

# 2023

MARINE CASUALTY INVESTIGATION BOARD

## REPORT OF INCIDENTS & INVESTIGATIONS



Reporting Period 1st January to 31st December 2023

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# Chairperson's Statement



**Claire Callanan,**  
Chairperson

Dear Minister,

In accordance with the requirements of Section 21 of the Merchant Shipping (Investigation of Marine Casualties) Act 2000, I present the twenty-first Incidents & Investigations report of the Marine Casualty Investigation Board (MCIB), covering the period 1 January – 31 December 2023.

The audited accounts of the MCIB will be presented to you later in the year on completion of the annual audit by the Comptroller & Auditor General, following which, both this report and the MCIB Financial Statement will be combined to create the MCIB Annual Report 2023, for publication on the MCIB website [www.mcib.ie](http://www.mcib.ie).

## Overview of 2023

The MCIB commenced investigations into ten marine casualties in 2023, eight of which were fatal incidents. That is a very high figure given we recorded no fatalities in 2021 or 2022. Of the eight investigations that involved fatalities, three arose on fishing vessels, and five involved recreational craft, including recreational angling vessels, a recreational motor boat, and a jet ski. These figures reflect again the dangerous nature of working in the fishing industry; and in the recreational sphere, the varied and different nature of the circumstances that can lead to these sad outcomes. In fatal cases the MCIB works with An Garda Síochána and I want to thank all the Gardaí who have assisted the MCIB investigations, in particular in the last year. Each fatality is a tragedy for family and friends and the community in which each person lived. The MCIB extends its condolences to all those affected by these deaths.

A further 51 incidents were considered by the Board which involved co-operation between the MCIB and the accident investigation bodies of other states. These incidents were in general considered to be minor in nature and not warranting investigation by either the flag state or the MCIB, or, were incidents where investigations were being conducted by the flag state. Some cases required the uploading of data by Ireland onto the European Maritime Casualty Investigation Platform (EMCIP)<sup>1</sup>.

During 2023 the MCIB also assessed 32 further incidents to determine whether an investigation should be carried out, and in these cases determined that they were either minor and/or that no useful safety recommendations were likely to be forthcoming from an investigation.

The Irish Coast Guard (IRCG) are involved in very many incidents reported to the MCIB. Most of those incidents do not proceed to an investigation. This is due, in no small way, to the expert professionalism of the Coast Guard and to the other members of the Search and Rescue Services. I would like to take the opportunity to thank the IRCG for their continued co-operation with the MCIB.

The MCIB was established 25 years ago and to the end of December 2023 it has published 264 reports into incidents under its statutory remit. The Board published nine final marine casualty investigation reports and two interim reports in 2023.

At 31 December 2023 there were in total, 14 ongoing investigations, ten of which occurred in 2023, three which occurred in 2021 (one of which was published in January 2024 and involved an injury to a crewmember onboard a fishing vessel off the coast of Co. Cork) and one which occurred in 2022 (involving an incident onboard a fishing vessel in Co. Louth, which was published in February 2024). Two further reports of investigations have been published to date as of April 2024. Currently, there are in total 12 investigations ongoing, including those commenced in 2024.

Included in the MCIB investigation reports published in 2023, is a report into the investigation of a grounding of an Irish flagged general cargo vessel in the United Kingdom MCIB Report No.324 (Report of Investigation into a Marine Casualty Involving the Merchant Vessel Arklow Raider in the Bristol Channel, 25 November 2022). This resulted in Recommendations to the UK Hydrographic Office and to the Gloucester Harbour Trustees (GHT). I would like to acknowledge the co-operation and assistance from those involved in the investigation which delivered useful learnings for all. MCIB Report No.321 (Report of an Investigation into a Marine Casualty involving the vessel Simmerdim off Ardmore Pier, Co. Galway, 8 November 2022) involved a serious accident at a Galway Bay fish farm when divers were

1. The European Marine Casualty Information Platform (EMCIP) is a database and a data distribution system operated by the European Maritime Safety Agency.

crossing from the support vessel to the fish farm platform. MCIB Report No.322 (Report of an Investigation into an Incident Involving the fishing vessel An Portán Óir, Dingle Bay, Co. Kerry, 14 October 2022) involved yet another small fishing vessel accident involving potting activities where the sole occupant narrowly escaped very serious injury. While MCIB Report No.319 (Report of an Investigation into the Sinking of FV Anna Louise near Glengarriff Harbour, Bantry Bay, Co. Cork, 2 July 2022) also involved the loss of a small fishing vessel on a potting expedition, where again, the sole operator succeeded in swimming to safety.

As noted in my report to the Minister in the 2022 Annual Report, in 2023 we published two reports involving kayaks in a club setting and in a commercial provider setting. I also want to take the opportunity to thank the Marine Survey Office (MSO), Water Safety Ireland (WSI), Canoeing Ireland (CI) and Rowing Ireland for their engagement with the MCIB in respect of possible safety recommendations. We note the recognition of our contribution, together with these entities and others, to improving safety in the recently published report entitled *Paddlesport Safety Culture in Ireland; An Exploratory Study* by Dr. John Pierce and Mr. Kevin O’Callaghan. This study was supported by Sport Ireland, Healthy Ireland, CI and Munster Technological University, noting with regard to the MCIB: *“Since 2021 there is a change in the way in which risk assessment is addressed within the reports, where there is a recognition of dynamic risk assessment. This is a direct result of the MCIB’s close working relationship with Canoeing Ireland.”*

During 2023 the Minister commenced a review of the Code of Practice for Recreational Craft. The MCIB was invited to contribute to the review and has done so, and the revised Code is awaited. The content of the Code is useful and informative on essential safety steps that should be taken. The Department published Marine Notice No.52 of 2023 *Think and Prepare - Important safety advice for owners and users of recreational craft* which reminds all masters, owners and users of recreational craft of the need to think and prepare before going out on the water and to follow the checklist of basic requirements and advice both before going on the water and while on the water. It remains the case, unfortunately, that the failure to follow basic safety recommendations, such as wearing a life jacket, remain a factor in a number of our current investigations. Failures in planning for emergencies is also a common thread across many investigations. There is clearly a challenge in delivering and imbedding the Code’s safety messages throughout the recreational sector and we continue to commend WSI and the Department of Transport Maritime Division for their continuing work in this regard.

### Board Changes

In July 2023, our then Board of four was delighted to be joined by three new Board members:

- Deirdre Lane FNI, MSc, Master Mariner, BSc (Hons) is Harbour Master, Dunmore East, Department of Agriculture, Food and the Marine, and a Fellow, Trustee and Executive Board member of the Nautical Institute and a Deputy Launch Authority for the Royal National Lifeboat Institution (RNLI).
- Phil Murphy is the Senior Marine Officer responsible for the management of Wexford Councils Piers/Harbours & Ports Section (with 11 piers/harbours, two Blue Flag Marinas and New Ross Port under his jurisdiction), and before that had 17 years seagoing experience on various vessel types - Bulk Carriers, Container Ships, Ultra Large Crude Carriers, including serving as Master onboard large passenger ferries (traditional and fast craft). Phil was also a Board member of New Ross Port Company Nov 2017 – Oct 2018.
- John Carlton is the Port Services Manager at Shannon Foynes Port Company since 2012, and has delivered various significant strategic and infra structure projects. Previously he was Engineering & Terminal Operations Manager at Shannon Foynes Port. John holds a BA in Business Management, a Chief Engineer certificate of competency (Unlimited), a Diploma in Marine Surveying (specialising in engineering surveys) and a Higher National Diploma in Marine/Plant Engineering.

We had to say farewell in March 2024 to our Deputy Chair, Dr. Dorothea Dowling, Chartered Insurer, FCII, Master of Laws (LL.M) in medical law and financial services, LL.B, FCI Arb, FCIS, Cert IoD as her term of office concluded and a further extension was not permitted due to the legislation. Our esteemed colleague has long and highly regarded experience in accident investigations, and has particular expertise in corporate governance. She was a highly valued member of the Board since her initial appointment in 2017. The Minister has appointed John Carlton to succeed Dr. Dowling as Deputy Chair.

### Legislative Changes

In my report to you in 2023, I noted that the MCIB had welcomed the announcement by the Minister in December 2022 of the drafting of a Merchant Shipping (Investigation of Marine Accidents) Bill to provide for a full-time Marine Accident Investigation Unit within the Department of Transport. The General Scheme provides for the establishment of the Marine Accident Investigation Unit (MAIU). The MAIU will replace the MCIB as the permanent body responsible for marine accident investigation. The draft legislation continues in preparation before making its way through the Houses of the Oireachtas.

## European Context and EMSA

A considerable amount of the work that the MCIB does involves engagement with the European Maritime Safety Agency (EMSA) in respect of maritime incidents that fall within the ambit of the European Union (EU) Directive 2009/18/EC (which establishes the fundamental principles governing the investigation of accidents in the maritime transport sector). EMSA is the EU agency that is tasked with providing technical expertise and operational assistance to improve maritime safety, pollution preparedness and response and maritime security throughout the EU. EMSA also ensures the consistent investigation of marine accidents throughout the EU and shares best practices on maritime safety, security, and environmental issues. EMSA has developed a methodology to analyse data reported to EMCIP with the view to detecting potential safety issues. As with other EU investigative agencies, the MCIB reports marine incident data to EMCIP.

EMSA provides training services for EU accident investigators and in 2024 commenced its first year of a new training academy with a Core Curriculum Course for EU accident investigators. The new EMSA Academy will deliver training on new or amended International Maritime Organisation (IMO)/EU acts and will provide operational training, using advanced tools. All trainings in EMSA Academy will comply with ISO 9001:2015, ISO 21001:2018 and ISO 29993:2017 standards. This is a very welcome development which will contribute to the continued learning of MCIB accident investigators, three of whom are currently engaged on the 2024 course.

The European Commission is continuing its review of EU maritime legislation and a new Directive is expected within the next 12 months. It is widely expected that more aspects of the EU wide fishing vessel safety investigation regime will be extended to the smaller category of fishing vessels (with a length overall of less than 15 m).

### The Department published 83 Marine Notices in 2023.

The full list can be accessed here gov - Marine Notices 2023 ([www.gov.ie](http://www.gov.ie))

### The following Marine Notices were published in 2023 following MCIB reports and investigations:

14 of 2023	Reminder – use of radio Distress, Urgency and Safety calls in the case of fire or other potentially serious incident.
18 of 2023	Electrical Systems in Small Pleasure, Fishing and other Craft.
27 of 2023	Health and Safety onboard vessels – Recent incidents resulting in serious injuries.
35 of 2023	Reminder – Dangers and requirements associated with the modification of vessels.
61 of 2023	Vessel Refuelling – Risks and Guidance.
67 of 2023	Reminder of Requirements Regarding the Correct Installation and Operation of Emergency Battery Systems.
71 of 2023	Reminder – Dangers Associated with Fishing Alone.

In addition two Marine Notices were published in 2023 with significant safety information:

30 of 2023	Application of SOLAS Chapter V to Recreational Craft (including weather, crew, limitations of vessel, contingency plan, navigational dangers, information ashore).
52 of 2023	Think and Prepare – Important safety advice for owners and users of recreational craft.

### External Investigations of Casualties

All investigations of casualties are carried out by external investigators. The Board has available to it a panel of investigators including personnel holding technical qualifications as master mariners, marine surveyors, marine engineers or deck officers. The panel reflects broad based maritime competence and experience which are of relevance in undertaking independent investigations. Safety investigations are conducted with the sole objective of preventing marine casualties and marine incidents in the future. They are not designed to determine liability or apportion blame.

A typical investigation process generally includes the following phases and outcomes:

<b>Notification</b>	When the MCIB is notified of a marine casualty or incident, an assessment has to be conducted to decide whether to investigate.
<b>Gather evidence</b>	Once the investigation is launched, gathering evidence expeditiously, including witness interviews, is important to understanding the circumstances of the occurrence and the sequence of the events.

<b>Analyse evidence</b>	Evidence has to be properly analysed to identify the factors that led to the marine casualty or incident. The focus is on understanding the reason why an unsafe action or condition leads to the casualty and the context, physical or organisational, in which the casualty or incident occurred.
<b>Draw conclusions</b>	Conclusions identify the safety issues and the missing or inadequate defences (material, functional, educational or procedural) for which safety actions may be developed to prevent marine casualties.
<b>Determine remedial actions</b>	Where appropriate the MCIB suggests Safety Recommendations i.e. proposals for remedial actions to prevent future marine casualties and incidents, to the Department of Transport and to other parties that are best placed to implement such measures.
<b>Report</b>	The investigation results in a report providing, amongst other things, the circumstances of the event, the analysis of contributing factors and its conclusions. The report is published in order to spread the safety lessons to the maritime community. Data on marine casualties and incidents are uploaded onto EMCIP, thus supporting their analysis.

### Reports Published in 2023

The Board published nine final and two interim reports during 2023. The full details are provided at pages 16 to 25.

### Investigations commenced in 2023

Investigations were initiated by the Board into ten incidents during 2023. Summary details of the incidents are provided in the table below. Full details of all incidents are set out on pages 11 to 15.

Three of the ten incidents which required investigation occurred in the fishing industry and were fatal incidents. The remaining seven involved various types of recreational vessels and five were fatal incidents.

Sector	Incidents	Sinkings	Fatalities	Injuries
Fishing	3	1	3	0
General Cargo	0	0	0	0
Recreational	7	0	5	0
Passenger	0	0	0	0
<b>Total</b>	<b>10</b>	<b>1</b>	<b>8</b>	<b>0</b>

### Fishing Vessels

There were three incidents involving fishing vessels.

- Fatal Incident, man overboard (MOB), off Aranmore Island, Co. Donegal.
- Fatal Incident, vessel sunk, Dundalk Bay, Co. Louth.
- Fatal Incident onboard vessel, off Blasket Islands, Co. Kerry.

### Recreational Craft

There were seven incidents involving recreational craft.

- Incident involving several Olympic style rowing boats, River Corrib, Co. Galway (Published April 2024).
- Fatal incident involving a Jet Ski, Killaloe, Co. Clare.
- Incident involving a sailing vessel entangled in discarded nets, Baltimore Co. Cork (Published March 2024).
- Fatal incident involving a recreational angling vessel, Lacken Pier, Beltra, Co. Mayo.
- Fatal incident involving a fire onboard a recreational vessel, Carrick on Shannon, Co. Leitrim.
- Fatal incident involving a recreational angling vessel, Nimmos Pier, Co. Galway.
- Fatal incident, MOB, recreational motor boat, Bruckless Pier, Co. Donegal.

Detailed tables of incidents investigated which occurred in the years 2014 to 2023 are at page 25 and 26 of this report.

A summary of all incidents investigated occurring in these years is provided in the table below:

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Fatalities	5	5	9	6	8	6	4	0	0	8
Injuries	1	0	14	0	0	1	2	2	6	0
Vessels Involved	7	7	15	5	5	11	8	8	21	11

### Ethics in Public Office

During 2023, all Board members were in compliance with the applicable provisions and requirements of the Ethics Acts and the Standards in Public Office Act, 2001.

### Acknowledgements

I want to thank my Board colleagues who have again given hugely of their time and very considerable expertise during this last year to the MCIB. None of that investigative work is possible without the diligent contribution and expertise of our investigators whom I would also like to thank. The increasing demands on the MCIB of course leads to added work for our very dedicated Secretariat, and I would like to thank each of them and our Board Secretary for all of the year's contribution. In particular in June 2024 the MCIB (together with all related maritime entities) was audited by the International Maritime Organisation. The MCIB received a fully compliant assessment. This was the result of preparation by our Board secretary over two years, for which added thanks is due for achieving such an excellent outcome.

This is the 25th year of the MCIB. It has to the end of 2023 published 264 reports. That is an output in terms of number and content that can hold its own in comparison with many larger national investigative bodies. I want to take the opportunity at this time to pay tribute and extend thanks to previous Board members, and in particular to my two predecessors as chair, Mr. John G. O'Donnell and Ms. Cliona Cassidy and to Board members:

Ms. Sinéad Brett

Mr. Thomas R. Power

Ms. Mary Lally

Mr. Brian Hogan

Mr. Martin Diskin

Mr. Brian Keane

Mr. Jurgen Whyte

Mr. Michael Frain

Mr. Nigel Lindsay

Mr. Frank Cronin

Dr. Dorothea Dowling

Board members in particular are due thanks for ensuring that Ireland has over the last 25 years carried out its international and EU obligations with regard to marine investigations. They have done this by giving of their time unstintingly and for very nominal remuneration. Each has contributed invaluable professional and experiential expertise. We all continue to be rewarded by hoping that in some small way MCIB investigations contribute to greater safety and to a reduction in lives lost, injury and the loss of vessels.

Finally, I wish to record my appreciation for the assistance that you as Minister, and that of your officials in the Maritime Safety Policy Division, have afforded to the Board during 2023.

CLAIRE CALLANAN  
CHAIRPERSON



# Board Members and General Information



**Ms. Claire Callanan,**  
Chairperson, Solicitor



**Dr. Dorothea Dowling,**  
Deputy Chairperson,  
Chartered Insurer and  
Accredited Mediator



**Mr. Frank Cronin,**  
(January-March 2023) Marine  
Engineer Class 1 combined,  
DCII, Chartered Insurer



**Mr. Keith Patterson,**  
CEng, CMarENG, Marine  
Engineer Class 1



**Ms. Deirdre Lane,**  
(July-December 2023) FNI, MSc,  
Master Mariner, Harbour Master  
Dunmore East



**Mr. Phil Murphy,**  
(July-December 2023) Class I  
Master Mariner



**Mr. John Carlton,**  
(July-December 2023) BSc in  
Marine Engineering, BA in  
Business Management, Marine  
Engineer Class 1

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The following is some general information regarding the MCIB.

## Establishment of the Board

The MCIB was established under the Merchant Shipping (Investigation of Marine Casualties) Act, 2000 ("the Act"). Under the European Communities (Merchant Shipping) (Investigation of Accidents) Regulations 2011 Statutory Instrument (S.I.) No. 276 of 2011 ("the Regulations") the MCIB is the body in Ireland mandated to investigate incidents that fall within EU Directive 2009/18/EC ("the Directive") governing the investigation of accidents in the maritime transport sector.

## Function of the Board

The function of the MCIB is to carry out investigations into Marine Casualties, as defined in Section 2 of the Act and the Regulations. In carrying out its functions the MCIB also complies with the provisions of the IMO's Casualty Investigation Code and the Directive. The Directive is given effect in Irish law by the Regulation (S.I. No. 276 of 2011) and applies to only some of the incidents under investigation. Investigations within the scope of the Directive are carried out in accordance with the requirements of the Directive and the Common Methodology as set out in Commission Regulation (EU) No. 1286/2011 of 9 December 2011.

**In accordance with the Act, Marine Casualty means an event or process, which causes or poses the threat of:**

- (a) death or serious injury to a person;
- (b) the loss of a person overboard;
- (c) significant loss or stranding of, damage to, or collision with, a vessel or property; or
- (d) significant damage to the environment,

in connection with the operation of:

- (i) a vessel in Irish waters;
- (ii) an Irish registered vessel, in waters anywhere; or
- (iii) a vessel normally located or moored in Irish waters and under the control of a resident of the State, in international waters contiguous to Irish waters.

**The purpose of each investigation is to:**

1. Establish the cause or causes of a marine casualty.
2. Report on the marine casualty with a view to making recommendations for the avoidance of similar marine casualties.

***It is important to note that it is NOT the purpose of an investigation to attribute blame or fault. The Board is non-prosecutorial. Any prosecution, which arises out of any casualty, is the function of Statutory Bodies i.e. An Garda Síochána, etc.***

## Status

The MCIB is an independent statutory body funded by the Oireachtas under Section 19 of the Act.

A copy of the final report of each investigation is sent to the Minister for consideration of the recommendations made therein.

All reports are made available to the public (on request) free of charge or can be accessed via the MCIB website at [www.mcib.ie](http://www.mcib.ie).

# Incidents and Investigations 2023



Reporting Period 1st January to 31st December 2023

# Introduction

Since establishment in 2002, and up to the end of 2023, the Board has published reports on 264 cases.

The statistics contained in this Report show the different types of craft involved and the cause of each incident and give the reader some insight into the scope and work of the Board. To date reporting formats have been maintained in a consistent format in order to allow comparison with earlier year's incidents and reports.

All reports are published on the Board's website, [www.mcib.ie](http://www.mcib.ie), and are available on application to the Secretariat.

# Summary of Incidents Investigated which Occurred During 2023

1st January to 31st December 2023

Name of vessel/incident: <b>River Corrib</b>	
<b>TYPE OF CRAFT</b>	Two Rowing Boats
<b>TYPE OF INCIDENT</b>	Loss of two rowing boats
<b>FATALITIES</b>	None
<b>SUMMARY</b>	<p>A scheduled training session on the River Corrib, Co. Galway for two competitive rowing boats resulted in a marine casualty event that caused the loss of the two rowing boats and posed a threat of death or serious injury to persons who had been operating recreational vessels in Irish waters.</p> <p>A complex system and an issue of risk normalisation – in which risky behaviour gradually becoming acceptable over time – had developed around rowing activities in the vicinity of the river’s Salmon Weir, especially during the river’s high flow rates and low water temperatures during winter months. This system was inherently sensitive to changes or omissions, even those that may not have been obvious to the persons charged with achieving the goal of a safe rowing activity. This sensitivity can be seen in the history of previous, similar incidents, in which the potential severity of the situation or the likelihood of a repeat outcome seems to have not been appreciated.</p> <p>As a result, what may have initially appeared to be an innocuous meeting on the river of the rowing boats from two clubs – one setting out upriver and the other returning downriver – set in motion a final sequence of events that resulted in the loss of two rowing boats and posed a threat of death or serious injury to the crews of these two boats.</p>

Name of vessel/incident: <b>FV Séimi</b>	
<b>TYPE OF CRAFT</b>	Fishing Vessel <15 m
<b>TYPE OF INCIDENT</b>	Man overboard
<b>FATALITIES</b>	1 Fatality
<b>SUMMARY</b>	<p>At approximately 20.00 hours (hrs), the FV Séimi was shooting a string of crab pots in a position approximately 60 nautical miles (NM) NNW of Aranmore Island off the NW coast of Ireland. The operation of shooting the pots required one crewmember to be on deck ensuring the pots ran freely off the deck while another crewmember manoeuvred the vessel along a predetermined course. The size and construction of the vessel allowed the crewmember in the wheelhouse to communicate verbally with the crewmember on deck, in addition the crewmember in the wheelhouse was able to visually monitor the deck via a camera on deck and a monitor in the wheelhouse. On this occasion a third crewmember was sitting at the entrance to the wheelhouse.</p> <p>As the last pot was leaving the deck, the Crewmember on deck became entangled in the rope connected to the pot and was dragged through the stern door opening, over the side and into the water. The vessel was stopped immediately, and an attempt was made to retrieve the MOB by hauling him back onboard using the same line that dragged him overboard. This proved unsuccessful and contact was lost with the MOB. By this time the alarm had been raised onboard and the remaining two crew assisted in searching for the MOB. He was not wearing a Personal Flotation Device (PFD).</p> <p>The MOB was sighted a short distance from the vessel and was successfully recovered onboard. The crew estimate that the Casualty was in the water for no longer than 15 minutes. Cardiopulmonary resuscitation was administered and advice received via satellite phone from Medico Cork, the 24-hour Emergency Telemedical support unit, via Malin Head Coast Guard. Despite the crew's efforts the Casualty did not survive.</p>

Name of vessel/incident: <b>Jet Ski, Killaloe</b>	
<b>TYPE OF CRAFT</b>	Personal Watercraft
<b>TYPE OF INCIDENT</b>	Drowning
<b>FATALITIES</b>	1 Fatality
<b>SUMMARY</b>	<p>At around 16.00 hrs a Sea-Doo personal watercraft (PWC) was launched into the water from a trailer at the public slipway south of Ballina. The PWC was being operated in the area between the launch slipway and the Shannon Bridge, with a couple of brief forays north of the bridge. At approximately 16.30 hrs the driver of the PWC invited two passengers to board the PWC from the Ballina pontoon. Only one of the three persons onboard the PWC was observed to be wearing a PFD.</p> <p>At approximately 17.00 hrs the PWC and the three occupants passed the pontoon at speed and made a sharp left turn in an area that was approximately mid river and just south of the bridge. All three persons fell off the PWC when it capsized during the sharp left turn. The two passengers, one of whom was wearing a PDF, recovered from the fall and swam ashore to the Ballina pontoon.</p> <p>The driver of the PWC, who was not wearing a PFD, was not visible from the shore and feared to have gone under the water. The alarm was raised by a member of the public and a search and recovery operation commenced.</p> <p>The Casualty was recovered from the water after a search involving local emergency services at approximately 18.45 hrs.</p>

Name of vessel/incident: **Sailing Vessel Inish Ceinn**

<b>TYPE OF CRAFT</b>	Recreational Craft
<b>TYPE OF INCIDENT</b>	Vessel aground
<b>FATALITIES</b>	None
<b>SUMMARY</b>	<p>The sailing yacht Inish Ceinn departed from Baltimore, Co. Cork at 14.00 hrs, for a short voyage to Cape Clear Island. The weather was moderate from the east and the yacht was taken out of Baltimore Harbour and then headed west on the planned course towards Cape Clear Island.</p> <p>At around 14.30 hrs the Skipper felt the yacht slow down rapidly and turn into the wind. Nothing could be seen in the water, so the engine was started and propeller engaged. Vibration was felt and a burning smell was noticed. The engine was shut down and the yacht was immobilised. The wind and swell quickly pushed the yacht towards the rocks and the yacht went aground. Four of the persons onboard were able to get onto the rocks and the Skipper sent a MAYDAY message on the Very High Frequency (VHF) radio. He also got onto the rocks. At this stage the Skipper noticed the hull was fouled with a large trawl net.</p> <p>Baltimore lifeboat came to the rescue and the rescue helicopter R115 also attended the scene. All five persons were evacuated from the rocks by the lifeboat and taken back to Baltimore. The yacht broke up and was lost. There were no serious injuries and no pollution.</p>

Name of vessel/incident: **Lacken Pier**

<b>TYPE OF CRAFT</b>	Recreational Vessel
<b>TYPE OF INCIDENT</b>	Man overboard
<b>FATALITIES</b>	1 Fatality
<b>SUMMARY</b>	<p>At around 10.20 hrs a recreational boat was launched from Lacken Pier in Co. Mayo to facilitate a day of sea angling for two people. After launching, the Survivor made an unsuccessful effort to hold the boat alongside the pier while the Casualty parked the launch tractor and trailer. When the tractor and trailer were parked, the Casualty attempted to board the drifting boat and entered the water at the pier steps. He got into difficulty and was swept out to sea. The boat with the Survivor onboard drifted out to sea.</p> <p>Emergency services were alerted to the incident and Killala Coastguard Unit and Sligo rescue helicopter R118 were mobilised. The drifting boat came ashore at Lacken Strand with the Survivor still onboard. Shortly after, the Casualty was recovered from the water by R118 and transferred to Sligo University Hospital where he was pronounced dead. The Survivor was recovered by R118 from the beach at Lacken Strand and transferred to Sligo University Hospital for treatment, and subsequently released.</p>

Name of vessel/incident: <b>Carrick-on-Shannon Boat Fire</b>	
<b>TYPE OF CRAFT</b>	Pleasure Craft
<b>TYPE OF INCIDENT</b>	Fire on boat
<b>FATALITIES</b>	1 Fatality
<b>SUMMARY</b>	Early in the morning, a 33ft motor cruiser berthed at a marina on the River Shannon in Carrick-on-Shannon caught fire. Attempts to put out the fire by members of the public that were staying on their own vessels nearby were unsuccessful. Units of the local fire brigade attended the scene and brought the blaze under control. The fire claimed the life of one individual that was sleeping onboard the vessel.

Name of vessel/incident: <b>Bruckless Pier</b>	
<b>TYPE OF CRAFT</b>	Recreational Motorboat
<b>TYPE OF INCIDENT</b>	Drowning
<b>FATALITIES</b>	1 Fatality
<b>SUMMARY</b>	<p>The owner of a recreational motor boat was alone aboard his vessel when he fell overboard and subsequently drowned. This occurred between 15.30 hrs and 16.30 hrs. The vessel was at its mooring approximately 50 metres (m) from the shore, in a rural area near Bruckless Pier, Co. Donegal. The weather conditions were poor, with winds of Force 6 and gusts of up to 35 knots (65 kilometres (km)/h). A Small Craft Warning was in effect.</p> <p>The vessel was an older model of a recreational motor boat. The vessel predated the introduction of modern design requirements to both minimise the risk of falling overboard and to facilitate reboarding, which were introduced in 2013 by the EU Directive for Recreational Craft. The vessel had no means of unaided reboarding, either accessible to - or deployable by - a person in the water.</p> <p>The Casualty was not wearing a PFD, he had no means of contacting the emergency services, and he had not left notice of his intentions with a shore contact. This marine casualty occurred because of a combination of causal factors.</p>

Name of vessel/incident: <b>FV Ben Thomas</b>	
<b>TYPE OF CRAFT</b>	Fishing Vessel <15 m
<b>TYPE OF INCIDENT</b>	Sinking
<b>FATALITIES</b>	1 Fatality
<b>SUMMARY</b>	Between 07.30 and 08.30 hrs the FV Ben Thomas sank North of Dunany point. At approximately 08.30 hrs, a crewmember working on the deck of the FV Sian Elizabeth heard someone calling for help. The vessel was stopped and after a short search the Skipper of the FV Ben Thomas was found clinging to an item that had floated when his vessel sank. The search for the second Casualty continued over the following days and navy divers recovered the body from the seabed.



Name of vessel/incident: **FV Breizh Arvor II**

<b>TYPE OF CRAFT</b>	Fishing Vessel >15m
<b>TYPE OF INCIDENT</b>	Incident onboard
<b>FATALITIES</b>	1 Fatality
<b>SUMMARY</b>	<p>The FV Briezh Arvor II was a conventional stern trawler of 22.4 m in length and was fishing for prawns off the west coast of Ireland. The vessel was two days into an intended fishing trip of ten to 13 days when one of the crew suffered a fall in the accommodation. The vessel was trawling at the time of the incident and the catch from the previous haul was being processed by the crew on deck. The weather was around Force 5 with fresh breeze and moderate to rough seas with the vessel rolling moderately. The Casualty was found unresponsive lying on the deck in the sleeping area, and efforts were made to revive him but unfortunately were not successful.</p>

Name of vessel/incident: **Lady Pixa**

<b>TYPE OF CRAFT</b>	Recreational Boat
<b>TYPE OF INCIDENT</b>	Drowning
<b>FATALITIES</b>	1 Fatality
<b>SUMMARY</b>	<p>At around 10.00 hrs a recreational boat with a Skipper and Crewmember onboard departed from the inner Nimmos Pier, The Claddagh, Co. Galway to go mackerel fishing in inner Galway Bay. The boat made the approximate 1.5 km voyage to the fishing area and commenced fishing using handlines. At around 12.30 hrs, the fishing concluded, and the two men decided to return to Nimmos Pier. The boat proceeded towards Nimmos Pier with the Skipper in the cabin operating the boat from the coxswain seat, while the Crewmember remained on the back deck of the boat tending to the catch and cleaning down the boat.</p> <p>On the return voyage back to Nimmos Pier, the Skipper of the boat noticed his Crewmember was no longer on the boat. The Skipper proceeded to alert the emergency services and commenced searching the immediate area they were fishing. Emergency services including Galway Bay RNLI, Sligo rescue helicopter R118, and Costello Bay Coastguard Unit were mobilised. The Crewmember was removed from the water approximately one hour after mobilization of the emergency services and transferred to Galway University Hospital where he was later pronounced dead.</p>

# Summary of Reports Published 2023

1st January to 31st December 2023

The following tables are summarised from published reports and are intended to give an overview. Full reports can be viewed on the MCIB website [www.mcib.ie](http://www.mcib.ie)

Name of vessel/incident: <b>Kayaking Incident on Caragh River</b>	
<b>DATE OF PUBLICATION</b>	28 February, 2023
<b>TYPE OF CRAFT</b>	Kayaks
<b>DATE OF INCIDENT</b>	2 November, 2019
<b>SUMMARY</b>	<p>On 2 November 2019 a group of 27 kayakers set out on a down-river trip of the Upper Caragh River, Co. Kerry. The kayakers consisted of experienced and beginner kayakers, split into three sub-groups. The first sub-group successfully navigated the river-run. The second and third sub-groups experienced difficulties. Two kayakers became distressed, and the emergency services were called. One kayaker was resuscitated but a second kayaker, who was trapped under a tree branch, was rendered unconscious and stopped breathing. The latter Casualty was recovered from the water, resuscitated and transferred to hospital but subsequently died.</p>
<b>INJURIES/FATALITIES</b>	1 Fatality
<b>CAUSE OF INCIDENT</b>	<p>The prevailing conditions including the features of the river were not suitable for all the members of the trip to manage safely. The trip was not properly assessed for the risks attached to the prevailing conditions and having regard to the skills and experience of the group taking part in what is a high-risk sport. The persons in charge of identifying and assessing the risks in advance, and on the day, were insufficiently trained and experienced themselves to be able to assess the risks, given the combined factors of river conditions and the nature of the group. This arose as there was a lack of adherence to the University of Limerick Kayak Club (ULKC) Safety Statement 2014 and the Trips Policy and Procedure which set out control measures, which led to a lack of accredited training, which in turn led to poor decision making. Had there being CI qualified instructors available (or persons with recognisable equivalent training and experience) they would have identified that the group was too large and its makeup too inexperienced and would not have approved a trip that involved a group of beginners in those conditions, and/or, having embarked would have realised that the conditions being experienced were not suitable and would have terminated the trip.</p> <p>The gaps in the Club safety environment were contributed to by the lack of any supervision/audit, or capacity to effectively supervise or audit, of the safety of university students engaged in high risk activities by the University of Limerick Students' Union (ULSU), and by the absence of any overarching, agreed, and communicated, spheres of responsibility between the ULSU and University of Limerick, leading to an environment at club level where there was a serious disregard of the ULKC Safety Statement 2014 and Trips Policy and Procedure, and CI recommended standards.</p>

Name of vessel/incident: <b>Yacht Black Magic</b>	
<b>DATE OF PUBLICATION</b>	23 March, 2023
<b>TYPE OF CRAFT</b>	Recreational Craft
<b>DATE OF INCIDENT</b>	13 December, 2021
<b>SUMMARY</b>	<p>The yacht Black Magic with one person onboard sailed from the Yacht Marina, Crosshaven, Co. Cork for Kinsale Harbour at approximately 10.30 hrs on 13 December 2021. Approximately one hour and a quarter later at 11.50 hrs the outboard engine mounted on the transom of the yacht, caught fire. The fire rapidly spread. The Skipper transmitted a MAYDAY distress broadcast using his handheld VHF radio. A fishing vessel working in the vicinity of the burning yacht relayed a MAYDAY to the IRCG radio station at Valentia who initiated a Search and Rescue operation.</p> <p>Another fishing vessel rescued the Skipper at approximately 12.00 hrs and brought him to safety. Shortly after, at 12.17 hrs the Skipper was transferred ashore by the Port of Cork Rigid Inflatable Boat (RIB) which had come from Crosshaven to assist. The Skipper was not injured during the incident. The yacht was consumed by fire. At 12.48 hrs Crosshaven RNLi reported that the yacht had sunk in Ringabella Bay.</p>
<b>INJURIES/FATALITIES</b>	None
<b>CAUSE OF INCIDENT</b>	<p>The continuous operation of the outboard engine onboard yacht Black Magic as it made passage from Crosshaven Marina to the vicinity off Ringabella Bay at the engine's maximum design capacity, caused the engine to suffer a significant mechanical failure. The mechanical failure of the engine was such that hot engine components were exposed to petrol fuel and oil lubricants which spontaneously ignited and caused a fire onboard the vessel. The fire consumed the vessel which subsequently sank off Ringabella Bay.</p> <p>The lack of wind and the sub optimal capacity of the yacht's outboard engine to power the yacht at the required speed as it motors sailed out of Cork Harbour was a contributory factor in the loss of yacht Black Magic.</p> <p>Refuelling the outboard engine by topping up the engine's fuel tank likely resulted in a fuel spillage in the vicinity of the engine and transom. The spilled fuel was likely to have been a contributory factor in the subsequent fire which started at the outboard engine and resulted in the loss of the yacht.</p>

Name of vessel/incident: <b>FV Anna Louise</b>	
<b>DATE OF PUBLICATION</b>	6 April, 2023
<b>TYPE OF CRAFT</b>	Fishing Vessel <15 m
<b>DATE OF INCIDENT</b>	2 July, 2022
<b>SUMMARY</b>	<p>The FV Anna Louise was an open fishing boat of 5.35 m in length with an outboard engine and on 2 July 2022 was taken on a routine fishing trip to lift lobster pots in Bantry Bay, Co. Cork. The Skipper was a qualified and experienced boat operator with valid certification. The Skipper had lifted two strings of lobster pots onboard with a total of ten pots and was retrieving the marker buoy when a wave came over the stern, flooding the boat. The Skipper tried to reach the bailing bucket, but a further wave swamped the boat, and the boat sank quickly. The Emergency Position Indicating Radio Beacon (EPIRB) floated free and was activated. The distress signal was received by Valentia Marine Rescue Sub-Centre who initiated rescue operations. Bantry inshore lifeboat was tasked as well as Castletownbere lifeboat and rescue helicopter R115.</p> <p>The Skipper swam ashore and made his way to a house from where he called to advise he was safe and well. The rescue operations were terminated. The boat was later salvaged from 12 m of water. There were no injuries and no pollution.</p>
<b>INJURIES/FATALITIES</b>	None
<b>CAUSE OF INCIDENT</b>	<p>The boat was swamped by waves coming over the stern and filling the boat with sea water. The boat sank quickly as there was no reserve buoyancy when it was full of water.</p> <p>The boat freeboard had been reduced due to additional weights onboard making it more vulnerable to swamping.</p> <p>Modifications had been carried out that reduced the freeboard and these modifications should have been presented, for approval, to the surveyor who had issued the Code of Practice (CoP) certificate in accordance with CoP requirement 1.5.5.2. The original freeboard was considered small but there is no minimum freeboard specified in the CoP for open boats of this size.</p> <p>The Skipper was wearing an approved automatic PFD as required and this enabled him to swim ashore and prevented a more serious outcome. This clearly shows the importance of wearing a PFD, especially when operating alone. The boat did have a float free EPIRB which activated and alerted the rescue response.</p>

Name of vessel/incident: <b>Kayakers on Mulroy Bay</b>	
<b>DATE OF PUBLICATION</b>	18 May, 2023
<b>TYPE OF CRAFT</b>	Kayaks
<b>DATE OF INCIDENT</b>	19 March, 2022
<b>SUMMARY</b>	<p>On Saturday 19 March 2022 a group of six kayakers set out on a morning's kayaking trip on Mulroy Bay, Co. Donegal. This is a tidal sea lough that extends 19 km/10 NM inland from the north Atlantic coast. This was a commercial, guided trip consisting of the Trip Organiser and five clients. The clients were adults who typically had little or no kayaking experience. Only one client wore a wetsuit as thermal protection against the effects of cold-water immersion, while the others wore clothing such as jeans and winter coats.</p> <p>The group got into difficulty when the wind speed increased, and the sea state deteriorated. The double kayak capsized but its two clients were able to right the kayak and make their way to one side of the lough. Another two clients, in single kayaks, separately made their own way to the other side of the lough, after one of them capsized and swam for about 20 minutes to reach the shore. The remaining client and the Trip Organiser both capsized and lost contact with their kayaks. They drifted in the water for approximately one hour, isolated about mid-way across the lough, until they were rescued by the Coast Guard. They required hospital treatment before being released later that day. This rescue only became possible because of the diligent actions of a member of the public, who saw people in the water and notified the emergency services.</p>
<b>INJURIES/FATALITIES</b>	Two persons hospitalised
<b>CAUSE OF INCIDENT</b>	This kayaking trip resulted in a marine casualty event that posed a threat of death or serious injury to persons who had been operating recreational vessels in Irish waters. This marine casualty event occurred because a combination of the following causal and contributory factors, which included unsuitable weather conditions, inadequate training and qualifications, inadequate trip planning, inadequate contingency planning, inadequate safety equipment, inadequate protective clothing and inadequate safety environment.

Name of vessel/incident: <b>FV An Portán Óir</b>	
<b>DATE OF PUBLICATION</b>	9 August, 2023
<b>TYPE OF CRAFT</b>	Fishing Vessel <15 m
<b>DATE OF INCIDENT</b>	14 October, 2022
<b>SUMMARY</b>	<p>The FV An Portán Óir was a decked fishing boat of 9.9 m in length with an inboard diesel engine. On Friday 14 October 2022 the boat was taken on a routine fishing trip to lift, bait and shoot lobster pots in Dingle Bay, Co. Kerry. The boat was operated by the owner (the Skipper). He was a qualified and experienced boat operator with valid certification. The Skipper was shooting the final string of 30 lobster pots, with ten pots in the water when his leg became entangled in the pot ropes. The boat was in gear to stretch the string and the rope tightened around the Skipper's leg and he was pulled aft. The Skipper grabbed the rope between the pots and tied it to the handrail to avoid being pulled overboard. He was unable to free himself as the rope around his leg was under tension and he remained stuck in this position until he was rescued around four hours later.</p> <p>Persons ashore noticed he had not returned as planned and raised the alarm. Several local boats as well as Dingle lifeboat and Coast Guard rescue helicopters searched until the boat was located by a local boat and the Skipper was brought ashore where an ambulance was waiting to take the injured Skipper to hospital. The Skipper suffered serious injuries to his leg.</p>
<b>INJURIES/FATALITIES</b>	Serious injuries sustained
<b>CAUSE OF INCIDENT</b>	<p>This was not an uncommon incident but was exacerbated by the Skipper being alone onboard and not having a knife to hand and not having a Personal Locator Beacon on his person to raise the alarm immediately.</p> <p>Fishing alone is a high-risk operation, and this especially applies to potting operations. This casualty shows that accidents can happen quickly even to a well experienced fisher. It is imperative that a risk assessment is carried out before every voyage to continuously remind the fisher of the potential risks and to have these risks mitigated wherever possible by having correct equipment and procedures in place. The weather forecast predicted increasing to Force 6 in the evening and there was a Small Craft Warning in place which increased the risk to the Fisher onboard alone.</p> <p>The importance of having a designated person ashore has been clearly shown in this casualty and even though it may be intrusive, regular contact with a person ashore is essential and can certainly prevent a minor incident becoming more serious.</p>

Name of vessel/incident: <b>FV Bikain</b>	
<b>DATE OF PUBLICATION</b>	17 August, 2023
<b>TYPE OF CRAFT</b>	Fishing Vessel > 15 m
<b>DATE OF INCIDENT</b>	25 November, 2022
<b>SUMMARY</b>	<p>The French registered FV Bikain was alongside at the end of the main pier in Dingle Harbour, Co. Kerry and was preparing to go to sea to resume fishing on 25 November 2022. The main engine was started and checks for sailing were being carried out when the controllable pitch propellers went to the full astern position. The Skipper tried to stop the main engine with the emergency stop button on the wheelhouse console, but this failed. The mooring ropes holding the vessel parted and the vessel went quickly astern and made heavy contact with the southern boat marina pontoon causing extensive damage to the pontoon and to several boats that were secured there at the time.</p> <p>The main engine was eventually stopped by shutting off the fuel and the vessel drifted across the harbour basin. Another trawler, moored on the main jetty, saw the incident, and quickly went to assist and towed the FV Bikain back alongside the jetty. There were no injuries and no pollution, but extensive damage was caused to the southern pontoon and moored boats.</p>
<b>INJURIES/FATALITIES</b>	None
<b>CAUSE OF INCIDENT</b>	<p>The electrical system was incorrectly designed on this vessel, and this was the root cause of the casualty. The design of this system necessitated that the emergency batteries were required to be in use at all times for the operation of the vessel, but the emergency batteries should only be used for emergency situations when the main power supply fails. The vessel could not operate without recourse to the emergency source of electrical power.</p> <p>Engine emergency stop systems for the main engine must be able to operate at all times and not rely only on emergency battery systems. Previous failure of the charging system was not identified as a critical failure and should have instigated a full investigation to identify why these failures were occurring. This investigation should have identified the design faults and prevented this casualty event. There were no written procedures for the test and maintenance of this critical system onboard the vessel.</p>

Name of vessel/incident: <b>Arklow Raider</b>	
<b>DATE OF PUBLICATION</b>	4 September, 2023
<b>TYPE OF CRAFT</b>	Cargo Ship
<b>DATE OF INCIDENT</b>	25 November, 2022
<b>SUMMARY</b>	<p>On the evening of 25 November 2022, the general cargo vessel Arklow Raider, proceeded on a laden passage up the Bristol Channel towards her destination port of Sharpness, United Kingdom. At around 19.19 hrs the vessel passed under the Severn Bridge and the Pilot commenced a planned turn to port to round Lyde Rock. Despite the Pilot applying starboard helm to counter the anticipated currents and counter currents, the vessel rapidly sheered to port, leaving the channel, before grounding heavily by the bow on a mud and rock bottom at approximately 19.21 hrs. After sounding all compartments and determining no apparent water ingress, the vessel was re-floated under its own power on the still rising tide. The passage was aborted and successfully completed on the following tide with the same Pilot. The vessel sustained damage to the shell plating and framing in the forepeak ballast tank, with water ingress subsequently detected in the forepeak. The vessel was dry-docked for repairs. No persons were injured, and no pollution occurred.</p>
<b>INJURIES/FATALITIES</b>	None
<b>CAUSE OF INCIDENT</b>	<p>The environmental conditions, including wind speed/direction and height of tide, were not unusual, and the vessel had successfully undertaken a similar manoeuvre in laden condition on three other occasions. The following morning the vessel successfully transited the area during similar tidal conditions with the same Pilot, by passing more directly over Slimeroad Sands. This is persuasive evidence that the track adopted, and the angle of the hull presented to the current during the previous passage was causative in causing a rapid swing to port.</p> <p>The potential presence of a strong counter-current at the Lyde Rock area is well known local knowledge. However, this information is unavailable in Admiralty Sailing Directions or via GHT pilotage information to mariners. There is no means of accurately measuring the height of tide or current flow at Lyde Rock, in addition Slimeroad Sands are only visually surveyed.</p> <p>The rapid sheer to port was not caused by any defect on the vessel, but rather the effect of strong current and counter currents acting on the port quarter and starboard bow of the vessel respectively. It is not possible to evidence whether the strength of current constituted an abnormal occurrence or whether the vessel's rudder had stalled. The effect of the currents may have been minimised if a track had been planned to maintain a perpendicular aspect of the hull to the turning effects of the current i.e., by heading more directly over Slimeroad Sands. There was sufficient Under Keel Clearance (UKC) to do so.</p> <p>Providing there is sufficient UKC, a more direct passage over Slimeroad Sands is preferable, rather than execution of a port turn passing close to Lyde Rock. The limited availability of real-time accurate tidal data, current data and the absence of regular hydrographic surveys in the area of Slimeroad Sands was a factor in this grounding.</p>



Name of vessel/incident: <b>FV John B</b>	
<b>DATE OF PUBLICATION</b>	13 December, 2023
<b>TYPE OF CRAFT</b>	Fishing Vessel >15m
<b>DATE OF INCIDENT</b>	17 July, 2020
<b>SUMMARY</b>	<p>An incident occurred on the 17 July 2020 onboard the FV John B, while it was engaged in fishing operations in the Irish Sea. Whilst hauling the nets and fishing gear onboard, a Crewmember was seriously injured when his leg became trapped between the centre weight and the weight retaining cage at the stern of the vessel. The load was adjusted allowing the injured Crewmember to extricate his trapped leg from the grip of the centre weight. Other crewmembers provided first aid care to the injured Crewmember.</p> <p>The vessel owners were informed of the incident and the vessel proceeded to the closest port, which was Howth Fishery Harbour Centre (FHC) in Co. Dublin. No external medical or emergency assistance was sought or requested by the Skipper or the owners. On arrival in Howth FHC the injured Crewmember was assisted from the vessel and transferred to Beaumont Hospital Emergency Department.</p>
<b>INJURIES/FATALITIES</b>	One serious injury
<b>CAUSE OF INCIDENT</b>	<p>No risk assessment for hauling the nets was shared with the crew. Some crewmembers were engaged without the mandatory training. The Skipper was inexperienced on the vessel and relied on his crew to recover the gear unsupervised, while he remained in the wheelhouse. The evidence from the Skipper asserting that Crewmember No. 1 had been warned about the dangers of standing on the weight while recovering the fishing gear but continued to do so is not supported by any detail or any other evidence. The assertion is denied by the Casualty. Irrespective of which is correct, the manner in which the exercise was being carried out led to a very serious incident. It is not the function of the MCIB to determine liability.</p> <p>The design and layout of the fishing gear on this vessel was poor, making communication between the winch operator and deck crew difficult. The winch operator could not see the crewmembers feeding the nets on to the reels. Clear lines of communication were also not in place given that the winch operator could not see the crewmembers feeding the nets on to the reels. Had there been a safe design and planned effective communications in place effective supervision could have been adhered to. Communications in general onboard the vessel was hampered by a language barrier between crewmembers.</p> <p>An important factor is the number of crew on the vessel. It appears to be the more probable case on the basis of the evidence available to the MCIB, the crew comprised five crewmembers and the Skipper on the trip in question and not the normal crew of six and the Skipper. One man less in the crew complement can of course increase the fatigue factor and also increase the workload on the remaining crew. In addition, there is the issues as to appropriate manning for particular operations. The Working Time Regulation records provided, raise some issues as to how many of the crew were working on the operation of deploying and recovering the nets on the day in question. Given the experience of the crew, the nature of the operations and the nature of the trip a crew of six and a Skipper would have been more appropriate on the vessel.</p> <p>Once the incident occurred, given the seriousness of the injury, the Skipper should have contacted Medico Cork through the Coast Guard Radio Station for advice and arranged safe evacuation to the hospital.</p> <p>The owners and operators of the vessel did not comply with a variety of legislation in place governing operations and safety of the crew of an Irish registered fishing vessel.</p>

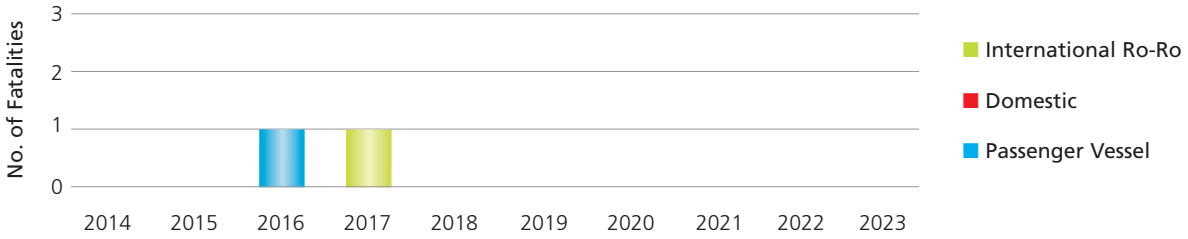
Name of vessel/incident: <b>Simmerdim</b>	
<b>DATE OF PUBLICATION</b>	20 December, 2023
<b>TYPE OF CRAFT</b>	Passenger Vessel
<b>DATE OF INCIDENT</b>	8 November, 2022
<b>SUMMARY</b>	<p>On the morning of 8 November 2022, the vessel Simmerdim departed Lettermullen, Connemara, Co. Galway with four salmon farm personnel onboard and proceeded to the offshore salmon farm site located off Ardmore Pier, Co. Galway. The vessel arrived at the worksite and made fast alongside the Feed Barge and all personnel transferred from the vessel to the Feed Barge. A smaller vessel (Polar boat) carrying five people to the salmon farm Feed Barge rendezvoused at the site and moored outboard of Simmerdim to alight three persons, being two diver contractors and one salmon farm personnel.</p> <p>The first of the three passengers from the Polar boat transited across Simmerdim to the Feed Barge. As the second person (a diver) of the group was transiting across to the Feed Barge, there was a coming together of the vessels, which pinned the individual between both vessels causing crush injuries to the pelvic area. The injured Casualty was brought back onboard Simmerdim and was subsequently airlifted to Galway University Hospital where his injuries were assessed and included multiple fractures to the pelvis and fractured hip socket joints.</p>
<b>INJURIES/FATALITIES</b>	Serious injuries
<b>CAUSE OF INCIDENT</b>	<p>In summary, this incident resulted in serious injuries to the Casualty because he was crushed between two vessels as he transited from one to the other. Means of safe access was not appropriate for transferring from one vessel to another and the practice of stepping over the side rails and onto the Feed Barge's tyre fender became normalised. The prevailing conditions including the direction and height of the swell were contributing factors to this incident. The licence required the vessel to operate in favourable weather. The weather was not favourable as defined and Simmerdim was operating outside its licensed conditions.</p> <p>There were missed opportunities during the purchase process to verify safe access to and from Simmerdim and the Feed Barge as although both vessels had safe means of access, they were not compatible when the vessels were moored alongside each other. The safe access issue could have been assessed during the procurement process in 2016 but was not, as there was no procurement process in place that would assess safety aspects of both vessels. Changes were subsequently made.</p> <p>The operator's risk assessment failed to identify the deficiencies in vessel transfer operations and in particular with regard to third parties such as the contracted diver. The task of transferring across to the Feed Barge should have been done under a Permit to Tender, issued by the MSO as required under Chapter 5 (Section 52, Tendering Operations Regulations) of the Merchant Shipping Act 2010.</p> <p>The operation was identified by the operator under their safe systems of work but was not authorised by the MSO by way of a Permit to Tender. A Tendering Operations Safety Plan Proposal, required to obtain a permit, would have informed the MSO of the personnel transfer at sea and prompted scrutiny of the operation as well as independent oversight of the transfer planning. Such a permit would have set parameters for the transfer arrangements, means of safe transfer from and to Simmerdim. Had the vessel operator, in the passenger licence application, informed the MSO of the at sea transfers Simmerdim was engaged in, the MSO could have noted the type of works on the licence and informed the operator of the need for a Permit to Tender.</p>

# Comparisons of Marine Casualties 2014 - 2023

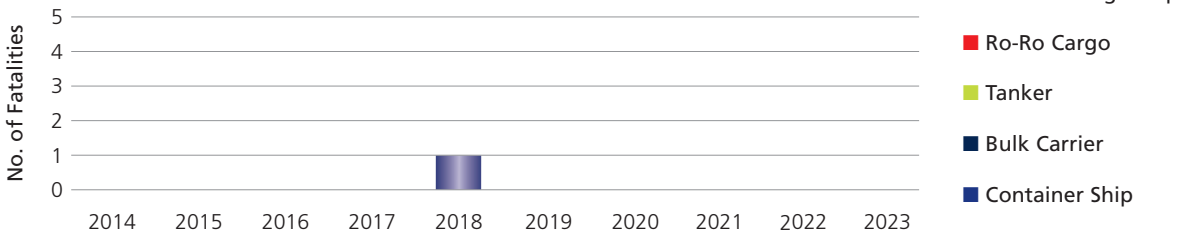
Type of Craft	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
<b>Passenger Ships/Vessels</b>										
International Ro-Ro			10 Injuries	1 Fatality						
Domestic			2 Injuries							
Passenger Vessel			1 Fatality 1 Injury						1 Injury	
<b>Sub total</b>	<b>None</b>	<b>None</b>	<b>1 Fatality 13 Injuries</b>	<b>1 Fatality</b>	<b>None</b>	<b>None</b>	<b>None</b>	<b>None</b>	<b>1 Injury</b>	<b>None</b>
<b>Cargo Ships</b>										
General Cargo Ships									1 Injury	
Ro-Ro Cargo										
Tanker										
Bulk Carrier										
Container Ship					1 Fatality					
Car Carrier										
Work Boat Pilot/Barge										
Heavy Lift										
<b>Sub total</b>	<b>None</b>	<b>None</b>	<b>None</b>	<b>None</b>	<b>1 Fatality</b>	<b>None</b>	<b>None</b>	<b>None</b>	<b>1 Injury</b>	<b>None</b>
<b>Fishing Vessels</b>										
< 15 metres	1 Fatality	1 Fatality	2 Fatalities	2 Fatalities	2 Fatalities	2 Fatalities	3 Fatalities 2 Injuries		1 Injury	2 Fatalities
15 - 24 metres							1 Fatality	1 Injury	1 Injury	1 Fatality
> 24 metres		2 Fatalities	2 Fatalities					1 Injury	2 Injuries	
<b>Sub total</b>	<b>1 Fatality</b>	<b>3 Fatalities</b>	<b>4 Fatalities</b>	<b>2 Fatalities</b>	<b>2 Fatalities</b>	<b>2 Fatalities</b>	<b>4 Fatalities 2 Injuries</b>	<b>2 Injuries</b>	<b>4 Injuries</b>	<b>3 Fatalities</b>
<b>Recreational Craft</b>										
Jet Skis										1 Fatality
Open Boats/Canoe	3 Fatalities/ 1 Injury		1 Fatality/ 1 Injury	1 Fatality	1 Fatality	3 Fatalities/ 1 Injury				3 Fatalities
Motor (Decked)		2 Fatalities	3 Fatalities		1 Fatality	1 Fatality				1 Fatality
Sail	1 Fatality									
Fast Power Craft/RIB				2 Fatalities	3 Fatalities					
<b>Sub totals</b>	<b>4 Fatalities/ 1 Injury</b>	<b>2 Fatalities</b>	<b>4 Fatalities/ 1 Injury</b>	<b>3 Fatalities</b>	<b>5 Fatalities</b>	<b>4 Fatalities 1 Injury</b>	<b>None</b>	<b>None</b>	<b>None</b>	<b>5 Fatalities</b>
<b>Total Incidents</b>	<b>7</b>	<b>7</b>	<b>15</b>	<b>5</b>	<b>5</b>	<b>10</b>	<b>8</b>	<b>8</b>	<b>11</b>	<b>10</b>
<b>Total Fatalities</b>	<b>5</b>	<b>5</b>	<b>9</b>	<b>6</b>	<b>8</b>	<b>6</b>	<b>4</b>	<b>0</b>	<b>0</b>	<b>8</b>
<b>Total Injuries</b>	<b>1</b>	<b>0</b>	<b>14</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>2</b>	<b>6</b>	<b>0</b>
<b>Total No. of Vessels involved</b>	<b>7</b>	<b>7</b>	<b>15</b>	<b>5</b>	<b>5</b>	<b>11</b>	<b>8</b>	<b>8</b>	<b>21</b>	<b>11</b>

# Fatality Trends 2014 - 2023

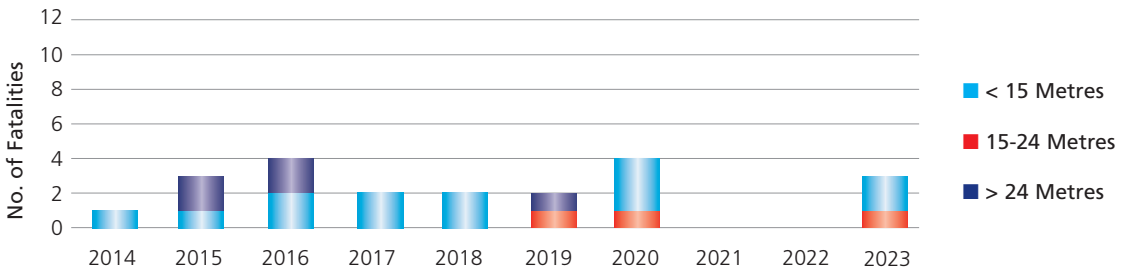
## Passenger Ships/Vessels



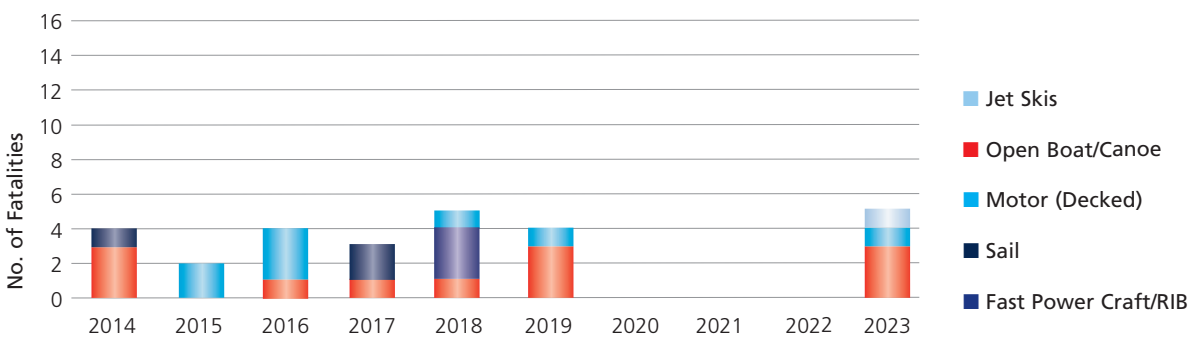
## Cargo Ships



## Fishing Vessels



## Recreational Craft



# Appendix A

The incidents set out under were considered by the MCIB but not investigated. Some of these incidents involved co-operation with other flag states or in some case the uploading of key data onto the European Maritime Casualty Investigation Platform (EMCIP).

MCIB Ref.	Vessel Name	Date	Incident details
MCIB/13/562	MT Gladiator	09/01/2023	Injured crewmember
MCIB/13/563	MS Epsilon	08/01/2023	Injured crewmember
MCIB/13/564	FV Mairi Maree	16/01/2023	Fouled propellor
MCIB/13/565	FV Silver Rose	16/01/2023	Sunken vessel
MCIB/13/567	FV Annelies Ilena	19/01/2023	Injured crewmember
MCIB/13/568	RNLI LB Myrtle Maud	19/01/2023	Vessel made contact with rocks
MCIB/13/569	FV Róise Catriona	04/02/2023	Injured crewmember
MCIB/13/570	FV Green Isle	12/02/2023	Injured crewmember
MCIB/13/571	FV Harvest Reaper II	15/02/2023	Fouled propeller
MCIB/13/573	FV Stella Maris	17/03/2023	Engine problem
MCIB/13/574	Ku-ee-tu- water bus	18/03/2023	Vessel aground
MCIB/13/575	FV Antarctic	23/03/2023	Injured crewmember
MCIB/13/576	FV Rackard	26/03/2023	Fouled propeller
MCIB/13/577	MV Pompei	12/03/2023	Collided with Barrow Rail Bridge
MCIB/13/578	MV Elbtrader	17/03/2023	Vessel not under command
MCIB/13/579	FV Ronsard	06/05/2023	Injured crewmember
MCIB/13/580	FV Zuiderzee	11/05/2023	Injured crewmember
MCIB/13/581	FV Boy Jason	10/05/2023	Fire onboard
MCIB/13/582	FV Emer Jane	18/05/2023	Injured crewmember
MCIB/13/583	FV Eilean Croine	20/05/2023	Electrical fire onboard
MCIB/13/584	Jet Ski - Carlingford	22/05/2023	1 fatality
MCIB/13/586	FV Grand Saint Bernard	02/06/2023	Vessel aground
MCIB/13/587	Open lake fishing boat	23/05/2023	Occupants in water after vessel hit rocks and ran aground
MCIB/13/588	T Burke 2	13/06/2023	Fire onboard
MCIB/13/589	MV Stena Estrid	22/06/2023	Engine failure
MCIB/13/590	SV Flashpoint	25/06/2023	Vessel capsized and sank
MCIB/13/591	GP14 Dinghies in difficulty	22/06/2023	Dinghies capsized
MCIB/13/592	FV Nuevo San Juan	02/07/2023	Sunken vessel

MCIB Ref.	Vessel Name	Date	Incident details
MCIB/13/593	Rib C-Breeze	08/07/2023	Fire onboard
MCIB/13/594	FV Custos Deus	17/07/2023	Injured crewmember
MCIB/13/598	Pontoon workboat	03/08/2023	Injured crewmember
MCIB/13/599	FV Migrator	16/08/2023	Injured crewmember
MCIB/13/600	MV Hermine	10/08/2023	Engine malfunction
MCIB/13/601	FV The Morning Lark	19/08/2023	Sunken vessel
MCIB/13/602	SV Brian Boru	21/08/2023	Injured crewmember
MCIB/13/603	SV Macif 27	10/08/2023	Injured crewmember
MCIB/13/605	Aqua Transporter	19/08/2023	Engine failure
MCIB/13/606	MV WB Yeats	06/09/2023	Fire onboard
MCIB/13/607	FV Men Scoedec	15/09/2023	Fouled propeller
MCIB/13/608	MV Strami	13/09/2023	Engine failure
MCIB/13/609	SV TI Carayb Solo Sail	11/09/2023	Engine failure
MCIB/13/610	FV Graceful Morn 2	26/09/2023	Vessel aground
MCIB/13/612	FV Ocean Crest	05/10/2023	Injured crewmember
MCIB/13/613	Boat fire Killaloe	08/10/2023	Fire onboard
MCIB/13/614	FV Northern Celt	11/10/2023	Injured crewmember
MCIB/13/615	MV Oscar Wild	29/10/2023	Injured crewmember
MCIB/13/616	FV Kennedy	26/11/2023	Injured crewmember
MCIB/13/617	FV Astrid	11/12/2023	Injured crewmember
MCIB/13/618	MV Wilson Nice	27/12/2023	Engine problem
MCIB/13/619	MV UHL Future	08/12/2023	Injured crewmember
MCIB/13/620	FV Boy Jason	12/12/2023	Electrical fault





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