Fatal Accident During Lifting Operations To Deploy A Ship's Tender on a Cayman Islands' Registered Yacht

23rd January 2026

This document, containing safety observations, has been produced for marine safety purposes only, on the basis of information available to date.

Extract from

The Cayman Islands' Merchant Shipping

(Marine Casualty Reporting and Investigation)

Regulations, 2018 – Regulation 4:

"*The sole objective of a marine safety investigation into an accident under these Regulations shall be the prevention of future accidents through the ascertainment of its causes and circumstances. It is not the purpose of a marine safety investigation to determine liability nor, except so far as is necessary to achieve its objective, to apportion blame.*"

NOTE

The investigation which led to this report has been conducted in accordance with regulation 13 of the Cayman Islands' Merchant Shipping (Marine Casualty Reporting and Investigation) Regulations 2018, as may be amended.

SUMMARY

On the morning of 23 January 2026, a deckhand (Deckhand A) on a Cayman Islands registered yacht (***Figure 1***) was fatally injured during operations to launch the yacht's port forward tender. Deckhand A was helping to lift the tender overside from its stowage position on the fore deck. He was standing directly beneath the crane's boom when a sheave block failed causing the boom and attached tender to fall, striking the deckhand before resting on the yacht's bulwark. Despite a prompt response from the yacht crew, including the designated nurse, it was immediately apparent that the deckhand had died instantly.

Image Removed for Reasons Regarding Confidentiality

Figure 1: Yacht at anchor

The investigation found that the sheave block which failed was in a location that made regular visual inspection difficult and, even if routine inspection by the crew had been possible, the defect leading to the failure was unlikely to have been apparent.

It was also found that a risk assessment pertaining to the tender launching operation had been carried out and had identified that standing under the crane boom was a significant hazard. It is likely that the Deckhand A had been involved in launching / recovery of the tender on more than 100 occasions, although it was not established whether he had been made aware of the risk assessment. Additionally, the yacht's safety management system

(SMS) procedures covering tender launching operations stated that the crane operator should take charge which left no one with an overview of the safe conduct of the operation.

FACTUAL INFORMATION

The night watch deckhand (Deckhand B) began his shift at 2200[1] on the 22nd of January 2026 and was due to go off watch at 0800 the next morning. At around 0645, Deckhand B began preparations to launch the port forward tender which included lowering the forward crane boom over the tender (***Figure 2***) and attaching fore and aft lifting slings to the crane hook. The crane was located on the centreline of the vessel and was used to launch both the port tender and the rescue boat which was stowed on the starboard side. When not in use the crane boom was secured vertically against the forward mast.

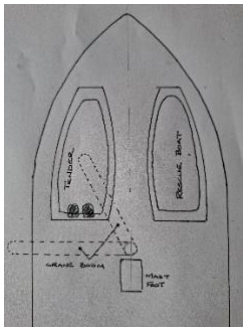


Figure 2: Schematic diagram of the position of forward crane when lifting the port tender

Concurrent with these preparations the rest of the crew were attending a scheduled morning meeting in the aft cockpit. The main focus of the meeting was confirming arrangements to lift a large 10 tonne tender, which was stored on the stern of the yacht, into the water with the assistance of a crane barge. This large tender was generally used when the owner was embarked for excursions to sites of interest. During deep sea transits, the tender was stored on the aft deck but for shorter passages it was towed behind the vessel. The large tender could only be lifted on or off the yacht with external assistance and the yacht's small tender (***Figure 3***) was to be used for transporting personnel to and from the crane barge.



Figure 3: Yachts small tender (post-accident)

The morning meeting lasted approximately 10 minutes from 0650 to 0700. Following the meeting the vessel's second officer (2/O) and Deckhand A went to the forward deck to assist with the tender launching operation.

The accident

The 2/O and Deckhand A arrived on the forward deck at around 0705 and they briefly discussed the task with Deckhand B. The 2/O then went to the forward end of the tender to guide the bow as it was lifted out of the stowage well and swung out over the yacht's side. Concurrently, Deckhand A took up position at the rear of the tender and prepared to steady the stern to prevent the outboard engines from impacting the sides of the well as it was lifted.

The forward crane was operated by Deckhand B using a remote control unit. In accordance with the yacht's procedure and risk assessment for the lifting operation, the crew member operating the crane was also the designated person in charge of the lifting operation.

The crane boom was raised lifting the tender clear of the well and then to a height which allowed the tender to clear the vessel's overside safety wires. Once at a suitable height, the boom was swung out over the vessel's side. As the tender swung outboard, the 2/O moved down the vessel's side keeping the bow under control and Deckhand A at the stern continued to steady the



Figure 4: Position of crew members at the time of the accident (image redacted for reasons regarding confidentiality)

[1] All times in this Report are UTC +9 hours

stern. At the point where the boom reached the lowering position lying at 90 degrees to the vessel's side, Deckhand B had moved to the side rail and was then standing directly beneath the crane boom (***Figure 4***).

At this point the crane's span block, located part-way up the forward mast, failed allowing the tender and boom to fall suddenly with the boom striking the deckhand standing at the aft end of the tender before the boom with the suspended tender struck the vessel's bulwark and came to rest there. The falling boom also sheared both the top and bottom overside safety wires.

The loud crash of the boom hitting the bulwark was heard and felt throughout the vessel and brought other members of the crew rushing onto deck to investigate the source of the noise. The 2/O at the forward end of the tender could see that his colleague had been severely injured and immediately radioed for the yacht's nurse to come to the forward deck. The captain and the yacht's mate were standing on the port bridge wing and when they heard the crash immediately went forward to investigate the cause. On arrival it was apparent that the injuries to Deckhand A were serious and the captain attempted to get some response from him. The yacht's nurse was very quickly on scene and it was obvious to her that the deckhand had died instantly from the impact of the boom; she confirmed this with tests for signs of life. In addition to the impact wounds from the boom, the sheared overside safety wires had caused significant laceration injuries to the Deckhand A's chest and abdomen.

Having assessed the situation presented no immediate threat to the yacht or personnel on board, the captain advised the remainder of the crew to avoid attending the scene and ensured that the area was cordoned off.

Medair[2], shoreside emergency services and the ship's agent were contacted. The body was covered and the yacht's nurse remained in attendance until the emergency services arrived.

At around 0820 emergency medical services arrived onboard and having looked at the body waited for the police to attend before moving it. The local police attended at 0835 and following a brief inspection advised the captain to document the scene before the body could be moved ashore to a mortuary.

Post-accident actions and findings

Immediately following the accident, components of the failed sheave block were collected from the deck ***(Figure 5).*** However, the threaded bearing sleeve retaining plate was not found and was assumed to have been lost overboard.



Figure 5: Parts of the failed block sheeve recovered from the deck

Examination of the available components indicated that the likely failure of the block was a result of the sheave bearing sleeve retaining bolt having worked loose, which could have allowed the cheek plates to separate and the sheave to be pulled out under load. The retaining bolt passed through the bearing locating housing and the centre of the bearing sleeve and screwed into a threaded hole in the opposite locating plate. The design of the block required the retaining bolt to be secured in the threaded hole with a thread locking compound.

[2] MedAir is an international SOS company which provides remote medical assistance to the maritime industry.



Figure 6: Cheek Plate of failed block showing witness marks

Witness marks on the cheek plate faces indicated that the bearing pin may have been off-centre for an extended period of time ***(Figure 6).*** This misalignment would have slightly distorted the cheek plates allowing slight lateral movement of the sheave, which in turn could have affected the security of the bearing sleeve retaining bolt.



Figure 7:Sheave Roller showing wear patterns.

Wear patterns on the sheave indicated that it had been loaded heavily on one side rubbing against the inside of the cheek plate. In addition to the centre bearing sleeve, the sheave had ceramic roller bearings on each side to account for side loading. The roller housings (***Figure 7***) were secured with three grub screws each side. These were found to be loose and the ceramic rollers were missing (some were found on the deck after the accident).

The location of the span block on the forward mast ***(Figure 8***) made visual examination impossible from the deck but even a local examination with the block still in its housing would not have revealed these anomalies.

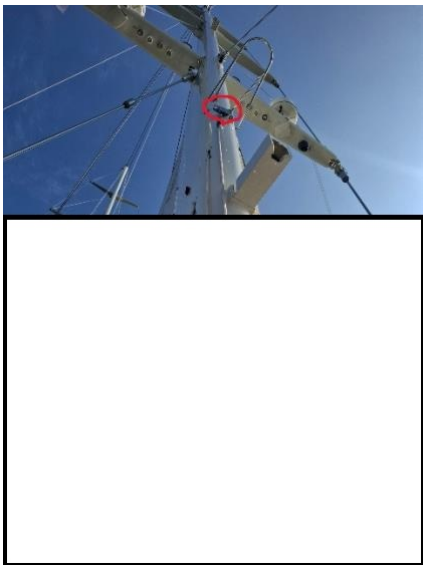


Figure 8: Location of span block on foremast as seen from the fore deck (image redacted for reasons regarding confidentiality).

The design of this block was different to many of the blocks on the yacht in that there was no bridge piece to prevent the cheek plates from distortion.

It was noted that none of the sheave blocks on the vessel displayed their safe working load (SWL) and this investigation was unable to locate any documentary evidence of these SWLs. Notwithstanding this, regular inspection of the lifting and rigging equipment had been conducted by approved contractors. The most recent inspection carried out during September 2025, included a load test of the "davit"[3] and hook to 110% of SWL. The crane was marked with an SWL of 2500kg.

Tender recovery

As a result of the shock loading when the boom struck the yacht's bulwark, the aft lifting sling failed leaving the tender hanging vertically from the crane with the stern and outboard motors underwater. The yacht's engineering team rigged an anti-pollution boom around the tender.

They then righted the tender and removed floodwater before manoeuvring it around the yacht to a secure position for ongoing investigation and repairs.

[3] Referred to in this report as the "crane"

Safety management system

The yacht's management company operated a voluntary safety management system which included safe systems of work and task specific risk assessments (RA). Whilst the documentation was reasonably comprehensive it had not been regularly reviewed.

The RA for operating the forward crane clearly identified the boom falling as a significant hazard, mitigated by instruction to the crew not to stand beneath the boom during lifting operations.

Crew

The overall impression of the crew was that they appeared both competent and highly motivated.

Vessel familiarisation and task specific training was carried out and generally documented although the training records were not always signed off. Regular emergency drills were also conducted and recorded in the official log book.

Deckhand A, an Italian national, was 26 years old and had been onboard for around 4 months. He was familiar with the tender launching operation and had received instruction in this task. It is likely that the Deckhand A had been involved in launching / recovery of the tender on more than 100 occasions, although it was not established whether he had been made aware of the RA.

The night watch deckhand, Deckhand B, began his shift at 2200hrs on the evening before the accident and was due to go off watch at 0800hrs. He appeared to be well rested, as did Deckhand A and the 2/O.

Tender launching

The crane was located on the centreline of the yacht and was used for launching both the forward tender, which was stowed in a well on the port side of the forward deck and the yacht's rescue boat which was located in a similar well on the starboard side. The crane had been upgraded to allow man-riding when launching the rescue boat. The upgrade involved additional controls to the hydraulic hoisting and slewing system but no alterations to the rigging arrangements.

The port tender was the yacht's most used boat and was often launched and recovered 2 or 3 times each day. It weighed 1.6 tonnes. As a consequence of its regular use, launching the tender was considered a routine task and structured briefings/toolbox talks were not usually carried out. The investigation identified that whilst there was an awareness of the danger of standing under the boom, it was not unusual for the crewman tasked to steady the rear of the tender to end up standing against the side rails and beneath the boom.

Vessel and environment

The yacht was a privately owned and not engaged in commercial operations but the owners voluntarily complied with SOLAS regulations. At the time of the accident, the vessel was at anchor, having arrived on 19 January 2026. At the time of the accident, the sea was calm with a light breeze.

ANALYSIS

The accident

Deckhand A was killed during a routine operation to lift the yacht's small tender from the fore deck into the water. The accident occurred when the span block, a sheave block carrying the rope which supported the crane boom and its attached load, failed allowing the full weight of the boom and suspended tender to strike him as he was stood underneath the boom while manoeuvring the stern of the tender.

Sheave block failure

The sheave block had not previously caused any issues during operation of the crane. The rigging configuration had remained unchanged throughout the life of the yacht and there was no record that this block had ever been replaced. However, the block had been periodically stripped down for inspection/maintenance. As well as the centre bearing sleeve, the sheave had ceramic roller bearings on each side to absorb side loading which could only be examined through disassembly of the block.

Once the bearing sleeve locating bolt had begun to work loose, deflection of the cheek plates allowed lateral movement of the sheave which in turn may have overcome the tolerance of the ceramic bearings thus allowing the left-hand sheave face to come into contact with the inside of the cheek plate. As the tender was the most used of the two workboats, wear on the sheave is most likely to have been apparent on this side. With the sheave plate rubbing on the cheek plate, the resulting vibration could have accelerated loosening of the bearing sleeve securing bolt until it became detached, causing the sheave block to fail during the lifting operation.

The lack of a cheek plate bridge piece on this design of block enabled distortion of the cheek plates which could have contributed to the block failing.

Tender launching operation

Although launching / recovery of the forward tender was considered a routine operation and often carried out 2 or 3 times each day, it falls under the description of a lifting operation which requires specific considerations. These include planning, provision of safe equipment, equipment maintenance, properly trained and competent personnel and a competent supervisor.

On the day of the accident, launching the forward tender formed part of the day's work plan but because of its routine nature the crew did not consider a specific plan necessary. The equipment was deemed safe; the crane was subject to planned maintenance and the fixed rigging routinely examined by approved contractors. Slings and loose lifting gear were examined by the yacht's crew as a monthly routine. Although the deck crew were all familiar with the task, training records were not signed off by the trainer as satisfactorily completed. Supervision of the operation was assigned to the crane operator whose main focus was likely to be on the behaviour of the load and the operation of the crane. Therefore, the crane operator was unable to completely focus on the overall scenario and was reliant on individual crew members performing their allotted tasks safely without close supervision.

Risk assessment

The yacht's safety management system contained a risk assessment for launching the forward tender. The risk assessment identified the boom falling as a significant hazard and, as mitigation against the hazard, stated that crew members should not stand beneath the

boom. The risk assessment had not been regularly reviewed and it was unclear how many of the crew were aware of it.

The night watch deckhand, Deckhand B, began his shift at 2200hrs on the evening before the accident and was due to go off watch at 0800hrs. He appeared to be well rested, as did Deckhand A and the 2/O.

CONCLUSIONS

Deckhand A was killed because the crane's standing rigging failed and the boom with the full weight of the attached load struck him directly causing an instantaneous fatal injury.

The rigging failed due to the design and location of the hoist sheave block. Even with regular close-up visual inspections deterioration of the sheave's mechanical integrity may not have been apparent.

The lack of a cheek plate bridge piece on this design of block enabled distortion of the cheek plates which could have contributed to the block failing.

While the risk assessment for launching the tender identified the hazard of the boom falling and stated that crew should not stand underneath the boom, it was not clear how widely the risk assessment had been promulgated.

It is likely that the deceased had been involved in launching / recovery of the tender on more than 100 occasions. However, probably due to the perceived routine nature of the operation, he had failed to register the danger posed when standing under the crane boom on this occasion.

The lifting procedure called for the crane operator to take charge of the operation. Due to the need to concentrate on the crane and its suspended load this requirement diminishes the crane operator's ability to monitor the overall safety of the launching party.

ACTION TAKEN

The sheave block manufacturer, Rondal has made an onsite modification of the existing block arrangement to provide additional security to the bearing sleeve retaining bolt. Rondal engineers attending the yacht have also proposed a redesign of the block to include a more substantial centre bearing and the inclusion of a cheek plate bridge.

The registered owner has agreed to engage an approved contractor to oversee the yacht's safety management system.

OBSERVATIONS

The sheave block that failed is in common use throughout the yachting industry. The Cayman Islands Shipping Registry may wish to issue a safety alert to its yacht fleet to warn of the potential for the catastrophic failure of such equipment. It may further wish to liaise with the sheave block manufacturer, Rondal, in order to facilitate the issue of a product alert, or similar, to the wider yachting industry.

The yacht's management team should conduct a review of its tender lifting procedure designed to ensure that one member of the lifting team is able to maintain an overview of the operation without distraction.

Crew training records would provide a more complete protocol if they were signed and dated by the appropriate trainer/observer.

Safety observations shall in no case create a presumption of blame or liability

SHIP PARTICULARS	
Flag	Cayman Islands
Classification society	Det Norske Veritas
Type	Pleasure Yacht
Minimum safe manning	9
Authorised cargo	n/a
VOYAGE PARTICULARS	
Port of departure	n/a
Port of arrival	n/a
Type of voyage	n/a
Cargo information	n/a
Manning	18
MARINE CASUALTY INFORMATION	
Date and time	23/01/2026 0705hrs
Type of marine casualty or incident	Very serious marine casualty
Place on board	Fore deck
Injuries/fatalities	1 fatality
Damage/environmental impact	Damage to forward crane / none
Ship operation	At anchor
Voyage segment	n/a
External & internal environment	Calm seas. No wind. Clear.