects



Appendix 2 – Buddy system with PPE donned during drill recreation



Appendix 3 – Difference in stretchers for medical response(generic)



SCOOP STRETCHER

Specifically designed to minimise spinal movement of a casualty during transport.



NEIL ROBERTSON STRETCHER

Specifically designed for vertical movement of casualties in confined spaces or with limited access.