Marine Safety Investigation Unit

Transport Malta

SAFETY INVESTIGATION REPORT

202509/007 REPORT NO.: 09/2026 September 2026

HSC *Your Magic*
Fatal fall of a crew member
at Marsa, Malta
06 September 2025

SUMMARY

On 06 September 2025, the crew of HSC *Your Magic* boarded the laid-up vessel at Marsa to inspect its fire-fighting and life-saving appliances as part of preparations for entry into service. Although the hull compartments could be reached through the engine-room entrances and internal watertight doors, the crew used emergency escape hatches located in the passenger aisles.

The hatches opened flush with the deck and led to the switchboard rooms. At about 0940, after completing the inspection of the starboard hull, the crew opened the port-side hatch to continue the work. No barriers or warning signs were placed around the opening.

At about 0955, while the master and chief mate were discussing the Fire and Safety Plan, the chief mate walked briskly along the port aisle towards the master. While speaking and looking towards him, the chief mate did not notice the open hatch and fell approximately 2.10 m onto the tank top of the port switchboard room. He sustained serious injuries and later died in hospital.

The MSIU issued one recommendation to the Company, aimed at strengthening task planning and layered risk controls.


HSC *Your Magic*

FACTUAL INFORMATION

The Vessel

Your Magic (**Figure 1**) was a high-speed passenger catamaran of 397 gt. The vessel was built at PT. Cahaya Samudra Shipyard in Indonesia in 2023. At the time of the accident, the vessel's registered owner was Gozo Fast Ferry Ltd., and the vessel was managed by Newcastle Ship Management Ltd. of Malta. Bureau Veritas (BV) acted as the classification society.

Your Magic was constructed of aluminium and had a length overall of 39.0 m, a moulded breadth of 10.0 m and a moulded depth of 3.25 m. The vessel, which was designed to carry 312 passengers, was fitted with two bunker tanks, each with a capacity of 5,000 litres.

Propulsive power was provided by two MTU 16V2000M72 high speed internal combustion marine diesel engines, each producing 2,880 kW at 2,250 rpm. This drove two fixed pitch propellers through reduction gearboxes, enabling the vessel to reach a service speed of 30 knots.

The vessel was provisionally registered under the Maltese flag on 23 June 2025. It arrived in Malta on 18 July 2025 from Perama, Greece, on a single voyage certification, issued by the Maltese Flag Administration.

Your Magic was issued with a Non-operational Certificate of Registry pending full completion of statutory surveys and certification prior to entering on the Company's local passenger trade routes in Maltese waters.

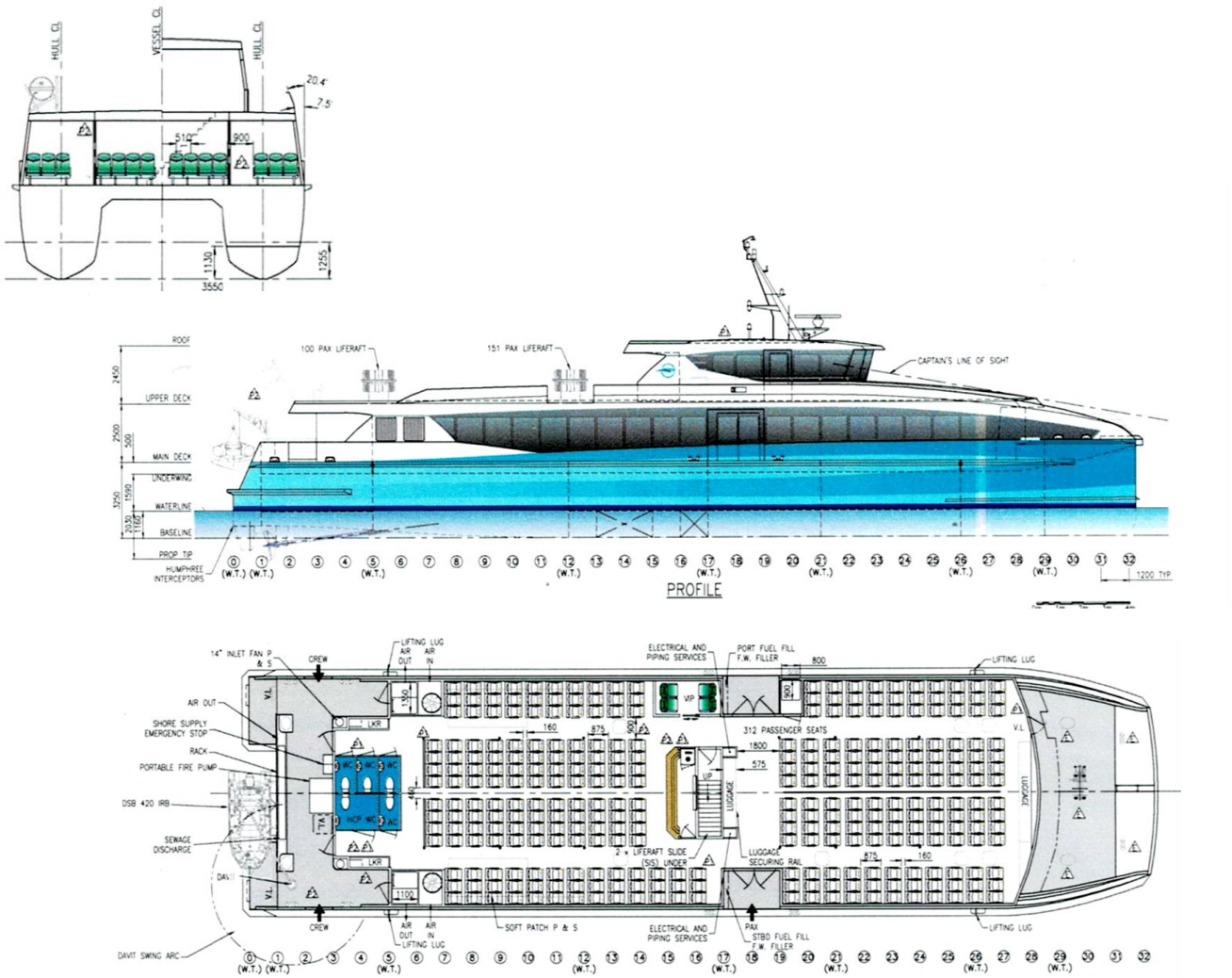

Figure 1: HSC *Your Magic*

Manning

On arrival at Valletta, the vessel was berthed at the Malta Maritime Hub facilities and had remained laid up there, undergoing repairs and surveys in preparation for entry into service.

The vessel was manned by a skeleton crew consisting of a master, chief mate and chief engineer. All crew members were Indonesian nationals. The chief mate and the chief engineer had joined the vessel at Perama, Greece, on 12 July 2025 and had remained assigned to the vessel since then. The master joined the vessel at Valletta on 14 August 2025.

Both the master and the chief mate held STCW II/2 certificates of competency, while the chief engineer held an STCW III/2 certificate of competency. The master had begun his nautical career in 1999, and records showed that he had eight years of experience as a master when he joined the Company and the vessel.

The chief mate's seaman's book recorded 11 years of service as chief mate and master before he joined the Company. Records showed that the chief engineer had 16 years of experience serving as chief engineer. He had also previously worked on board Company sister vessels in 2021 and 2022.

Familiarisation forms had been duly completed for all three officers.

Vessel statutory and class certification

The vessel was in Class, with the next annual Class survey due by 15 February 2026. At the time of the accident, it had no Conditions of Class. The vessel was required to comply with the national Non-Convention Vessel (NCV) Code[1], Loadline Certification, High Speed Craft (HSC) Safety Equipment Certificate, as well as the International Safety Management (ISM) Safety Management Certification. The NCV Code and HSC Safety Equipment surveys had commenced but were still in progress. Implementation of the SMS and the issue of an Interim SMC for the vessel were still pending at the time of the occurrence. The NCV Code required additional fire and safety equipment on board, necessitating an amendment of the Fire & Safety Plan.

The work plan for 06 September 2025, the day of the accident, was to check and verify all life-saving appliances (LSA) and fire-fighting appliances (FFA) against the existing Fire and Safety Plan and record any newly added equipment. The details would then be forwarded to the responsible naval architect so that the plan could be amended for eventual approval by the Flag State Administration.

Course of events

The crew members were accommodated ashore. On 06 September, they boarded the vessel at approximately 0800. The master, chief mate and chief engineer commenced the planned inspection of the FFA and LSA at approximately 0830, beginning on the starboard-side lower deck within the starboard hull.

Access to the compartments below the main deck was normally through the respective main engine-room entrances for each hull, from where access forward could be obtained through watertight doors into successive compartments. The only compartment

[1] The Maltese NCV Code is applicable to all Non-Convention Vessels ≥ 15 m in length overall (LoA). For the purpose of the Code, a Non-Convention vessel means a commercial vessel of ≥ 15 m LoA, which:

- is a non-SOLAS vessel (self-propelled vessels < 500 GT other than passenger vessels; and non-self-propelled vessels) engaged on international navigation, which, depending on its GT, may or may not be covered by the provisions of other IMO Conventions; and / or
- is a vessel operating exclusively on domestic voyages, irrespective of its GT (including vessels operating exclusively in Maltese Waters).

ordinarily accessed solely *via* a hatch from the passenger deck was the void space located at the forward end of the starboard hull.

Despite the availability of these access routes, the crew entered the hull spaces through the emergency escape hatches located near midships in the port and starboard passenger aisles on the main deck, at the forward end of the aft passenger hall (**Figure 2**).

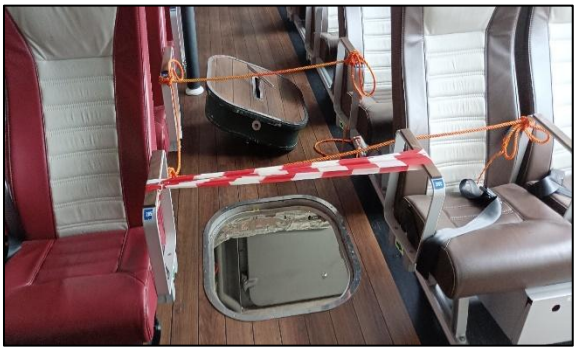

Figure 2: Port side switchboard room emergency escape hatch opening on the port side passenger aisle

Photo taken after the accident.

These hatches, which were opened by the chief engineer, led to the port and starboard switchboard rooms (**Figures 3** and **4**).

Figure 3: Port side switchboard room from the passenger hall

Photo taken after the accident.

The hatches opened flush with the passenger deck and were not fitted with coamings. The chief engineer stated that he opened the emergency escape hatches on the master's instructions. No barriers, warning signs or other physical safeguards were placed around the openings.

Figure 4: Port switchboard escape ladder and open escape hatch cover

After completing the inspection inside the starboard hull, all three officers exited through the starboard escape hatch for a short break before commencing the inspection of the port hull. This occurred at approximately 0940. While the master and the chief mate continued discussing the inspection findings,

the chief engineer closed the starboard escape hatch.

Preparations were then made to access the port hull through the emergency escape hatch in the port-side passenger aisle, leading down to the port switchboard room. The chief engineer opened the hatch. CCTV footage confirmed that no physical barrier or warning sign was placed around the opening. There was no record of either the master or the chief mate, who also served as the safety officer, raising concern about the absence of such safeguards.

The events immediately preceding the accident occurred over a short period and were captured on CCTV footage covering the aft passenger hall, recorded by a camera mounted on the deckhead at the port aft corner. The footage showed the master and the chief mate seated in the forward row of passenger seats, apparently reviewing items on the Fire and Safety Plan, while the chief engineer was seated near the starboard boarding door.

The master was subsequently observed standing and walking aft along the starboard passenger aisle, before crossing behind the last row of seats to the port side aisle. During this movement, he appeared to pause while referring to the plan and visually comparing it with installed equipment.

At approximately 0955, the chief mate was observed standing and moving towards the chief engineer on the starboard side before crossing to the port side, where he briefly entered the VIP room (**Figure 5**).

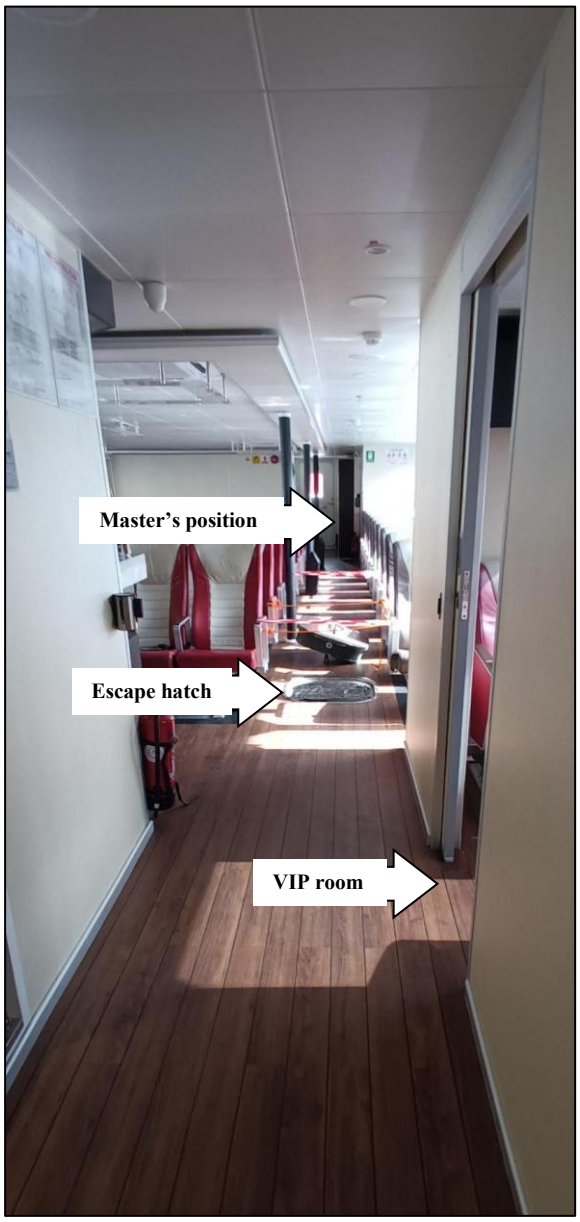

Figure 5: VIP room and accident site

On leaving the VIP room, he turned and proceeded briskly along the port-side passenger aisle towards the master at the aft end. During this movement, he appeared to be speaking and looking towards the master and did not seem to notice the open emergency escape hatch. Consequently, he fell through the opening into the port switchboard room, falling approximately 2.10 m onto the tank top.

CCTV footage showed the master and chief engineer immediately walking towards the

open escape hatch. The chief engineer descended into the port switchboard room to assist the chief mate, while the master raised the alarm and contacted the master of a sister vessel, who in turn informed the Designated Person Ashore (DPA). The master subsequently contacted the vessel's superintendent and requested emergency medical assistance.

The chief engineer reported that the chief mate appeared unconscious, was making low vocal sounds, and had a small amount of blood in his nostrils.

An ambulance crew and Civil Protection Department personnel arrived at approximately 1030, administered first aid and stabilised the injured crew member before transferring him to hospital for further specialised treatment. At approximately 1900 on the same day, the DPA was informed by the hospital that the chief mate had succumbed to his injuries.

The body of the deceased crew member was subsequently released by the authorities and was repatriated.

Environment

At the time of the accident, the sea was calm and the weather was clear. A light Southeasterly breeze was blowing, and no swell was recorded. The air and sea temperatures were 32 °C and 26 °C, respectively.

ANALYSIS

Aim

The purpose of a marine safety investigation is to determine the circumstances and safety factors of the accident as a basis for making recommendations, and to prevent further marine casualties or incidents from occurring in the future.

This analysis was prepared exclusively for the purposes of a marine safety investigation. It was not prepared, either in content, method or evidential purpose, for use in adversarial, disciplinary, civil, criminal or administrative proceedings.

Its purpose was not to test legal liability, fault, negligence, causation in law, or the credibility of persons according to forensic standards. Rather, it examined how the occurrence developed within the interaction of people, shipboard systems, cargo characteristics, procedures, technical limitations, organisational arrangements and the information available at the time.

Analytical approach[2]

While the factual circumstances of the accident were established, namely that the chief mate fell through an open and unguarded emergency escape hatch in a passenger aisle and sustained fatal injuries, this section examined how the interaction of people, procedures, equipment and

[2] The analytical approach adopted in this safety investigation report was materially different from that applied in judicial proceedings. A court of law is generally required to determine legal facts, allocate rights and obligations, and, where relevant, attribute responsibility by reference to applicable legal tests and standards of proof. By contrast, this safety investigation considered the occurrence as a dynamic operational event and sought to identify safety factors, system interactions, adaptations, uncertainties and conditions that may support future prevention. For that reason, the findings, analysis, conclusions and recommendations in this safety investigation report should not be read as findings of legal causation, fault, negligence, breach of duty, civil liability or criminal responsibility.

Any attempt to use this analysis for purposes other than the promulgation of safety lessons would risk distorting its meaning and may be misleading. This is because the safety investigation did not apply the evidential, procedural or philosophical assumptions that govern litigation, including adversarial proof, attribution of legal responsibility, examination and cross-examination of witnesses, and determination of disputed facts for the purpose of liability. The safety investigation report should therefore be read only within its statutory safety-investigation purpose.

organisational context reduced the system's capacity to prevent that outcome. The analysis did not seek to attribute the occurrence to individual actions in isolation.

As in other safety investigations, the MSIU examined the accident on board *Your Magic* from a systems-based safety perspective, considering human performance, organisational influences, vessel design and the operational context at the time.

This approach recognises that accidents typically emerge from the interaction of multiple conditions rather than from a single unsafe act. The analysis therefore considered how normal human performance, together with situational and systemic conditions, reduced safety margins until a normal variation in attention had a fatal outcome[3].

Operational context and system state

At the time of the accident, *Your Magic* was in a transitional operational state. The vessel had been newly acquired and was laid up, undergoing modification and upgrade work while awaiting completion of statutory surveys and full implementation of the Safety Management System (SMS). Although non-operational and not carrying passengers, the vessel was engaged in preparatory activities essential to entry into service, including verification of fire-fighting and life-saving equipment.

The safety investigation considered that periods of transition may involve work which differs from the vessel's eventual normal operating condition, with established routines coexisting with survey, modification and preparatory activities. Such circumstances may require personnel to adapt established work methods to changing conditions. In this case, SMS implementation and certification remained in progress, while procedures, forms and familiarisation arrangements were already available on board.

No documented task-specific risk assessment or toolbox discussion was identified in relation to the use of the emergency escape hatches.

More significantly from a safety perspective, no formal or informal mechanism was identified which resulted in the temporary fall hazard being made sufficiently salient and effectively controlled. This did not necessarily indicate a need for additional procedures for routine work; rather, it illustrated the importance of safety-management arrangements supporting professional judgement when work departs from normal arrangements or introduces a material additional hazard.

On-board work practices and access arrangements

The safety investigation identified variability in work-as-done relative to the documented safe-working arrangements: emergency escape hatches were used for routine access, and no physical barriers were placed around them while open. A systems-based analysis therefore considered how this adaptation emerged from the immediate operational context.

The vessel was provided with permanent access routes to the underdeck compartments through the engine-room entrances and internal watertight doors. The use of an emergency escape hatch for access therefore represented an adaptation from the normal access arrangement. The available accident data did not establish why this method was selected; proximity, ease of access or perceived efficiency may have influenced the choice. The significant change introduced by this adaptation was that an opening was created in a passenger walking surface.

[3] It was noted that the inoperative CCTV camera within the switchboard room limited the ability to reconstruct the precise dynamics of the fall itself. The analysis therefore relied on available CCTV footage from the passenger spaces, witness statements, vessel documentation, and academic human factors principles.

Earlier that morning, the inspection inside the starboard hull had been completed using an identical access arrangement without adverse consequences. This experience may have reinforced the perception that the arrangement was acceptable for similar work inside the port hull[4]. In the absence of passengers, and with only senior officers present, the open hatch may not have been perceived as an immediate or elevated hazard.

The absence of physical barriers and prominent warning cues meant that control of the fall hazard depended entirely on individual awareness. This reduced the system's tolerance for normal variations in attention and movement and increased its vulnerability during routine activity.

Human performance and attention

Immediately before the accident, the chief mate was walking along the passenger aisle while speaking with the master. The associated narrowing of visual attention was consistent with normal human cognitive performance.

Research indicates that human attention is selective and context dependent. When individuals are engaged in cognitive tasks such as discussion, planning or verification, visual scanning of the surrounding environment may be reduced. In this case, the emergency escape hatch was flush with the deck and located in an area normally free of openings. Without a sufficiently prominent physical or visual cue, the opening did not interrupt the expectation of a continuous walking surface.

The rapid and uninterrupted nature of the fall, as observed on the CCTV footage, suggested that the chief mate was operating with an expectation of deck continuity. This expectation was shaped by the vessel's normal configuration and may also have been reinforced by earlier movement through the same area without incident.

Experience, authority, and communication

All three officers were experienced and appropriately certificated for their respective ranks. Their experience provided an important resource for task performance, coordination and adaptation. Nevertheless, experience could not provide an independent defence against an unexpected opening in a normally continuous walking surface. The fact that the arrangement was accepted by all three officers is relevant to understanding how the hazard was perceived within the local context, rather than as evidence that their experience or professional judgement was deficient.

The available accident data did not indicate that concerns were raised about either the selected access method or the absence of guarding around the open hatch. All three officers were actively involved in the task. Their collective acceptance of the arrangement suggested that, within the circumstances prevailing at the time, the associated fall hazard was not perceived as requiring additional control. This should not, however, be interpreted as evidence of an established behavioural or safety-culture deficiency on board or within the Company.

Although an interpreter was required during the safety investigation interviews, the three officers were Indonesian nationals and were able to communicate with one another in their shared language during the task. The available accident data did not indicate that language or communication difficulties contributed to the accident.

[4] The safety investigation did not establish that the use of emergency escape hatches for routine access represented an established or recurring working practice. The relevance of the earlier starboard-hull activity was therefore limited to its potential influence on the crew's perception of the arrangement during the work undertaken that morning.

Design and physical barrier systems

From a system-safety perspective, reliance on human vigilance alone may be insufficient to control fall risk. Physical design features and temporary safeguards can provide independent layers of defence by preventing an accident or mitigating its consequences.

In this case, the emergency escape hatch opened flush with the deck and did not provide an inherent barrier around the opening when raised[5]. In the absence of temporary guarding, control of the fall hazard depended on warning measures and individual awareness. As neither was provided, no independent layer of defence remained.

This lack of redundancy meant that a normal variation in attention may have led directly to a very serious outcome.

Organisational safety management

At the time of the accident, implementation and certification of the SMS on board *Your Magic* were still in progress. Relevant procedures, forms and familiarisation arrangements were nevertheless available to the crew. The available accident data were insufficient to assess how fully the SMS was being applied across other shipboard activities. In relation to the task undertaken at the time of the accident, however, the selected access arrangement created a temporary fall hazard without an accompanying physical barrier or sufficiently prominent warning cue.

Interaction of system conditions

The safety investigation was of the view that the accident developed through the interaction of several conditions rather than from a single action or failure.

[5] The safety investigation acknowledged that a raised hatch cover could be a serious tripping hazard to passengers and crew members during normal vessel operations.

These included:

- the vessel's transitional operational state, during which survey, modification and preparatory activities differed from eventual normal operating routines;
- the adaptation of emergency escape hatches for routine access;
- the absence of physical barriers and prominent warning cues around the open hatch;
- normal variability in attention during movement and technical discussion; and
- reliance on individual awareness without complementary layers of defence.

None of these conditions, considered individually, would necessarily have resulted in a serious outcome. Together, however, they reduced safety margins and allowed a normal variation in attention to have fatal consequences.

The professional judgement and adaptive actions of the officers formed part of the safety system rather than being external to it. However, the accident did not arise because personnel adapted the normal method of access, or because some formal procedure was absent. Rather, the safety investigation believes that it developed when the adopted work arrangement created a high-consequence physical hazard without an accompanying defence sufficiently robust to accommodate normal variability in perception and attention.

Risk perception and safety management during transitional operations

This accident highlighted the challenges associated with work undertaken during transitional operational states such as lay-up, modification and pre-certification. During such periods, established operating arrangements may coexist with temporary

work arrangements, newly introduced systems and preparatory activities. These circumstances may change how work is organised and how hazards are perceived without necessarily indicating a deficiency in the underlying SMS.

Risk perception in operational settings does not always involve a deliberate acceptance of hazard. It is also shaped by contextual cues that influence how work is framed at a given time. In this case, the vessel was non-operational, was not carrying passengers and was engaged in preparatory statutory work. These conditions may have framed the inspection as routine by the crew members and reduced the perceived need for formal safeguards despite the fall hazard.

The presence of an unguarded opening in an area normally experienced as a continuous walking route illustrated how system vulnerabilities may remain without immediate consequence. When physical or visual cues do not signal a change in the environment, personnel may continue to act on the expectation of continuity. Under such conditions, normal shifts in attention can have severe consequences.

Physical hazards are not diminished by a vessel's regulatory or certification status. The risks associated with falls, confined spaces and altered access arrangements remain present during lay-up, modification and pre-certification work, even when the vessel is not operational or carrying passengers.

The accident underscored the importance of maintaining functional safety systems throughout every stage of a vessel's lifecycle, particularly during periods of transition and change.

CONCLUSIONS

1. The accident became possible when a flush-mounted emergency escape hatch was left open in a passenger aisle without a physical barrier or prominent warning cue.
2. With no independent layer of defence, control of the fall hazard depended entirely on each person's continued awareness of the opening. The system therefore had little tolerance for normal variations in attention during movement and technical discussion.
3. The use of the emergency escape hatches for access represented an adaptation from the vessel's normal access arrangements. The available accident data did not establish why this method was selected. Once adopted, however, the resulting temporary opening in the passenger aisle was not accompanied by a physical barrier or sufficiently prominent warning cue.
4. The chief mate was moving through an area normally experienced as a continuous walking surface while speaking and looking towards the master. Without a physical or visual cue sufficiently prominent to interrupt that expectation, he did not detect the opening.
5. The earlier completion of the starboard-hull inspection, using the same arrangement without adverse consequence, may have reinforced the perceived acceptability of the adopted access method when work moved to the port hull. The safety investigation did not establish that this represented an established or recurring practice.
6. During the vessel's transition into service, implementation and certification of the SMS remained in progress. Procedures, forms and familiarisation arrangements were available on board. In this instance, however, the temporary fall hazard

arising from the selected access arrangement was not identified and effectively controlled.

7. The non-operational setting, absence of passengers and presence of experienced senior officers may have contributed to the task being framed as routine, with less salience attached to the need for additional safeguards.
8. While the vessel's normal and established access arrangements provided a distinguishable boundary between routine access and emergency escape, the adaptation of the escape hatch for the inspection during that morning was not accompanied by an additional layer of protection against the temporary fall hazard that it created.

SAFETY ACTIONS TAKEN DURING THE COURSE OF THE SAFETY INVESTIGATION[6]

Following the accident, the Company conducted an internal investigation and disseminated the resulting safety lessons across its managed fleet. The Company also reinforced arrangements that emergency escape routes are not to be used as routine access, where designated access arrangements are available. Moreover, where an emergency hatch or other opening in a walking surface is required to remain open for inspection, maintenance or other necessary purposes, appropriate controls, including physical barriers are to be applied.

SAFETY LESSONS

Crew members may adapt work methods to meet local operational needs. However, where an adaptation materially changes the working environment, the associated change in risk needs to be recognised and appropriately controlled. Routine activities can have serious consequences when system defences are reduced and changes in the working environment are not made sufficiently visible. Successful completion of an adapted work method may also reinforce its continued use, even where the associated risk has not been fully recognised.

Where temporary work introduces a material change to the normal working environment, particularly a high-consequence hazard such as an opening in a walking surface, the change needs to be made sufficiently visible and supported by controls proportionate to the hazard.

Formal planning tools may assist this process and complement professional judgement, shared hazard recognition and active crew participation. Effective safety arrangements should provide sufficiently robust defences so that a temporary shift in attention or a locally reasonable decision does not, by itself, result in a serious outcome.

Safety systems should accommodate normal variability in human performance and provide multiple, independent layers of protection so that a brief shift in attention does not lead directly to a fatal outcome.

RECOMMENDATIONS

Newcastle Ship Management is recommended to:

09/2026_R1 review its task-planning arrangements to ensure that, where non-routine work, departures from normal working arrangements or temporary conditions introduce a material additional hazard, the work and associated controls can be adapted proportionately to the changing conditions, with the active participation of the personnel involved.

[6] **Safety actions and recommendations shall not create a presumption of blame and / or liability.**

SHIP PARTICULARS

Vessel Name:	*Your Magic*
Flag:	Malta
Classification Society:	Bureau Veritas (BV)
IMO Number:	1017361
Type:	Passenger HSC
Registered Owner:	Gozo Fast Ferry Limited
Managers:	Newcastle Ship Management Ltd.
Construction:	Aluminium
Length Overall:	39.0 m
Registered Length:	38.0 m
Gross Tonnage:	397
Minimum Safe Manning:	-NA-
Authorised Cargo:	-NA-

VOYAGE PARTICULARS

Port of Departure:	Perama, Greece
Port of Arrival:	Valletta, Malta
Type of Voyage:	International
Cargo Information:	-NA-
Manning:	3

MARINE OCCURRENCE INFORMATION

Date and Time:	06 September 2025 at about 09:55
Classification of Occurrence:	Very Serious Marine Casualty
Location of Occurrence:	Marsa, Malta
Place on Board	Accommodation / switchboard room
Injuries / Fatalities:	One fatality
Damage / Environmental Impact:	None
Ship Operation:	Maintenance / Alongside
Voyage Segment:	Alongside
External & Internal Environment:	Sea was calm and the weather clear. A Southeasterly light breeze was blowing and no swell recorded. The air and sea temperatures were 32 °C and 26 °C respectively.
Persons on board:	3