HM Government of Gibraltar
Office of the Marine Accident Investigation Compliance Officer

MAIB
MARINE ACCIDENT INVESTIGATION BRANCH
ACCIDENT REPORT

VERY SERIOUS MARINE CASUALTY | REPORT NO 14/2025 | SEPTEMBER 2025

Collision between the tender to *Isabell Princess of the Sea* and the rigid inflatable boat *Vega* in Göcek, Turkey, resulting in one fatality on 27 July 2024

BACKGROUND

This investigation into a very serious marine casualty was conducted by the Marine Accident Investigation Branch (MAIB) on behalf of the Gibraltar Office of the Marine Accident Investigation Compliance Officer. The events described in the report were drawn from the evidence collected during the investigation. The investigators' access to witnesses and evidence was restricted due to the parallel judicial investigation. No access was provided to police records or the postmortem report. The narrative and facts presented are therefore a best representation of the information gathered.

SUMMARY

On the evening of 27 July 2024, the tender to the motor yacht *Isabell Princess of the Sea* was underway within the inner harbour in Göcek, Turkey. The tender was heading in a southerly direction at a speed of about 28 knots (kts) when it collided with the drifting rigid inflatable boat (RIB) *Vega*. The tender rode up over the port quarter of *Vega*, damaging the helm seat and knocking the coxswain overboard. *Vega*'s sole passenger was at the RIB's stern and was trapped under the tender when it came to rest on top of the smaller vessel.

A local boat was quickly on scene and its skipper helped the tender's crew to recover *Vega*'s passenger. Despite prompt first aid, the passenger was later declared deceased.

The investigation found that the passenger on *Vega* died as a result of the injuries sustained during the collision and drowning. The tender's unplanned, high-speed passage violated harbour speed limits, and the judgement of the person at the tender's helm might have been impaired by the consumption of alcohol. Both vessels were being used for recreational purposes.

Tender to *Isabell Princess of the Sea* and RIB *Vega*

This investigation was carried out by the UK Marine Accident Investigation Branch (MAIB) on behalf of the Office of the Marine Accident Investigation Compliance Officer (OMAICO), in accordance with the Memorandum of Understanding between the MAIB and the Red Ensign Group Category 1 registries of Isle of Man, Cayman Islands, Bermuda and Gibraltar.

Extract from The Gibraltar Merchant Shipping (Accident Reporting and Investigation) Regulations 2012 – Regulation 4:

"4.(1) These Regulations seek to improve maritime safety and the prevention of pollution by ships, and so reduce the risk of future marine casualties, incidents or accidents by−

(a) facilitating the expeditious holding of safety investigations and proper analysis of marine casualties and incidents in order to determine their causes; and

(b) ensuring the timely and accurate reporting of safety investigations and proposals for remedial action.

(2) Investigations under these Regulations shall not be concerned with apportioning blame nor with determining civil or criminal liabilities."

NOTE
This report is not written with litigation in mind and, pursuant to Regulation 19(10) of The Gibraltar Merchant Shipping (Accident Reporting and Investigation) Regulations 2012, shall be inadmissible in any judicial proceedings whose purpose, or one of whose purposes is to attribute or apportion liability or blame.

All reports can be found on our website:

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FACTUAL INFORMATION

Narrative

On 9 July 2024, the motor yacht *Isabell Princess of the Sea* (*Isabell*) arrived at its berth at Club Marina, Göcek, Turkey **(Figure 1)**. There were no guests on board the motor yacht, which was being prepared for its next charter that was due to start on 3 August 2024.

On 27 July 2024, most of *Isabell*'s crew went ashore; the master opted to visit the owner's representative's house in Göcek for a barbecue.

During the evening, the owner's representative and *Isabell*'s master drank some beer and discussed local venues that might be suitable for hosting *Isabell*'s future guests. The owner's representative was eager to show the master a coastal restaurant located about 14km south-west of Göcek that was inaccessible directly by road. After some discussion, the owner's representative decided that they would make their way to the restaurant using *Isabell*'s tender. At about 2240, the owner's representative and two family members, accompanied by *Isabell*'s master, returned to *Isabell* to collect the tender that was moored alongside the yacht's port side.

Image courtesy of Google Maps

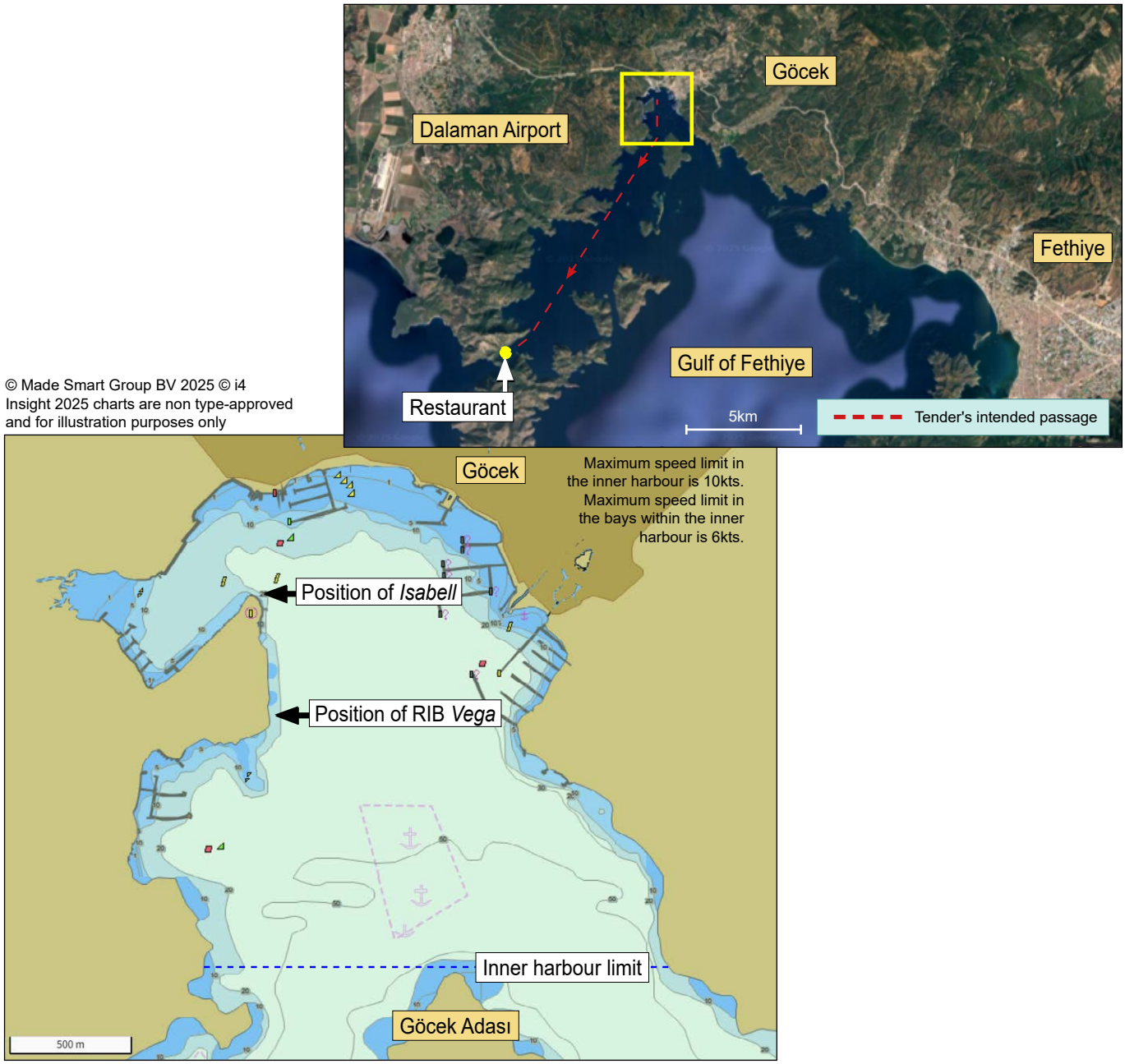

Figure 1: The port of Göcek and (inset) the tender's intended passage

At about the same time, the RIB *Vega* was on the way to another charter vessel in the port. On board were the coxswain and their friend, who was to join the charter vessel that night. The coxswain stopped *Vega* near to the southern point of the headland to the west of the bay **(Figure 1)** then switched off the engine and the side lights, leaving *Vega* adrift with only the RIB's single all-round white light showing. The coxswain and their friend were sitting in *Vega*'s aft section.

By 2250, *Isabell*'s owner's representative had boarded the tender and switched on the chart plotter and the engine. They manoeuvred the tender to the quay at the yacht's port quarter. The two family members boarded the tender and shouted to the master to fetch some alcoholic drinks and snacks to take with them. The master went on board *Isabell* and collected the supplies before returning to the quay and boarding the tender. No one on the tender was wearing a personal flotation device as it left the quay.

At 2251, with the owner's representative at the helm, the tender backed away from its berth then turned and proceeded along *Isabell*'s port side into the inner harbour. Prompted by the master, the owner's representative switched on the tender's navigation lights along with the internal and external downlights **(Figure 2)**. By the time the tender rounded *Isabell*'s bow, it had reached a speed over the ground (SOG) of 8kts. The owner's representative increased the speed of the tender further to about 28kts as it made its way south along the western headland **(Figure 3)**. The tender crossed two shallow patches with obstructions, heading directly towards an anchored gulet[1], *Gozden-1*. At 2252, *Gozden-1*'s owner, unsure that the approaching tender had seen their vessel, shone a bright light towards the closing boat to draw attention to its presence. Almost immediately, the tender altered course by about 20° to port.

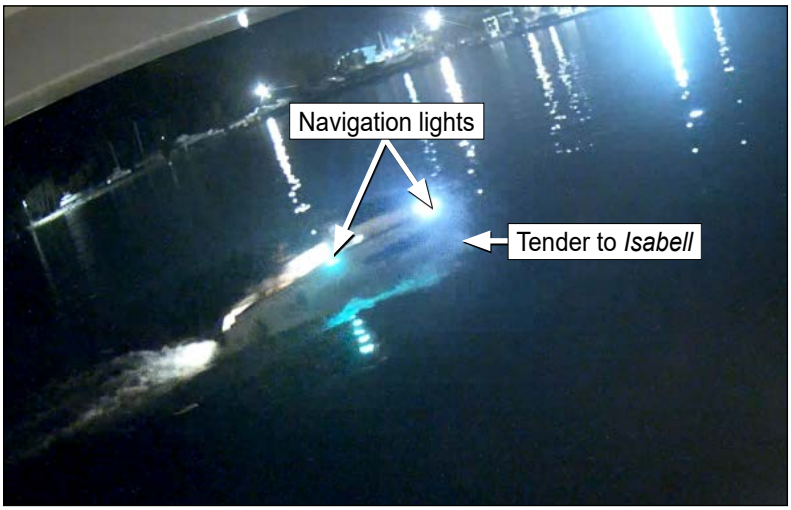

Figure 2: CCTV still, showing the tender underway

As the owner's representative altered the tender's course, *Vega*'s coxswain spotted the approaching tender and shouted to indicate their position. Seeing no response from the tender, the coxswain moved towards the steering console to start the engine and manoeuvre out of the way. At 2252:30, the tender collided with *Vega* at a SOG of about 27kts. The tender rode up the RIB's port quarter, dislodging the helm seat from its mountings and ejecting the coxswain overboard.

The owner's representative and *Isabell*'s master instantly realised that the tender had collided with an obstruction. The owner's representative reduced the throttle to zero and then, prompted by the master, stopped the engine. From the water, *Vega*'s coxswain shouted in Turkish that their friend was missing. The family of the owner's representative translated what they heard and then used their mobile phone to call the coastguard. The master jumped into the water to assist the coxswain back to the partly submerged RIB.

At about the same time, *Gozden-1*'s owner also contacted the coastguard by mobile phone to report the collision. They then proceeded to the accident site in their own boat to assist.

By the time *Gozden-1*'s owner reached the scene of the accident, *Vega*'s passenger had been found trapped under the tender's hull with their head submerged. *Gozden-1*'s owner, *Isabell*'s master and the owner's representative pushed the tender off the RIB to free the passenger. The casualty was unresponsive and had no pulse so the master and owner's representative commenced cardiopulmonary

[1] A traditional two-masted sailing vessel popular in the Eastern Mediterranean.

resuscitation, continuing until the coastguard arrived. The coastguard transported the casualty and *Vega*'s coxswain to the shore, where the casualty was later declared deceased. The tender and its occupants returned to *Isabell* without shore assistance.

At 0400 on 28 July 2024, the owner's representative was reportedly breathalysed by the local police and found to be more than the 0.25 milligrams per litre alcohol in breath limit prescribed by the Gibraltar Merchant Shipping (Manning, Training and Certification for Seafarers) Regulations 2006 and reflected in the Fraser Worldwide S.A.M. (Fraser) drug and alcohol policy.

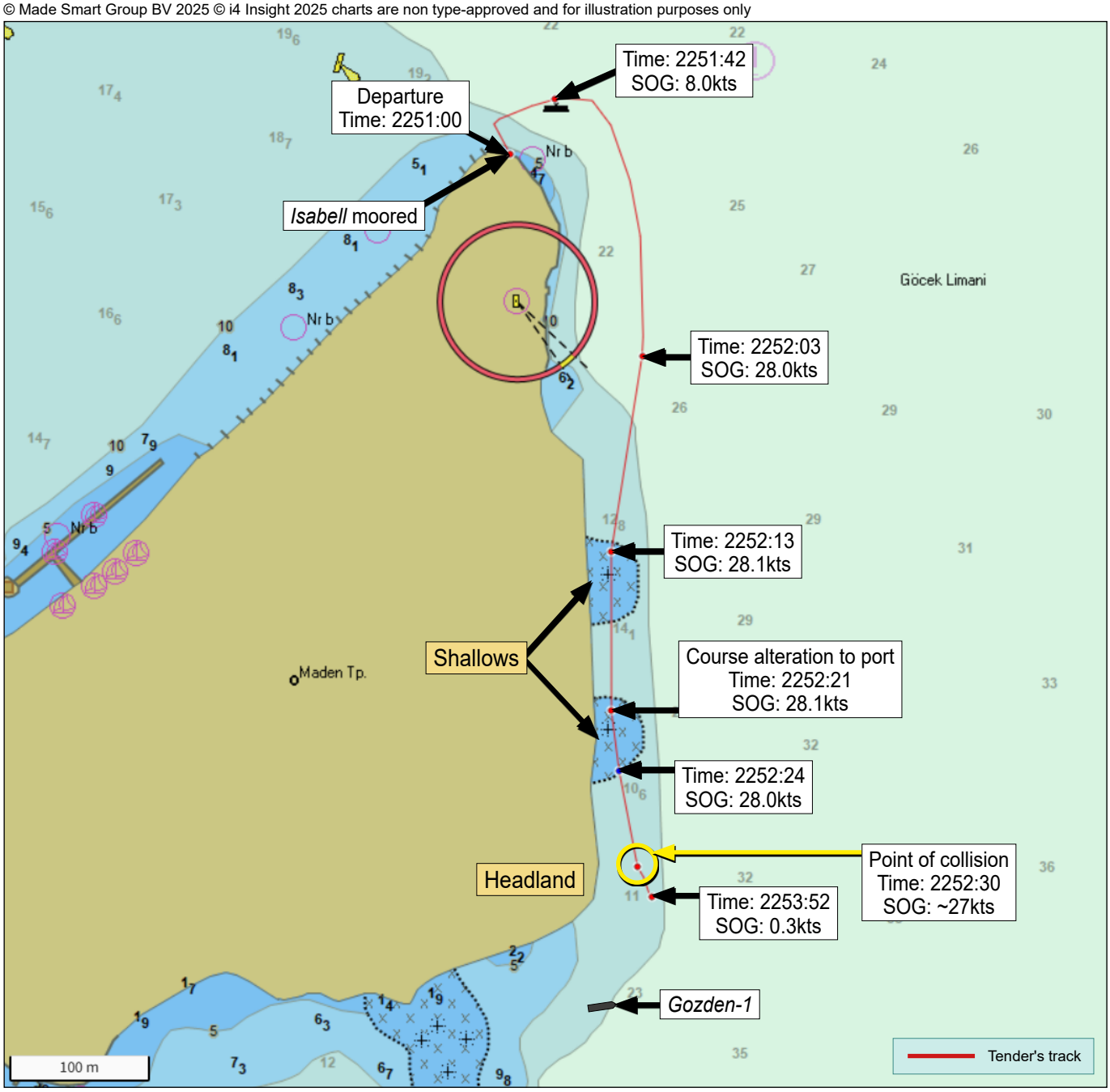

Figure 3: The tender's chart plotter track to the east of the headland

Environmental conditions

At the time of the accident there were light airs, and the sea was rippled. It was dark and mainly overcast with good visibility. The air and water temperatures were about 26°C.

Isabell Princess of the Sea and the tender

Isabell was a 63.77m motor yacht built in 1990. The vessel could accommodate 12 guests in its six staterooms. In June 2023, *Isabell* was purchased by IFZA Limited (IFZA) and used for both private and commercial activities. It was one of two motor yachts owned and operated by the company. *Isabell* was registered with the Gibraltar Yacht Registry as a commercial yacht.

The technical management for the two motor yachts was overseen by IFZA, while Fraser was responsible for the operation of the onboard safety management system (SMS).

The tender to *Isabell* was a 7.35m monohull boat constructed from glass reinforced plastic (GRP) with a draught of about 0.5m. The tender was purchased in 2023. Its boat builder's plate indicated that it was constructed to the requirements of the Recreational Craft Directive (RCD) design category D[2] and could carry a maximum of 14 people. The tender was equipped with a 250 horsepower (hp) inboard engine driving a single fixed pitch propeller, making it capable of a top speed of 35kts. The tender was equipped with a chart plotter that was set to display and record its track and speed. Port, starboard, stern and forward navigation lights were installed as well as internal and exterior lighting. The accident caused minor paint scuffs to the tender's lower hull.

The master

Isabell's master held an STCW[3] II/2 master less than 3,000 gross tonnage (gt) certificate of competency that had been issued by the UK in November 2013 and last revalidated in August 2023. The master had completed the required STCW safety and radio communication courses. The master had joined *Isabell* in Port Said, Egypt on 6 July 2024 and held a letter of authority, dated the same day, that empowered them to *assume control of the yacht* as its captain. The letter had been signed by the owner's representative as a director of IFZA. This was the master's first contract with IFZA.

The owner's representative

The owner's representative held an STCW II/2 master unlimited certificate of competency issued by Norway in December 2020. They first held command in 1999 before entering the superyacht sector in 2001. The owner's representative lived in Göcek.

The owner's representative joined IFZA in April 2024 and held a letter of authority for their appointment to *Isabell* as senior captain; the letter was signed by IFZA's chair as a director. The letter mirrored that issued to the master, permitting the owner's representative to *assume control over the yacht* and to *act as the captain*, but had an additional clause empowering the owner's representative to:

> *assign temporary Captain, Crew for the yachts registered under owning company "IFZA Limited".* [sic]

Safety management system

The Fraser SMS was divided into standard operating procedures (SOP), risk assessments and manuals that contained the plans and guidance required to operate the yacht. Only the SOPs were vessel specific. The master was responsible for implementing the SMS on board *Isabell*.

Section 2.2 of the SMS stated that:

> *Any level of alcohol consumption by crew members has implications for the safety of the vessel, the crew and any passengers. Even small quantities of alcohol have been shown to sufficiently impair judgment and increase the risk of accidents.*

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[2] Designed for a wind of up to force 4 and a significant wave height up to 0.3m, with occasional waves of 0.5m maximum height.

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

Section 5.1 of the SMS detailed the master's overriding authority and included that:

> *He/she has full authority and discretion to take whatever course of action is necessary for the safety and security of the vessel, passengers and crew, or protection of the environment. The Master shall not be constrained by the Company, the charterer or any other person from taking or executing any decision, which, in the professional judgment of the Master, is necessary to maintain the safety and security of the vessel. Nothing within this Safety Manual should be construed as limiting in any way the Master's overriding authority.* [sic]

On tender operations, section 7.14 of the SMS required that *safe speeds must be maintained at all times and all local rules adhered to i.e. speed limits and no-go areas*. It did not state criteria for the use of the tender by crew for recreational purposes.

The SMS did not specify the role, responsibilities or authority of an owner's representative.

RIB *Vega*

The RIB *Vega* had an overall length of 5.60m. The boat's hull was constructed from GRP and it had dark grey inflatable rubber sponsons. *Vega*'s builder's plate stated that it was built to an RCD design category C[4] for the carriage of up to seven people. *Vega* was equipped with a 130hp outboard engine and was capable of a top speed of 38kts when new. Its steering console was equipped with a radio stereo and gauges for fuel and engine speed. When examined following the accident, no evidence was found of any navigational equipment or a fixed very high frequency radio. The boat was equipped with port and starboard navigation lights and a single all-round white light located on the aft port quarter. The all-round light was on a stanchion that extended about 40cm above the sponsons **(Figure 4)**.

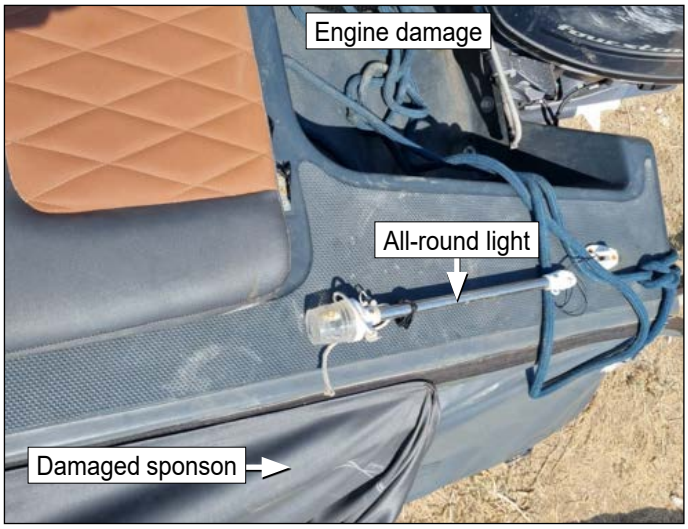

Figure 4: Damage to *Vega*'s aft port quarter

Damage noted during the inspection included:

- impact marks on the aft port quarter section of the hull and outboard motor;
- displacement of the helm seat and aft seating area; and
- the all-round light had been torn from its bracket.

The coxswain

Vega's coxswain was reported to be a 17-year-old Turkish national who was studying to qualify as a deck cadet. Local investigation indicated that the coxswain held an *amateur seaman certificate*, reportedly a Royal Yachting Association Yachtmaster Coastal certificate. The coxswain was not seriously injured in the collision.

The deceased

Vega's passenger was reported to be Güllü Torun Vasilev, a 28-year-old Turkish national who had previously been employed as a stewardess on vessels in the Göcek region. Güllü was reported to have worked for the company that operated *Vega* and was known to the coxswain.

[4] Designed for a wind of up to force 6 and a significant wave height up to 2m.

The postmortem examination report concluded that the cause of Güllü's death was the *combined effects of traumatic rib fractures, hemopneumothorax*[5] *from lung injury, focal brain hemorrhage, and drowning* [sic]. Toxicology was negative for alcohol and illegal substances.

Göcek

Göcek is a town in the north-east of the Gulf of Fethiye, on the southern coast of Turkey. The port area is at the northern end of a bay with the island of Göcek Adası at its entrance. The port had seven marinas and was busy with tenders ferrying passengers and crew to and from the shore throughout the day. Vessels transiting to the western marinas would skirt the headland to the west of the bay. The waters of the port were congested during the summer months.

At night, the lights of moored boats and buildings surrounding the bay, boats moored on the island of Göcek Adası, and at anchor, presented a background of light sources. Moving vessels would need to be noticeable against this backdrop.

The Göcek Port Authority had overall responsibility for the inner harbour area. On 24 July 2024, three days before the accident, the port authority issued local notice to mariners 2/2024, specifying a speed limit of 10kts for this area, reducing to 6kts within the smaller bays around its periphery **(**see **Figure 1)**.

Port information was available from the port authority's website, various online yachting guides and Admiralty Sailing Directions NP49 – Mediterranean Pilot Volume 5. Charts for Göcek harbour depicted two shallow patches on the western coastline **(**see **Figure 3)**. The shallows were less than 10m deep and either contained a danger not clearly marked by its symbol (e.g. an isolated rock) or outlined an area with numerous dangers, making navigation unsafe.

International Safety Management Code

The International Safety Management (ISM) Code applied to vessels that were required to comply with the International Convention for the Safety of Life at Sea (SOLAS),1974 as amended[6]. Section 5 of the ISM Code required the company to clearly define the master's responsibilities and ensure that the SMS contained a clear statement emphasising the master's authority, establishing that the master had the overriding authority and the responsibility to make decisions with respect to safety. The Gibraltar Yacht Registry required *Isabell* to comply with the requirements of the ISM Code.

Convention on the International Regulations for Preventing Collisions at Sea

The Convention on the International Regulations for Preventing Collisions at Sea, 1972 (IRPCS, also referred to as the COLREGs), as amended, applied to *all vessels upon the high seas and in all waters connected therewith navigable by seagoing vessels*. The rules therefore applied to both the tender and *Vega* as *power-driven vessels underway*. The IRPCS specified the navigation rules to be followed by vessels to prevent collisions, including:

Rule 5 (look-out)

> *Every vessel shall at all times maintain a proper look-out by sight and hearing as well as by all available means appropriate in the prevailing circumstances and conditions so as to make a full appraisal of the situation and of the risk of collision.*

Rule 6 (safe speed)

> *Every vessel shall at all times proceed at a safe speed so that she can take proper and effective action to avoid collision and be stopped within a distance appropriate to the prevailing circumstances and conditions.*

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[5] When the lungs collapse due to the accumulation of air and blood in the area between the lungs and chest wall.

[6] Cargo ships of 500gt or more and passenger ships on international voyages.

In determining a safe speed the following factors shall be among those taken into account:

(a) By all vessels:

(i) the state of visibility;

(ii) the traffic density including concentrations of fishing vessels or any other vessels;

(iii) the manoeuvrability of the vessel with special reference to stopping distance and turning ability in the prevailing conditions;

(iv) at night the presence of background light such as from shore lights or from back scatter of her own lights;

(v) the state of wind, sea and current, and the proximity of navigational hazards;

(vi) the draught in relation to the available depth of water.

Rule 23 (power-driven vessels underway) specified the lights and shapes to be shown by each vessel.

Effects of alcohol

The key effects of the consumption of alcohol on a person can include reduced peripheral vision; poor night vision; affected cognitive ability; a deterioration in judgement; and significantly slower reaction times.

Night vision

It takes time for humans to develop effective night vision when moving from a well-lit environment. The cone cells in the retina of the eye (responsible for colour vision and visual acuity in brighter light) can adapt within a few minutes but the rod cells (responsible for vision in low light) can take up to 20 minutes to adapt to dim light[7]. Alcohol consumption can negatively affect the generation of the protein rhodopsin, which is essential for the effective function of rod cells[8].

ANALYSIS

Aim

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

The accident

The tender collided with the drifting *Vega* because neither the owner's representative nor the *Isabell*'s master saw the RIB in sufficient time to take avoiding action.

The owner's representative had altered the tender's course when alerted by *Gozden-1*'s owner, indicating that some form of lookout was being maintained as required by Rule 5 of the IRPCS.

[7] Lee, J. D., Wickens, C. D., Liu, Y. and Boyle, L. N. G. (2017). *Designing for People: An Introduction to Human Factors Engineering* (3rd edition). CreateSpace Independent Publishing Platform.

[8] Mitchell,D.C., Lawrence, J.T., Litman, B.J. (1996). *Primary alcohols modulate the activation of the G protein-coupled receptor rhodopsin by a lipid-mediated mechanism*. J Biol Chem, 9 Aug 1996; 271(32):19033-6.

When the tender struck *Vega*, its speed was sufficient for the larger vessel to ride up and over the RIB's aft section. The impact, combined with the stopping of the engine, brought the tender to an abrupt halt. It was fortunate that the occupants of the tender were uninjured considering the force of impact and sudden deceleration.

The postmortem report for *Vega*'s passenger confirmed that she died as a result of the combination of the serious injuries sustained in the collision and through drowning as a result of being pinned underwater by the weight of the tender.

The conduct of the tender's passage by the owner's representative

The tender collided with RIB *Vega* 1 minute 30 seconds after leaving *Isabell*. For the first minute the tender proceeded slowly, at speeds up to 8kts, and for the next 30 seconds it proceeded at about 28kts until striking *Vega*. The RIB's dark grey hull, stationary in the water and showing a single all-round light that could have been obscured by background lights from other vessels anchored to seaward, would have been difficult to see under the best of circumstances. It is therefore unsurprising that the owner's representative helming the tender, whose eyes would still have been developing their night vision, did not see *Vega* before the impact. That the helm's night vision was impaired is also evidenced by them not detecting the gulet, *Gozden-1*, whose owner had to shine a bright light directly towards the tender to draw attention to its presence.

The tender's passage from *Isabell* to the restaurant relied on the owner's representative's local knowledge of the area and no attempt had been made to use the chart plotter to avoid navigation hazards or to keep the tender on track. Navigating by eye at night using local knowledge is more challenging than during daytime, but the owner's representative did not monitor the tender's progress on the chart plotter and post-accident analysis shows that the tender crossed two shallow patches close to the shore before the collision. The lack of planning and assessment of the navigational risks associated with making the passage to the restaurant in the dark put the tender, its occupants, and other water users at risk. To attempt the passage without making best use of the navigational aids available increased the risk of an accident occurring.

The investigation was unable to positively determine that the owner's representative was affected by alcohol, though the alcohol they consumed during the evening and their reported breath alcohol level obtained 5 hours after the accident indicates this might have been the case. Their diminished peripheral and night vision, deterioration in judgement and slowed reaction times were all consistent with impairment due to alcohol consumption.

RIB *Vega*

Vega's coxswain was appropriately qualified and familiar with operating in the local area. However, the reasons for switching off the sidelights required by the IRPCS and for stopping the vessel in the position they did could not be determined. Regardless of the reason, the decision to stop and drift in an area of the port routinely used by transiting vessels did pose a degree of risk to the vessel.

The IRPCS placed a responsibility on all vessels to act to avoid a collision. *Vega* was drifting, so able to manoeuvre out of the way given sufficient time for the coxswain to start and engage the engine.

The approaching tender was well-lit, and the warning light shone at the tender by *Gozden-1*'s skipper provided a limited opportunity to alert those on *Vega* to the presence of the tender. However, had the tender been sighted by the coxswain of *Vega* before this warning, its change of bearing would have indicated that the tender was going to pass clear and therefore did not pose an immediate risk.

It is unclear when the coxswain first detected the fast-approaching tender but it is evident that, in the few seconds available between the tender altering course directly towards *Vega* and the collision, they were unable to take action to avoid the accident.

The coxswain's movement forward to start the engine in the seconds before the collision probably prevented them from being seriously injured.

Master's authority

When the owner's representative decided to use the tender for the recreational visit to the restaurant, the master did not challenge that plan and there was no evidence that the master considered using their authority to prevent the use of the tender from *Isabell* that evening.

The SMS clearly stated that the master had overriding authority in line with the ISM Code, but did not define the role of an owner's representative. Further, while the SMS identified that alcohol consumption by crew members had implications for the safety of the vessel, these requirements had not migrated to any use of the tender by the crew for recreational purposes.

The owner's representative had signed the master's letter of authority but they had also been appointed as *Isabell*'s senior captain by the chair of the owning company. Consequently, it was unclear who held ultimate authority when the owner's representative was on board *Isabell*. However, given that the owner's representative had appointed the master, it is likely that the master deferred to their authority. The master was new to the company and unfamiliar with the Göcek area whereas the owner's representative, being a local resident, had extensive knowledge of the area and its facilities. It is also possible that the owner's representative's willingness to navigate the tender at speed in the dark gave the master a misguided confidence that the voyage would be conducted safely.

The master's deference, combined with the owner's representative's confidence in a familiar location, undermined the incumbent master's overriding authority to prevent the ill-conceived activity before it started.

Regulation

Clearly defined speed limits imposed for both commercial and recreational vessels were promulgated through local notices and port guides within Göcek Port Authority's area of responsibility.

The notice to mariners issued by the port authority three days before the accident showed that the need to control vessel speed within the inner harbour area had been recognised and action initiated. However, in the limited time between the issue of the notice and the accident the enforcement actions taken by the port had not been sufficient to prevent the high-speed passage of the tender.

The IRPCS clearly defined requirements for maintaining a lookout, displaying the correct navigation lights and proceeding at a safe speed. The operation of the tender, and to an extent that of *Vega*, were outside the requirements of the IRPCS and placed the occupants of both vessels and other port users at serious risk.

CONCLUSIONS

- Güllü Torun Vasilev died as a result of the collision between the tender to *Isabell Princess of the Sea* and RIB *Vega*, through the serious injuries sustained in the collision and drowning as a result of being trapped underwater.
- The tender to *Isabell Princess of the Sea* was proceeding at an unsafe speed that reduced the time available for the detection of *Vega*.
- At the time of the accident, *Vega* was lit only by a single all-round white light, as required by the IRPCS, that was possibly obscured or inconspicuous against the background lights immediately before the collision.
- Given the speed at the point of impact it was fortunate that other people were not injured in the collision, including those on board the tender.
- The responsibilities and authority of the owner's representative was not adequately defined in the SMS, making the master's authority difficult to impose.

- The tender to *Isabell Princess of the Sea*'s passage was unplanned, conducted at a speed in excess of the harbour speed limit in place, and in close proximity to underwater hazards. Its conduct posed a danger to the people on board the tender and on other vessels in the bay.
- The recent implementation of local speed restrictions in the port of Göcek was ineffective in preventing the high-speed collision.
- Consumption of alcohol might have affected the ability of those on board the tender to *Isabell Princess of the Sea* to safely operate the vessel.

ACTIONS TAKEN

Göcek Port Authority actions

On 9 August 2024, Göcek Port Authority announced its intention to enforce an inspection regime to ensure that vessels operating within the port area, both privately owned and commercial, show navigation lights that comply with the IRPCS.

Fraser Worldwide S.A.M. actions

In consultation with the Gibraltar Maritime Authority, Fraser Worldwide S.A.M. has updated its SMS to set out its policy for the use of tenders at night.

IFZA Ltd actions

In consultation with the Gibraltar Maritime Authority, IFZA Ltd has amended the format of the letters of authority used to define the responsibility and authority of the master on board *Isabell Princess of the Sea*.

RECOMMENDATIONS

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

VESSEL PARTICULARS		
Vessel's name	Tender to *Isabell Princess of the Sea*	*Vega*
Flag	Gibraltar	Turkey
Classification society	Not applicable	Not applicable
IMO number/fishing numbers	Not applicable	Not applicable
Type	Motorboat	Rigid inflatable boat
Registered owner	IFZA Limited	Privately owned
Manager(s)	IFZA Limited	Not applicable
Year of build	Unknown	Unknown
Construction	Glass reinforced plastic	Glass reinforced plastic
Length overall	7.35m	5.60m
Registered length	Not applicable	Not applicable
Gross tonnage	2	Not applicable
Minimum safe manning	Not applicable	Not applicable
Authorised cargo	Not applicable	Not applicable

VOYAGE PARTICULARS		
Port of departure	Göcek, Turkey	
Port of arrival	Göcek, Turkey	
Type of voyage	Coastal	
Cargo information	Not applicable	
Manning	2	1

MARINE CASUALTY INFORMATION		
Date and time	27 July 2024 at 2252:30	
Type of marine casualty or incident	Very Serious Marine Casualty	
Location of incident	Göcek, Turkey	
Place on board	Bow	Stern
Injuries/fatalities	None	1 fatality
Damage/environmental impact	Minor scuffs to hull	Burst buoyancy chamber, displaced seating, detached all-round light
Vessel operation	Recreational	Recreational
Voyage segment	Mid-water	Mid-water
External & internal environment	Light winds; rippled seas; dark and overcast; air and sea temperatures 26°C	
Persons on board	4	2