MAIB
MARINE ACCIDENT INVESTIGATION BRANCH

ACCIDENT REPORT

VERY SERIOUS MARINE CASUALTY | REPORT NO 1/2025 | JANUARY 2025

Fatality of the chief engineer on board the motor yacht *Baton Rouge* at Falmouth Harbour, Antigua on 23 February 2024

BACKGROUND

This investigation into a very serious marine casualty was conducted by the Marine Accident Investigation Branch on behalf of the Isle of Man Ship Registry, a member of the Red Ensign Group.

SUMMARY

Image courtesy of Nigel Burgess Limited

Baton Rouge

On the morning of 23 February 2024, the chief engineer on the Isle of Man registered motor yacht *Baton Rouge* was electrocuted while working on the vessel's engine room ventilation system. The chief engineer was replacing a damper actuator, which was situated in a ventilation overpressure duct compartment. Despite efforts to resuscitate him the chief engineer's heart could not be restarted, and he was pronounced dead later that morning.

The investigation found that the chief engineer commenced the actuator replacement without isolating the electric supply and without a permit to work for electrical maintenance in place. This was likely because he had rationalised the risk and wanted to avoid the limitations of restricting the vessel to emergency power.

It was also found that the location of the overpressure duct compartment and the means of access to it met the definition of an enclosed space in industry guidance. However, the definition in the onboard safety management system was not aligned to this and instead focused on toxic atmospheres. As a result, the crew did not consider the overpressure duct compartment to be an enclosed space and did not follow enclosed space working and entry procedures.

Since the accident the yacht's manager, Nigel Burgess Limited, has updated its permit to work guidance for electrical systems; revised the enclosed space definition in the safety management systems of vessels under its management; and promulgated fleet guidance on the changes to the enclosed space definition, permits to work and the need for on board risk controls, training and drills.

In view of the actions taken, no recommendations have been made in this report.

This investigation was carried out by the UK Marine Accident Investigation Branch (MAIB) on behalf of the Isle of Man Administration 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 Isle of Man Merchant Shipping (Accident Reporting and Investigation) Regulations 2001 – Regulation 4:

"The fundamental purpose of investigating a casualty, an accident, or an incident under these Regulations is to determine its circumstances and the causes with the aim of improving the safety of life at sea and the avoidance of accidents in the future. It is not the purpose to apportion liability, nor, except so far as is necessary to achieve the fundamental purpose, to apportion blame."

NOTE
Under Section 4 of the Isle of Man Merchant Shipping Act 1985 a person is required to answer an Inspector's questions truthfully. If the contents of this report were subsequently submitted as evidence in court proceedings then this would contradict the principle that a person cannot be required to give evidence against themselves. Therefore, the Isle of Man Ship Registry makes this report available to interested parties on the understanding that it shall be inadmissible in any judicial proceedings whose purpose, or one of whose purposes is to attribute or apportion liability or blame.

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FACTUAL INFORMATION

Events before the accident

At around 2100[1] on 22 February 2024, *Baton Rouge* lost electrical power. When the power had been restored, an engine room ventilation damper located in the starboard ventilation overpressure duct compartment **(Figure 1)** failed to reset and remained closed. The compartment containing the starboard ventilation overpressure duct was accessed via a bolted hatch cover in a storage locker on the bridge deck.

Images courtesy of Nigel Burgess Limited

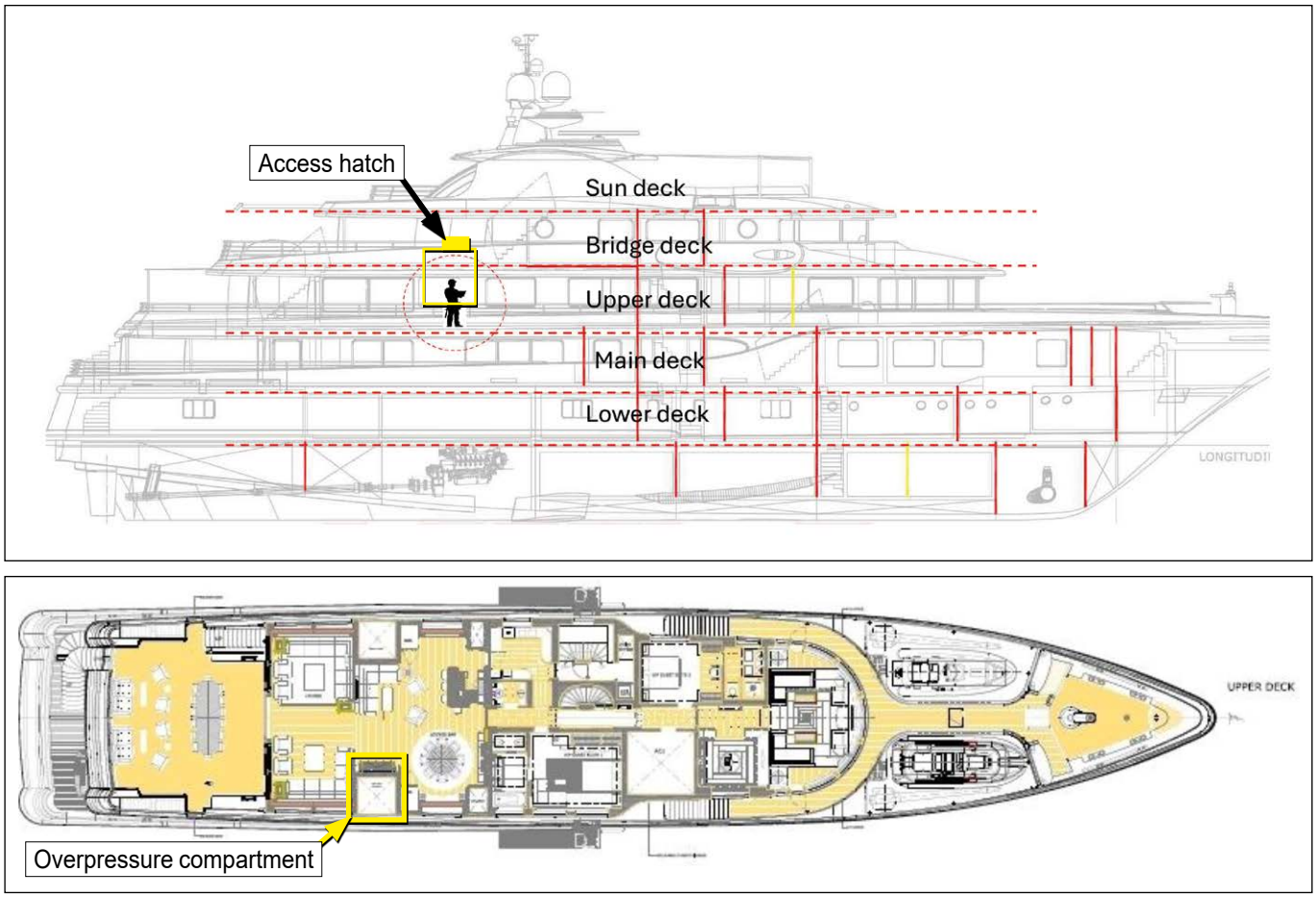

Figure 1: Location of overpressure compartment on upper deck

At approximately 2200, the chief engineer (C/E), assisted by the second engineer (2/E), removed the bolted hatch cover **(Figure 2)** and the C/E entered the overpressure duct compartment to inspect the failed ventilation damper. No permit to work (PTW) was issued for this task.

The C/E removed the failed actuating mechanism and opened the damper, leaving the actuating mechanism connected to the 230-volt alternating current (VAC) electrical power supply **(Figure 3)**. The C/E then exited the overpressure duct compartment, leaving the hatch cover off to allow for airflow through the duct. The C/E and master discussed the repair and decided the work would be continued the following day.

[1] All times used in this report are UTC-4 unless otherwise stated.

Figure 2: Access to overpressure duct compartment

Image courtesy of Nigel Burgess Limited

Figure 3: Removed damper actuator and junction box showing the wiring

The accident

At 0700 on 23 February 2024, the C/E and the master discussed the repair task. The ambient temperature inside the overpressure duct compartment was 50°C to 55°C so, to reduce the risk of heat exhaustion, the master and C/E agreed that the C/E would limit his time inside to 10 minutes followed by a period for rehydration. This was to be monitored by the chief officer (C/O) from the bridge deck. The C/E agreed to inform the C/O via ultrahigh frequency (UHF) radio each time he wished to enter the overpressure duct compartment. The master understood that the task could be completed with the vessel's main generators running. No PTW was issued for entering the overpressure duct compartment or for disconnecting and replacing the electrical wiring for the actuator.

Before starting work the C/E assigned several engine room-based tasks to the 2/E. These tasks did not include helping with the repair work, which the C/E had elected to complete without assistance. At 0723, the C/E went to the engine room to gather tools and replacement parts. At 0734, the C/E entered the overpressure duct compartment for the first time that day, having first informed the C/O via the UHF radio. Between 0734 and 0848, the C/E made three return trips from the overpressure duct compartment to the engine room for additional equipment. He informed the C/O via the UHF radio each time, and took rehydration breaks. For the first three entries the C/O remained on the bridge deck while the C/E was in the space, periodically checking on him. In between entries the C/O worked in their office. At some point after 0848, the C/E entered the overpressure duct compartment for a final time and continued the work with the actuator wiring on the open electrical junction box **(Figure 4)**. Post-accident analysis of the closed-circuit television (CCTV) showed that he was visibly hot and sweaty as he approached the bridge deck.

At 0856, a series of engine room ventilation system alarms were activated on the machinery monitoring system. The 2/E, who was completing tasks in the engine room, observed the alarms and ran to the overpressure duct compartment entrance to inform the C/E. When the 2/E arrived at the entrance they saw the C/E slumped over the ventilation trunking in the space. The 2/E shouted to the C/E but received no response so ran to the crew mess to raise the alarm. At 0858, the alarm was raised via the UHF radio and the C/O immediately ran from their office to the overpressure duct compartment and climbed down the ladder to reach the C/E. The C/O received an electric shock from the C/E when they touched him.

Image courtesy of Nigel Burgess Limited

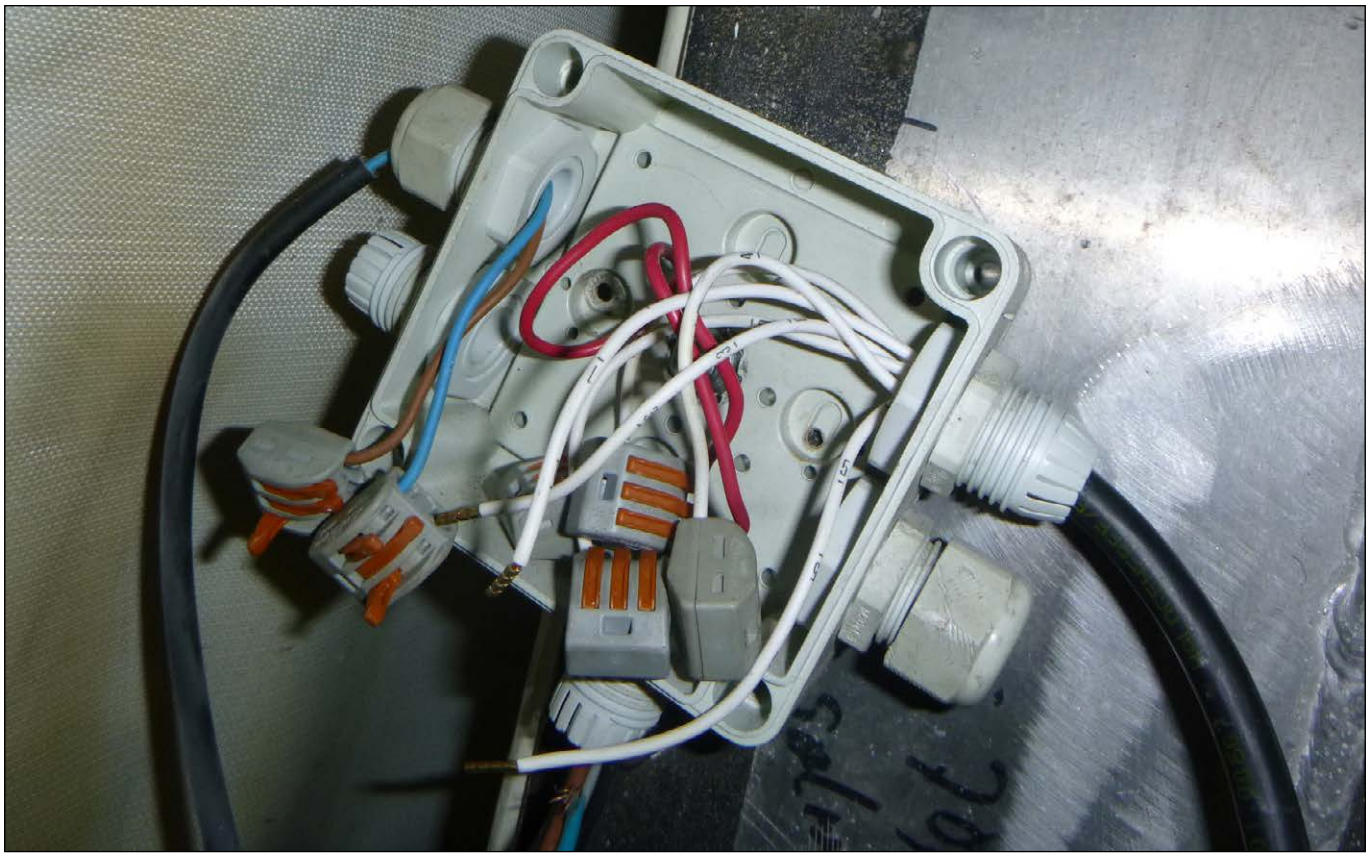

Figure 4: Junction box

The rescue

On deck the crew responded to the emergency call and began preparations to rescue the C/E. In the overpressure duct compartment, the C/O assessed that the C/E had suffered a cardiac arrest and attempted to carry out cardiopulmonary resuscitation (CPR). The master alerted the marina harbour authorities to the situation via the bridge UHF radio. At 0902, Antigua and Barbuda Search and Rescue (ABSAR) was called. After several unsuccessful attempts to extract the C/E from the overpressure duct compartment, the crew of *Baton Rouge* eventually succeeded in removing him by using an endless sling around his chest and supporting his legs while hauling him from above. The C/E was laid on the bridge deck, where the crew continued CPR. At 0910, ABSAR paramedics arrived on *Baton Rouge* and took over the C/E's care. At 0952, an ambulance arrived and transferred the C/E to a local hospital accompanied by the C/O. The C/E was declared deceased at 1019.

Postmortem report

The pathologist's postmortem report noted that the C/E had a full thickness burn[2] to his right hand and a second partial thickness burn[3] on his left upper arm in the region of the elbow. The C/E's cause of death was recorded as hypoxia[4] with petechial haemorrhage[5], and full and partial thickness burns.

Post-accident actions and findings

Following the accident the scene was photographed before the engine room ventilation system was restored. The images showed an open junction box with various wires disconnected from the terminal block **(Figure 4)**. The 230VAC feed wire was completely removed from the junction box and was lying on the deck. The exposed live and neutral conductors were melted together and showed signs of burning **(Figure 5)**. The replacement actuator mechanism had been fitted to the ventilation dampers but not connected to the electrical circuit.

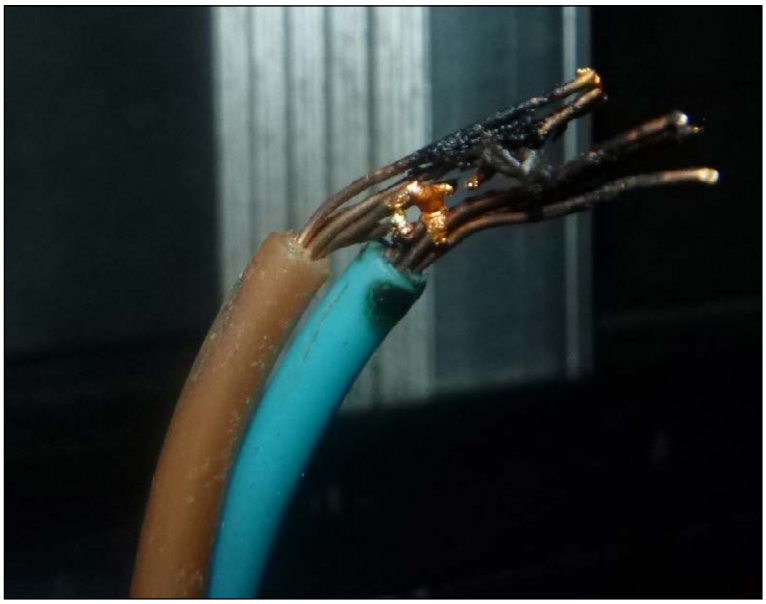

Figure 5: Exposed live wires

The electric circuit breaker for the power was in the *on* position. The electric circuit uninterruptible power supply (UPS) was subsequently found to be defective and replaced.

On 24 February, a relief C/E arrived on board *Baton Rouge*. In discussion with the master and other stakeholders, the relief C/E decided to complete the task of replacing the failed actuator and connect it to the power supply.

On 28 February, work started to complete the replacement of the ventilation damper. A PTW was issued for replacing the actuator mechanism and working on electrical equipment. The PTW stated that the overpressure duct compartment was not considered an enclosed space and that the primary hazards were high ambient temperature and compromised wiring circuits. Before isolating the electrical circuit in line with the PTW, the main generators were shutdown to prevent the diesel engines becoming starved of air when the ventilation dampers closed as electrical power was lost.

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[2] A severe burn injury, also known as a third-degree burn, where all three layers of skin, underlying fatty tissue, nerves and tendons are damaged.

[3] A second-degree burn, also known as a deep dermal burn, where two layers of skin are damaged.

[4] Lack of oxygen supply.

[5] Ruptured tiny blood vessels (capillaries).

The associated risks with completing the task were identified and mitigations were put in place. These included:

- posting a sentry at the hatch entrance;
- having rescue and medical kits to hand;
- independent monitoring of the actions taken; and
- an agreed rescue and action plan in case of unexpected events.

The vessel

Baton Rouge was an Isle of Man registered commercial yacht with capacity for 12 guests. It was certified under the Red Ensign Group Yacht Code Part A, January 2019 Edition. The vessel was crewed and managed by Nigel Burgess Limited (Burgess), which managed over 100 yachts globally. At the time of the accident *Baton Rouge* was berthed alongside at Falmouth Harbour marina, Antigua with 17 crew and no guests on board.

Engine room ventilation system

Baton Rouge's engine room ventilation was provided by a forced supply and exhaust system that maintained a positive pressure within the engine room space. Excess pressure was vented into the ventilation overpressure duct compartments via pressure regulating valves. There were two duct compartments, one on each side of the engine room. The ventilation fans automatically adjusted the flow of air to counteract the effect of running machinery.

The ventilation ducting was fitted with automatic dampers that closed in the event of an engine room fire. The dampers operated in fail-safe shut mode and would close in the event of a loss of power supply to the operating actuators. Electrical power had to be supplied to the damper actuators to maintain the dampers in the open position. The power to the circuit was supplied from the emergency generator switchboard. A UPS was fitted to the electric circuit to prevent the dampers closing in the event of a loss of power supply.

The overpressure duct compartment was approximately 1.74m wide x 1.78m long x 2.12m high. The compartment's bolted hatch cover was located inside a locker behind a bar **(Figure 2)** on the bridge deck. A vertical ladder led down to a platform in the compartment. The overpressure duct compartment contained ventilation trunkings, exhaust uptake pipe work and ventilation fans. The exhaust air from the engine room flowed through the duct and was vented to the atmosphere via a shipside louvre in the compartment. There was no fixed lighting in the duct compartment.

Crew

Baton Rouge's crew held appropriate qualifications for their role and had completed familiarisation training that included knowledge of safe working practices.

The C/E, Roy Temme, was 47 years old and was employed by Burgess Crew Services, a subsidiary of Burgess. He had served on *Baton Rouge* since June 2022 and had rejoined the vessel on 6 January 2024. He held an STCW[6] III/2 Chief Engineer certificate of competency. On 8 March 2022, he had been issued with a medical certificate that stated he was medically fit and did not require any prescription medication.

Onboard safety management

Baton Rouge's safety management system (SMS) included policy statements, personnel responsibilities, resources and procedures for shipboard operations and emergencies. The onboard documentation stated the purpose of risk assessments and provided guidance for their completion. The combined risk assessments and standard operational procedures (RASOP) included enclosed space entry and working on electrical equipment. The vessel's SMS referenced the Maritime and Coastguard Agency

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

(MCA) Code of Safe Working Practices for Merchant Seafarers (COSWP) 2015 edition[7], which had been recommended by the Isle of Man Ship Registry as a guide to safe working practices. The SMS required PTW to be issued for enclosed space entries and for electrical maintenance and repair, and they were to be authorised by either the C/O or C/E.

The SMS risk assessment for the maintenance or repair of electrical equipment identified the hazard of injury due to electric shock and used a PTW to mitigate the risk. The risk assessment required that *equipment was to be isolated and labelled as per tag out procedure*. [sic]

The associated PTW checklist stated that:

> *Work on or near live equipment should be avoided if possible. When it is essential for the safety of the ship, or for testing purposes the precautions in COSWP 20.13.10 should be followed.*

The SMS document for enclosed space entry defined a *dangerous (enclosed) space* as:

> *Any enclosed or confined space in which it is foreseeable that the atmosphere may at some stage contain toxic or flammable gases or vapours, or be deficient in oxygen, to the extent that it may endanger the life or health of any person entering that space.* [sic]

This definition was taken from Chapter 11 of the COSWP, Safe Movement On Board Ship.

The document also detailed the procedures to be adopted when entering an enclosed space and referred to Chapter 15 of the COSWP, Entering Enclosed Spaces, and the MCA leaflet Enclosed Spaces – Guidance for merchant vessel operators[8].

The RASOP for enclosed space entry listed all the identified enclosed spaces on board *Baton Rouge*; the list did not include the overpressure duct compartments. The RASOP listed eleven hazards associated with enclosed space entry, including excessive heat and an unconscious person requiring rescue.

Regulation and guidance

On working on electrical equipment, section 20.13.1 of the COSWP referred to the risks of electric shock being much greater on ships than normally ashore because *moisture, high humidity and high temperature (including sweating) reduce the contact resistance of the body* and that, *in those conditions, severe and even fatal shocks may be caused at voltages of 60V or lower*. The COSWP stated that the energy source should be properly isolated before any electrical work was carried out and that additional precautions were required if work on live equipment could not be avoided for essential safety and testing purposes. These included:

- having an electrically competent second person continually in attendance;
- adopting a safe and secure working position;
- wearing insulated gloves if practical; and
- avoiding contact with the deck and other bare metal.

The COSWP highlighted that hand-to-hand shocks were particularly dangerous and also recommended the use of a dry insulating mat at all times.

[7] Amendment 7, October 2022.

[8] Link via https://www.gov.uk/guidance/enclosed-spaces-on-sea-going-vessels

Both the MCA guidance leaflet and Chapter 15.1 of the COSWP defined an enclosed space as:

> *…one that is not designed for continuous worker occupancy and has either or both of the following characteristics:*
>
> - *limited openings for entry and exit;*
> - *inadequate ventilation.*

Chapter 15 of the COSWP further referenced The Merchant Shipping and Fishing Vessels (Entry into Enclosed Spaces) Regulations 2022, which defined an enclosed space in the same way. The Chapter 15 definition also aligned with the definition in the Red Ensign Group Yacht Code Part A, Annex C, which referenced International Maritime Organization (IMO) Resolution A.1050(27) – Revised Recommendations for Entering Enclosed Spaces Aboard Ships.

ANALYSIS

The accident

Baton Rouge's C/E was electrocuted when he came into contact with a live electrical circuit while repairing a failed ventilation damper. His hot and sweaty condition provided good conductivity and the electricity likely passed through his heart, causing it to stop. Despite CPR efforts on board by the vessel's crew and attending paramedics the C/E's heart could not be restarted and he died from the resultant hypoxia.

Actuator failure

The UPS was designed to prevent the ventilation dampers closing during a loss of power. However, in this case the UPS failed to prevent the damper closing when the blackout occurred. When the power was restored, the failed actuator prevented the damper from opening, necessitating the replacement attempted by the C/E. The causes of the actuator and UPS failures could not be determined as both had been replaced following the accident and before the investigators were able to attend.

Electrocution

Working on live equipment presented a risk of electrocution that had been identified in the vessel's SMS risk assessment, which stated that power supplies were to be isolated before starting electrical work. The C/E did not adopt any of the additional precautions detailed in the COSWP to cover the circumstances when work on live electrical equipment could not be avoided. It cannot be known why the C/E started work without isolating the electrical circuits or taking any of the additional COSWP precautions for working on live electrical equipment. It is possible that he was trying to save time and effort despite the risk.

Isolating the damper actuator circuit involved shutting down the main generators and running on emergency power until the job was completed. This meant that hotel services and air conditioning systems could not operate while the repair was in progress. The desire to avoid shutting down the hotel services and ventilation, and that the voltage was only 230VAC, the same as UK domestic voltage, possibly led the C/E to rationalise the job as being low risk.

There were no witnesses to how the C/E came to be slumped over the ventilation trunking in the overpressure duct compartment. However, his injuries were consistent with him coming into contact with 230VAC and the burns indicated the entry and exit points of the current as it flowed through his body to earth. The length of time that the C/E was in contact with the live supply can be estimated as a period of several minutes: from the point when the engine room ventilation alarms activated to the point when the C/O received an electric shock upon touching the C/E. Given the level of voltage and the time the C/E would have been in contact with it, this most likely caused the fatal cardiac arrest.

It cannot be known how the C/E initially touched the live conductors. It is possible that the C/E became disorientated or suffered a medical event while attempting to disconnect the wiring circuit in the high ambient temperatures. The last CCTV image of the C/E indicated that he was hot and sweaty, which likely improved the conductivity of the voltage flowing through his body to earth.

Enclosed space working

Baton Rouge's SMS included a definition of an enclosed space from the COSWP Chapter 11 (Safe Movement On Board Ship) rather than from Chapter 15 (Enclosed Space Entry). The two definitions did not align and the definition in Chapter 11 was contrary to UK legislation and the IMO definition of an enclosed space. However, the hatch was accessed via a cramped locker and the overpressure duct compartment was not designed for continuous worker occupancy. These conditions clearly matched the enclosed space definitions in the COSWP Chapter 15 and the Red Ensign Group Yacht Code Part A. Additionally, a high ambient temperature inside the overpressure duct was a foreseeable identified hazard.

The COSWP Chapter 11 enclosed space definition, and by extension *Baton Rouge*'s SMS, was written in a way that led the reader to understand that enclosed space procedures only applied to spaces with toxic or oxygen deficient atmospheres. The SMS therefore failed to describe an enclosed space as one with limited access and not normally designed for continuous occupation by a worker. The associated RASOP for enclosed space entry identified the enclosed spaces on board *Baton Rouge*, though the list did not include the overpressure duct compartments. This combined with the description of an enclosed space in the SMS probably led the crew to believe that enclosed space procedures could be disapplied.

As the Chapter 11 definition reproduced in the SMS was heavily focused towards potentially dangerous atmospheres, it is possible that the crew believed the airflow through the duct space removed the need to treat it as an enclosed space. Consequently, additional precautionary measures such as posting a sentry at the entrance, a plan to rescue a person from the overpressure duct compartment, and other actions in line with RASOP were not implemented. The C/O monitored the C/E's first three entries into the space but did not stay in continuous visual contact with him. Additionally, the monitoring arrangements relied on the C/E to inform the C/O that he wanted to enter the space and, as such, did not amount to a dedicated sentry controlling access to the space and directly monitoring the C/E. This meant that no immediate assistance, agreed rescue and action plan or equipment was available when the accident happened, which delayed the C/E's recovery from the overpressure duct compartment.

Permit to work

The use of a PTW is an integral part of safety management and Baton Rouge's SMS required one to be raised when conducting electrical maintenance and repair. The purpose of a PTW is to identify the major risks associated with a particular job or task and provide instructions on how those risks can be minimised. The process of putting a PTW in place acts as a natural pause before starting a job and helps to ensure hazards have been considered and mitigated in advance.

The principal hazards associated with the planned work to replace the actuator were: the enclosed space, the electrical hazards, and the hot environment. Despite this there were no PTW in place for the work, and only the temperature had been recognised as a hazard and ad hoc mitigations put in place. Without any PTW there was neither a hazard identification checklist nor authorising officer to verify that all necessary precautions had been taken to mitigate risk or to ensure adherence with such measures. This meant that an opportunity was missed to make certain that the work could be completed safely.

Neither the master nor the C/O, as PTW authorising officers, challenged the C/E's decision to proceed without issuing any PTW. For the electrical systems work the master and the C/O might not have challenged the C/E simply because they deferred to him as the perceived authority on engineering matters. In the case of enclosed space entry, the master's and C/O's lack of challenge might have been because the SMS did not include the overpressure duct compartment on its list of enclosed spaces. The SMS defined an enclosed space as one having a toxic or oxygen deficient atmosphere and the crew

therefore reasoned that the overpressure duct compartment was not an enclosed space as there was a continuous flow of fresh air through it. As a result, a PTW was not issued and additional measures associated with enclosed space entry were not put in place.

Without any PTW there was no assurance that the hazards involved in the work had been considered and the risk of injury to the C/E had not been fully mitigated. A fully operational ventilation system was critical to both the running and protection of machinery in the event of a fire in the engine room. It is possible that this consideration contributed to the urgency of completing the task and informed the actions of those involved.

The subsequent repair

The task to complete the fitting of the damper actuator was planned by the relief C/E and the associated hazards were identified. However, although many of the enclosed space hazard mitigation measures were put in place, the overpressure duct compartment was still not considered an enclosed space for the purpose of entry by the yacht's crew. This indicated that the crew were relying strictly on the SMS definition of an enclosed space rather than considering reference documentation or assessing the space based on the hazards present. Although a PTW was issued and the risk mitigation measures were enacted and effective, it appears that the crew's identification of an enclosed space was entirely based on compliance with the list of identified enclosed spaces on board *Baton Rouge* and the vessel's SMS definition derived from the incorrect chapter of the COSWP.

CONCLUSIONS

- The C/E was electrocuted because he came into contact with live 230VAC conductors while working on the ventilation damper electric circuit. The reason why the C/E came into contact with the live conductors is unknown.
- The PTW system was not used to identify the hazards associated with the repair task and put measures in place to mitigate them, meaning that the risk of injury to the C/E was not fully addressed before the work began. This was likely because the crew did not recognise the work area as an enclosed space and there was a lack of challenge from authorising officers.
- The C/E had probably chosen to work on the live circuit to avoid the limitations of restricting the vessel to emergency power. In doing so it is possible that he rationalised that the level of risk from the non-isolated circuit was small.
- The C/E was a lone worker in the space. The monitoring arrangements in place did not amount to a dedicated sentry. No one observed the C/E's final entry to the space, and immediate action could not be taken when he came into contact with the live conductors.
- No rescue plan had been put in place to recover a person from the overpressure duct compartment.
- The vessel's SMS incorrectly defined criteria for an enclosed space based on Chapter 11 of the COSWP rather than Chapter 15. This contributed to *Baton Rouge*'s overpressure duct compartment not being considered an enclosed space by the vessel's crew.
- Chapters 11 and 15 of the COSWP contained different definitions for an enclosed space. The Chapter 11 definition focused on toxic atmospheres and was contrary to that in the underpinning UK Regulations, the Red Ensign Group Yacht Code Part A and the IMO Resolution.

ACTION TAKEN

MAIB actions

The MAIB has written to the MCA to highlight the contradiction between the enclosed space definitions within Chapters 11 and 15 of the COSWP, requesting that this discrepancy is reviewed during the next revision phase of the Code.

Actions taken by other organisations

Nigel Burgess Limited has:

- Amended its PTW for electrical work to provide greater emphasis on: the elevated risk of electrical shock on board ships; the necessary precautions to be taken before working on electrical equipment; and the need to avoid working on live electrical systems wherever possible.
- Updated its safety management manual to provide clearer qualification as to when a PTW is required.
- Revised its company RASOP template to include the COSWP Chapter 15 definition of an enclosed space and to provide greater emphasis on the register of enclosed spaces.
- Directed that RASOPs across the fleet are reviewed on board to ensure that the vessel's register of enclosed spaces is correct, and instructed that these RASOPs are to be verified by the designated yacht manager.
- Promulgated a circular to its fleet to draw attention to the changes to the safety management system specifying procedures for controlling hazards associated with enclosed spaces and the PTW updates.
- Instructed Burgess internal auditors to commence a concentrated 2025 audit focus to confirm that the register of enclosed spaces reflects the COSWP Chapter 15 definition and that any entrance to an enclosed space is identified, marked, and controlled against unauthorised entry.

RECOMMENDATIONS

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

SHIP PARTICULARS	
Vessel's name	*Baton Rouge*
Flag	Isle of Man
Classification society	Lloyd's Register
IMO number	1010935
Type	Motor yacht
Registered owner	Baton Rouge Yachting Ltd
Manager	Nigel Burgess Limited
Year of build	2010
Construction	Steel
Length overall	62.0m
Registered length	52.36m
Gross tonnage	1,423
Minimum safe manning	7
Authorised cargo	Not applicable

VOYAGE PARTICULARS	
Port of departure	Falmouth, Antigua
Port of arrival	Not applicable
Type of voyage	Not applicable
Cargo information	Not applicable
Manning	17
Persons on board	17

MARINE CASUALTY INFORMATION	
Date and time	23 February 2024 at 0849
Type of marine casualty or incident	Very Serious Marine Casualty
Location of incident	Starboard overpressure duct compartment
Place on board	Machinery space
Injuries/fatalities	One fatality
Damage/environmental impact	Nil
Ship operation	Alongside
Voyage segment	Alongside
External & internal environment	Air temperature 28°C; sunny; 53°C