MARINE CASUALTY INVESTIGATION BOARD

Annual Report 2024

MCIB
Marine Casualty Investigation Board
Bord Imscrúdú Taismí Muirí

The Marine Casualty Investigation Board was established on the 25th March, 2003 under the Merchant Shipping (Investigation of Marine Casualties) Act 2000.

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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 (as amended), I present the twenty-second Incidents & Investigations report of the Marine Casualty Investigation Board (MCIB), covering the period 1 January – 31 December 2024.

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 2024, for publication on the MCIB website www.mcib.ie.

Overview of 2024

The MCIB commenced investigations into four marine casualties in 2024, one of which was a fatal incident. In fatal cases the MCIB works with An Garda Síochána and I want to thank all the Gardaí who have assisted 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 67 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)[1].

During 2024 the MCIB also assessed 27 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 MCIB was established 26 years ago and to the end of December 2024 it has published 274 reports into incidents under its statutory remit. The Board published ten final marine casualty investigation reports and five interim reports in 2024.

At 31 December 2024 there were in total nine ongoing investigations, four of which occurred in 2024, and five which occurred in 2023. As of March 2025, there are in total ten investigations ongoing including those commenced in 2024. Of the ten ongoing investigations, five involve fatalities that occurred in 2023, one that occurred in 2024 and one in 2025. Five occurred on fishing vessels, four involved recreational craft, including recreational angling vessels, a recreational motorboat, and a jet ski, and one involved a passenger vessel.

The MCIB extends its condolences to all those affected by these deaths and wishes to acknowledge the dedication and commitment of the first responders in particular the Irish Coast Guard (IRCG) and the other members of the Search and Rescue Services. We also thank and appreciate all the co-operation with An Garda Síochána in respect of the fatalities, and with many Coroners over the year.

Included in the MCIB investigation reports published in 2024, is a report (MCIB Report No.325) into the investigation of a scheduled training session on the river Corrib for two competitive rowing boats which 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. Since this casualty event, many changes had been enacted in the operation of rowing activities in the boat club. The MCIB made safety recommendations addressed to the University of Galway Boat Club, Rowing Ireland and Sport Ireland, all rowing clubs operating on the River Corrib, Water Safety Ireland, and the Minister for Transport.

Another report involved a fishing vessel fatality when a crewmember was shooting a string of crab pots (MCIB Report No. 326). The operation of shooting the pots required one crewmember to be on deck ensuring the pots ran freely off the deck. As the last pot was leaving the deck, the crewmember on deck became entangled in the rope connected to

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

the pot and was dragged through the stern door opening, over the side and into the water where he drowned. He was not wearing a Personal Flotation Device (PFD). Two other fatalities from recreational boats where PFDs were not worn were also reported on in MCIB reports No.329 and No.332. In December 2024 MCIB Report No.336 was published. This involved a very serious collision between a fishing vessel and a laden motor vessel on course from Milford Haven to the USA where the outcomes for the fishing vessel crew would have been extremely serious, with potentially fatal consequences, had the Skipper increased his vessel's speed around one minute earlier. The MCIB would like to thank their sister organisation in Singapore for its co-operation during this investigation.

During 2024 the Minister published a revised version of the Code of Practice for the Safe Operation of Recreational Craft. The content of the Code is useful and informative on essential safety steps that should be taken. As an educational tool, the Code of Practice for the Safe Operation of Recreational Craft is a way to inform recreational craft owners, operators and users of the legislative requirements, safety guidelines and best practice operational advice that applies to a range of recreational craft that operate in Irish coastal and inland waters. The Code of Practice was first published in 2006 following a review of safety measures on small watercraft and a public consultation process. Revised editions were published in 2008 and 2017. The new and revised Code of Practice represents the culmination of a review and stakeholder consultation process undertaken in 2022 and 2023 which included the MCIB.

Legislative Changes

There has been legislative progress with the Merchant Shipping (Investigation of Marine Accidents) Bill 2024 (which provides for a full-time Marine Accident Investigation Unit (MAIU) within the Department of Transport). The MAIU will replace the MCIB as the permanent body responsible for marine accident investigation.

European Context and EMSA

In 2024 MCIB continued its involvement 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.

As reported in the MCIB Annual Report for 2023, in 2024 EMSA commenced its first year of a new training academy with a Common Core Curriculum for EU accident investigators. This is a very welcome development which will contribute to the continued learning of MCIB accident investigators. Three MCIB investigators successfully completed the new course in 2024.

On the 27 November 2024 Directive (EU) 2024/3017 of the European Parliament and of the Council was published amending Directive 2009/18/EC of the European Parliament and of the Council establishing the fundamental principles governing the investigation of accidents in the maritime transport sector and repealing Commission Regulation (EU) 1286/2011. As previously reported it was expected that the Directive would, among many other changes, introduce some level of mandatory investigations for fishing vessels of less than 15 metres (m) length overall. In paragraph 8 of the preamble in the Directive the following is recited:

> *"Fishing vessels of less than 15 metres in length are at present excluded from the scope of Directive 2009/18/EC. As a result, the conduct of safety investigations involving such fishing vessels is neither systematic nor harmonised. Such vessels are more prone to capsizing and it is relatively common for members of their crew to fall overboard. Therefore, in order to protect such fishing vessels, their crew and the environment, it is necessary to provide for a preliminary assessment of very serious marine casualties involving such fishing vessels to determine whether the authorities are to open a safety investigation, taking into account, inter alia, the evidence available as well as the potential for the findings of the safety investigation to lead to the prevention of future marine casualties and incidents. That measure is expected to have a significant positive impact in terms of the number of lives saved at sea and injuries avoided, protecting in particular the lives and health of European fishers."*

Article 5 (2) of the new Directive provides that:

> *"In the case of a fishing vessel of less than 15 metres in length, the safety investigation authority shall without delay and no later than two months after the very serious marine casualty referred to in paragraph 1 of this Article, carry out a preliminary assessment to determine whether to conduct a safety investigation. Where the safety investigation authority decides not to conduct such a safety investigation, the reasons for that decision shall without delay and no later than two months after the very serious marine casualty be recorded and notified in accordance with Article 17(3)."*

The Directive provides that by 27 June 2027 Member States must have introduced legislation to comply with the Directive. This will increase very considerably the work of the planned MAIU although less so than some other Member

States as marine casualties involving fishing vessels of less than 15 metres in length are not excluded from investigation under the Merchant Shipping (Investigation of Marine Casualties) Act 2000 (as amended) and are regularly involved in MCIB incidents and investigations.

The Department published 65 Marine Notices in 2024

The full list can be accessed at - Marine Notices 2024 (www.gov.ie)

The following Marine Notices were published in 2024 following MCIB reports and investigations:

11 of 2024 Reminder of Safety Requirements to Shipowners, Operators and Masters and those involved in Marine Aquaculture Activities.

24 of 2024 Safety requirements with regard to operation of cranes and other lifting equipment on fishing vessels.

29 of 2024 REMINDER - Safe Manning Document Fishing Vessels.

54 of 2024 New Code of Practice for the Safe Operation of Recreational Craft.

In addition, two Marine Notices were published in 2024 with significant safety information:

8 of 2024 Passenger Ship Tendering Operations and Crew/Technicians embarking or disembarking other seagoing vessels at anchor (Amended 01/03/24).

30 of 2024 International Certificate for Operators of Pleasure Craft (ICC).

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:

Notification	When the MCIB is notified of a marine casualty or incident, an assessment has to be conducted to decide whether to investigate.
Gather evidence	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.
Analyse evidence	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.
Draw conclusions	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.
Determine remedial actions	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.
Report	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 2024

The Board published ten final and five interim reports during 2024. The full details are provided at pages 14 to 23.

Investigations commenced in 2024

Investigations were initiated by the Board into four incidents during 2024. Summary details of the incidents are provided in the table below. Full details of all incidents are set out on pages 11 to 13.

Two of the four incidents which required investigation occurred in the fishing industry. One incident involved a passenger vessel and one involved a recreational craft, which was a fatal incident.

Sector	Incidents	Sinkings	Fatalities	Injuries
Fishing	2	1	0	0
General Cargo	0	0	0	0
Recreational	1	0	1	0
Passenger	1	1	0	0
Total	**4**	**2**	**1**	**0**

Fishing Vessels

There were two incidents involving fishing vessels.

- Incident involving vessel grounding, Inishmore, Co. Galway.
- Sunken vessel, off the coast of Malin Head, Co. Donegal.

Passenger Vessel

There was one incident involving a passenger craft.

- Sunken vessel, Skellig Islands, Co. Kerry.

Recreational Craft

There was one incident involving a recreational craft.

- Fatal Incident involving vessel, Inishbofin, Co. Galway.

Detailed tables of incidents investigated which occurred in the years 2015 to 2024 are at page 24 and 25 of this report. A summary of all incidents investigated occurring in these years is provided in the table below:

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Fatalities	5	9	6	8	6	4	0	0	8	1
Injuries	0	14	0	0	1	2	2	6	0	0
Vessels Involved	7	15	5	5	11	8	8	21	11	4

Ethics in Public Office

During 2024, 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. I would also like to thank the diligent contribution and expertise of our investigators and our very dedicated Secretariat, and Board Secretary for all of the year's contribution.

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 2024.

CLAIRE CALLANAN
CHAIRPERSON

Board Members and General Information

Ms. Claire Callanan,
Chairperson, Solicitor

Mr. John Carlton,
Deputy Chairperson (as of 1 April 2024), BSc in Marine Engineering, BA in Business Management, Marine Engineer Class I

Dr. Dorothea Dowling,
(January-March 2024) Deputy Chairperson, Chartered Insurer and Accredited Mediator

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

Ms. Deirdre Lane,
FNI, MSc, Master Mariner, Harbour Master Dunmore East

Mr. Phil Murphy,
Class I Master Mariner

Secretary:	Ms. Margaret Bell
Secretariat:	Mr. Paul Hallissey
	Ms. Diptiben Bhatt (January-August 2024)
	Ms. Diane Nesbitt Flood (July-December 2024)

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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 International Maritime Organisation's (IMO) 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 the 9 of 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 Gárda 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.

Incidents and Investigations 2024

MCIB
Marine Casualty Investigation Board
Bord Imscrúdú Taismí Muirí

Reporting Period 1st January to 31st December 2024

Introduction

Since establishment in 2002, and up to the end of 2024, the Board has published reports on 274 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, and are available on application to the Secretariat.

Summary of Incidents Investigated which Occurred During 2024

1st January to 31st December 2024

Name of vessel/incident: **FV Ambitious**	
TYPE OF CRAFT	Fishing Vessel >15m
TYPE OF INCIDENT	Grounding
FATALITIES	None
SUMMARY	At approximately 17.00 hours (hrs), the fishing vessel (FV) Ambitious departed Rossaveel Harbour, Connemara, Co. Galway. The vessel commenced fishing operations south of Rossaveel at approximately 18.00 hrs, towing their fishing gear east parallel to the coastline. At 23.00 hrs the crew were called to recover the fishing gear onboard and by 23.45 hrs the nets and catch had been retrieved. The vessel was now three miles south of Spiddal Harbour and the drive was disengaged. The crew were processing the catch while the Skipper rested. At around 01.00 hrs the catch had been processed and the crew woke the Skipper as previously agreed. Due to the poor catch retrieved onboard and the improving weather forecasted, the Skipper decided to try alternative fishing grounds north of the Aran Islands. The Skipper engaged the drive and placed the vessel on an approximate heading of 265 degrees, setting the speed at 4 knots (kts). The Skipper requested that two crewmembers remain on watch, maintaining the vessel course/speed and instructed them to wake him at 04.00 hrs. During the passage the required watch was not maintained. At about 04.40 hrs, the FV Ambitious, ran aground on the north side of Inishmore Island, Co. Galway. As the vessel began to list to port, the only liferaft onboard was deployed and the crew entered the liferaft from the forward deck. The rescue helicopter R115 arrived on the scene at approximately 06.18 hrs and the crew were winched onboard. The crew were then transferred to hospital in Galway as a precaution and were released later that day.

Name of vessel/incident: **FV Sainte Catherine Laboure**	
TYPE OF CRAFT	Fishing Vessel >15 m
TYPE OF INCIDENT	Sinking
FATALITIES	None
SUMMARY	While fishing for haddock in the area of the Rockall Bank, the Skipper of the FV Sainte Catherine Laboure was on watch in the wheelhouse while the remainder of the crew were resting. At around 22.00 hrs the Skipper noted an engine room bilge alarm light flickering. He proceeded to the engine room and activated the primary bilge pump, checking it was pumping over the side. As the water level was still rising, a second bilge pump was started and the Skipper called the Mate. Both the Skipper and the Mate checked under the plates in the engine room but could not ascertain where the water was coming from. As the water level continued to rise, the remainder of the crew were woken and a PAN-PAN call was made. Two vessels responded to the PAN-PAN, a Scottish vessel, the FV Good Hope, which was 01.5 hrs away and a fishery protection vessel the MPV Jura 01.75 hrs away. The Mate now ensured the crew were in suitable clothing and issued them with lifejackets. The Skipper maintained contact with the FV Good Hope and the MPV Jura and at 22.44 hrs activated the digital selective calling (DSC) and the Emergency Position Indicating Radio Beacon (EPIRB). Both liferafts were launched, and the crew abandoned the vessel at 23.15 hrs. The crew were recovered to the FV Good Hope circa 23.45 hrs. The MPV Jura arrived on scene and stood by. The MPV Jura confirmed that the FV Sainte Catherine Laboure sank at 01.00 hrs and remained on scene to collect any debris until the morning. FV Good Hope proceeded to Ullapool on the Scottish west coast and landed the survivors there in the morning.

Name of vessel/incident: **Inishbofin Island**	
TYPE OF CRAFT	Recreational Craft
TYPE OF INCIDENT	Drowning
FATALITIES	1 Fatality
SUMMARY	A lone fisher took to sea in a small aluminium vessel from Inishbofin, Co. Galway to engage in lobster fishing. The weather conditions were moderate with a small craft warning in effect. The vessel made its way towards lobster pots located off the north side of the island. The Casualty, who was familiar with the area, tended to his pots as part of his routine, working solo despite forecasted moderate to fresh, sea conditions. The exact details of the circumstances of this incident cannot be determined with certainty. However, having examined the various possible sequence of events, the most likely scenario is that at some point during the day the Casualty encountered a fouled lobster pot and attempted to free it by tethering the vessel to the pot riser and used the swell to lift the vessel to aid dislodging the fouled lobster pot from the seabed. The combination of moderate to fresh seas and the added strain from the tethered pot compromised the vessel's stability. In the process of trying to free the pot, the vessel likely took on water, ultimately capsizing and most probably causing the Casualty to go overboard. Although the Casualty was wearing a lifejacket, water temperature was estimated at 14°-15°Celsius (C), with no means to communicate distress. Due to the absence of an emergency communication device, such as an EPIRB, Personal Locator Beacon (PLB) or Very High Frequency (VHF) radio, no automatic distress signal was sent, and the incident went unnoticed until the following day. Local search efforts were initiated, and emergency services, including the IRCG and the Clifden Royal National Lifeboat Institution, were later mobilised. Despite these efforts, the deceased Casualty was located onshore.

Name of vessel/incident: **Sea Breeze III**	
TYPE OF CRAFT	Passenger Vessel
TYPE OF INCIDENT	Sinking
FATALITIES	None
SUMMARY	At around 07.45 hrs the 11.58 m long sightseeing motor vessel (MV) Sea Breeze III, departed from Portmagee, Co. Kerry, bound for Skellig Michael Island. The vessel had two crew and 12 passengers onboard. The weather conditions were favourable with a light breeze of 4 to 6 kts, a low swell and good visibility. The vessel proceeded directly to the concrete landing stage located on Skellig Michael Island, and at approximately 09.00 hrs, the 12 passengers were landed ashore accompanied by one crewmember, leaving the Skipper alone onboard. It was standard practice for the vessel to move away from the landing stage and drift, awaiting the return of the passengers and crewmember in around two and a half hours. At approximately 09.10 hrs the engine compartment bilge alarm sounded onboard MV Sea Breeze III. The Skipper inspected the compartment and he observed water at the base of the engine. He started the engine compartment bilge pump and telephoned the vessel Owner. They agreed that the vessel would return to Portmagee and that the Owner would rendezvous on passage using another quicker vessel, the MV Skellig Flier. The stern of MV Sea Breeze III gradually became lower in the water and when the Owner reached the vessel at around 09.35 hrs it was already close to sinking. The Owner manoeuvred alongside and instructed the Skipper to transfer across to his vessel. Within minutes MV Sea Breeze III sank, stern first in around 80 m of water, in a position approximately 2.9 nautical miles (NM) to the north of Little Skellig Island. The EPRIB was activated at 09.38 hrs as the vessel sank.

Summary of Reports Published 2024

1st January to 31st December 2024

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

Name of vessel/incident: **FV Aquila**	
DATE OF PUBLICATION	30 January, 2024
TYPE OF CRAFT	Fishing Vessel > 15 m
DATE OF INCIDENT	7 November, 2021
SUMMARY	FV Aquila with five crew onboard left the fishing port of Union Hall, Co. Cork at approximately 21.00 hrs on the evening of the 6 November 2021 to fish south of the Kinsale Gas Rigs. At approximately 12.00 hrs on the 7 November the fishing vessel was at the fishing grounds and the crew were hauling the second haul of the day using the vessel's net handling crane when the crane's hydraulic system experienced a sudden loss of hydraulic oil pressure causing the crane's jib and power head to uncontrollably lower inboard trapping a Crewmember between the power head and the underside of the deck supporting the net drum. The Crewmember suffered crush injuries. The Skipper contacted the Cork Coast Guard Radio (CGR) by VHF radio at 12.38 hrs advising them of the incident and requesting a medical evacuation of the injured Crewmember. At approximately 15.00 hrs the IRCG rescue helicopter R115 airlifted the injured Crewmember ashore to Cork University Hospital (CUH) for medical attention. He was discharged from CUH on the 8 November as passed fit to fly home and returned to the Philippines to recover. He recuperated and has since returned to work as a fisher onboard an Irish registered fishing vessel.
INJURIES/FATALITIES	One serious injury
CAUSE OF INCIDENT	The incident occurred as a result of loss of fluid from the main jib hydraulic cylinder which occurred between the cylinder and the check valve. The position of the main cylinder valve block underneath the main hydraulic cylinder exposes the valve block and its associated steel pipework to mechanical damage. The use of threaded connections is a source of failure due to the creation of stress raisers and also has the potential for over-torquing of the threaded connector when installing the fitting. The crane operator's elevated control position on the Wheelhouse Deck does not give the operator a clear view of the entire working area around the net pounds located on the vessel's Main (working) Deck. An adequate risk assessment was not made when the crane was first installed as the crane operator's elevated control position did not have a clear view of the crane's underneath surfaces during the net recovery slewing operation and did not give a clear spatial appreciation of the crane's main lift cylinder relative to the vessel's bulwark or guard rail. By placing himself underneath the net drum deck and at the forward side of the net pounds, the Crewmember put himself out of view of the crane operator but reduced his risk of going overboard. By doing so, the Crewmember put himself into harm's way of a descending crane jib in the event of crane failure. That he was at risk from a sudden failure and out of sight of the crane operator indicates a failure to recognise the risk by himself (the Crewmember) and by the crane operator.

Name of vessel/incident: **FV Ardent**	
DATE OF PUBLICATION	29 February, 2024
TYPE OF CRAFT	Fishing Vessel >15 m
DATE OF INCIDENT	31 October, 2022
SUMMARY	At approximately 15.05 hrs on the 31 October 2022 the FV Ardent departed Port Oriel Harbour, Clogherhead, Co. Louth with four crew onboard, to commence fishing activities in the Irish Sea. At 15.15 hrs the Skipper and a Crewmember commenced the tank washing and cleaning operation in preparation for refilling of the Refrigerated Sea Water (RSW) tanks with seawater. A small amount of seawater had remained within the centre tank. The Skipper then operated the tank discharge pump, expelling the water overboard. The Crewmember entered the centre tank via the small deck hatch, to collect some fish remnants that had become entangled in the cooling system. While down in the tank he fell to the tank floor close to the ladder. A potential recovery plan was discussed and agreed by the other crewmembers. One Crewmember donned a safety harness and attached a recovery line that was manned by another Crewmember. Another Crewmember entered the tank by descending on the ladder. While trying to assess the condition of the first Crewmember, the second Crewmember was affected by the atmosphere within the tank. He immediately attempted to climb the ladder to escape. When approximately halfway up the ladder he lost consciousness and was hauled aloft by a third Crewmember via the line attached to the harness. The Skipper and third Crewmember recovered the second Crewmember to the deck. The vessel returned to Port Oriel and rescue services with breathing apparatus recovered the first Crewmember from the tank. At approximately 16.40 hrs both injured crewmembers were taken to hospital where medical treatment was administered.
INJURIES/FATALITIES	Two injured crewmembers
CAUSE OF INCIDENT	The FV Ardent discharged fish on the 25 October 2022 in Ardglass, Co. Down. System flushing was carried out on the 25 and 26 October. It appears that some product/material remained within the RSW system piping or tanks. Additional tank cleaning and preparation was conducted on the 31 October and during this process a mixture of fish product and seawater containing soluble gas was released into the centre tank space. The liquid surface area and agitation of the material that remained in the system aided the release of gases into the tank space. Probable Source of Asphyxiation: A mixture of rotting fish and seawater was held within sections of the RSW system piping, cooler and valve chest below the shelter-deck over a prolonged period (approximately 150 hrs), at a temperature of approximately 15°C. This produced dangerous levels of toxic gases. When the mixture was released during the system cleaning and preparation, via the RSW system upper & lower diffuser, the soluble gas within the liquid was released due to the liquid cascading. The remaining water was discharged overboard, trapping the released gases that were heavier than air, at lower levels within the tank. Both Casualties were overcome by the toxic atmosphere when they lowered their heads into the toxic pool. The first Casualty was overcome while passing below the tank centre boards. The second Casualty was overcome while checking the condition of the first Casualty who was lying on the tank floor. The actions taken by the crewmembers including the opening of additional hatches and vents would have provided additional ventilation below decks. The vessel did not carry any enclosed space rescue equipment or breathing apparatus. An attempted rescue/recovery was initiated, and a safety harness was donned by a crewmember, and he was attached to a recovery rope manned on deck. While this aided his recovery from within the tank, the condition and suitability of the harness in use was suspect. This incident could have had far more serious outcome but for proximity and response of the emergency services, the short distance to the accident and emergency department along with some of the actions taken by the crew onboard.

Name of vessel/incident: **Sailing Vessel Inish Ceinn**	
DATE OF PUBLICATION	26 March, 2024
TYPE OF CRAFT	Recreational Craft
DATE OF INCIDENT	6 June, 2023
SUMMARY	The sailing yacht Inish Ceinn departed from Baltimore, Co. Cork on 6 June 2023 at 14.00 hrs, for a short voyage to Cape Clear Island. The Skipper was a well-qualified and experienced yacht master and diver. There were three other experienced persons onboard and one guest. 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. The planned course was around 0.5 miles from the southern shore of Sherkin Island. 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 VHF radio. He also got onto the rocks. At this stage the Skipper noticed the hull was fouled with a large trawl net. 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
INJURIES/FATALITIES	None
CAUSE OF INCIDENT	This casualty was caused by a floating trawl net that became entangled on the bottom of the yacht. This was a large net, and it completely immobilised the vessel. The wind and waves pushed the vessel quickly towards the rocks and there was very little that could be done to gain control. The experience and calm response of the Skipper ensured all five persons onboard were safely landed on the rocks in a very difficult situation and prevented a far more serious situation developing with potential loss of life. The vessel broke up due to the continuous hammering against the rocks. The discarded trawl net was the root cause of this casualty. Had this fishing gear been properly discharged ashore or had it been reported and recovered if accidentally lost, this incident could have been prevented. The source of the net cannot be established as it had no tags and there is no record of it having been reported to any Irish authority.

Name of vessel/incident: **Rowing Vessels River Corrib**	
DATE OF PUBLICATION	17 April, 2024
TYPE OF CRAFT	Rowing Vessels
DATE OF INCIDENT	14 January, 2023
SUMMARY	On the 14 January 2023, a scheduled training session on a river 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. 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. 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
INJURIES/FATALITIES	None
CAUSE OF INCIDENT	A complex system had developed around rowing activities on the River Corrib, with safety contingent on an interplay between the disperse factors. An issue of risk normalisation had developed around rowing activities in the vicinity of the weir, especially during the river's high flow rates and low water temperatures during winter months. The omission of PFDs had the potential to have been a causal factor in this marine casualty event. The University of Galway Boat Club had three club members afloat who were not wearing the PFD required of them by the relevant legislation. None of the eight rowers in the two rowing boats were wearing a PFD, nor were they required by the relevant legislation to do so because of the exemption pertaining to rowers in this type of competitive rowing boat.

Name of vessel/incident: **Sailing Yacht Jelly Baby**	
DATE OF PUBLICATION	11 June, 2024
TYPE OF CRAFT	Recreational Craft
DATE OF INCIDENT	24 October, 2021
SUMMARY	On the 24 October 2021 yacht Jelly Baby with nine persons onboard was competing in the last race of the 2021 Autumn League series race in Cork Harbour. On rounding the third mark of the racecourse, W2 buoy, the crew were preparing to change sails when they encountered difficulties rigging a gennaker which is a type of downwind sail. During efforts to overcome these difficulties the gennaker and the Bowman went over the side of the yacht. The Bowman was pulled back onboard by the crew but the gennaker became entangled around the keel, rudder and propeller and disabled the yacht. The yacht luffed up to port towards the shore and shortly thereafter went aground on a lee shore on Bull Rock at Weavers Point on the west side of the entrance to Cork Harbour. The Bowman was successfully recovered, and the crew were uninjured, but the yacht remained aground until floated on the following flood tide and was then towed to Crosshaven.
INJURIES/FATALITIES	None
CAUSE OF INCIDENT	The MCIB investigation found key causative factors leading to the putting at risk the Bowman and crew and the grounding and loss of yacht Jelly Baby: a) The crew's response to sailing mishaps were not consistent with those to be expected from an appropriately trained yacht crew. The disruption initiated by a snagged halyard started the chain of events. This was followed by the Bowman going over the side and hanging on while he was trying to retrieve the sail in the water. b) Irrespective of the policy of Irish Sailing that reflects the issues around whether tethers should be worn or not and in what circumstances, it remains a fact that the Bowman was not wearing a tether which led to the risk situation being far greater and contributed to the decisions that were made. c) The crew were overwhelmed by these events and failed to react correctly in a prompt and efficient manner as was required in the situation. The absence of crew training to keep control of, or stopping, the yacht while appropriately coping with the mishaps as they occurred. d) While the different interpretation and application of Tethered Man Overboard/MOB urged on the MCIB is noted, the absence of the initiation of a MOB procedure or crisis management outstretched the capability of the crew to effectively manage a succession of escalating mishaps. e) The absence of appropriate actions by the crew and their lack of training for these sorts of events. The responsibility for the crew's safety and training is primarily with the person in charge/skipper of a yacht competing in a race. However, where the race or event is being run by a club under its rules and directions it has an influence (possibly a very great influence) on safety aspects. The Royal Cork Yacht Club did not evidence an appropriate balance of risk versus competitiveness required in the prevailing conditions. Consideration should have been given to mandating the wearing of PFDs. Also, regard should have been given to the fact that the Club exercises no oversight in respect of crew training and that the unwritten regime on the wearing of tethers might lead to an absence of better or more sensible risk assessments.

Name of vessel/incident: **Lacken Pier**	
DATE OF PUBLICATION	3 July, 2024
TYPE OF CRAFT	Recreational Craft
DATE OF INCIDENT	16 July, 2023
SUMMARY	On the morning of the 16 July 2023 at around 10.20 hrs, a recreational boat was launched from Lacken Pier, Beltra Co. Mayo to facilitate a day of sea angling for two people. The boat was launched from a trailer towed by a tractor. The Casualty (the owner of the boat) was driving the tractor, and the Survivor was in the boat which was on the trailer. 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 East Pier steps. He got into difficulty and was swept out to sea. The boat with the Survivor onboard drifted out to sea. Emergency services were alerted to the incident by a member of the public (MOP) and Killala CGU 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 and returned to Germany where he resided.
INJURIES/FATALITIES	1 Fatality
CAUSE OF INCIDENT	This incident resulted in a fatality, which was likely caused by drowning. The Casualty got into difficulty after he entered the water whilst attempting to wade and/or swim to the boat, which was drifting out to sea. The failure to secure a line or painter to the shore, as well as lowering and having the engine ready for use during the boat launching procedure was the immediate causal factor in this incident. Had the Casualty been wearing a PFD/lifejacket his chances of survival would have been greatly improved. Had the Survivor been wearing a PFD/lifejacket, a) the Casualty may have assessed the risk to his companion differently and may not have felt the need to enter the water, and b) the Survivor might have exited the boat before it was out of his control and/or before it got too far from the pier while still in water he could wade in. Had the boat been equipped with a foghorn or distress flares, the Survivor may have been able to alert the Casualty at an earlier stage to the fact that he was drifting with no control over the boat. He might also have been able to alert a MOP, which might have resulted in either an earlier call to the emergency services or one that alerted the latter to there being someone in the water. The Survivor also had no mobile phone although he may not have been aware how to call the emergency services. The lack of communications facilities was a contributing factor. The presence of signage requiring wearing of lifejackets by persons on the pier may have prompted the Casualty and Survivor to don the lifejackets that were available to them. While the boat was adequately prepared for sea angling in Killala Bay, there was a lapse in detailed planning for the launch and especially concerning actions in emergencies and the prevailing conditions. The Survivor's inability to assist in boat operations was due to a deficiency in knowledge, training, experience, and a lack of pre-departure briefing on engine controls and operation. Inadequate planning was the root cause of this incident.

Name of vessel/incident: **FV Séimi**	
DATE OF PUBLICATION	22 August, 2024
TYPE OF CRAFT	Fishing Vessel 14.9 m
DATE OF INCIDENT	4 February, 2023
SUMMARY	On the evening of 4 February 2023 at approximately 20.00 hrs, the FV Séimi was shooting a string of crab pots approximately 60 NM north northwest of Arranmore Island off the northwest 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. 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. As the last pot was leaving the deck, the crewmember on deck became entangled in the rope connected to the pot and was dragged over the side and into the water. The vessel was stopped immediately, and an attempt was made to retrieve the MOB. 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 PFD. 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 (CPR) was administered and advice was 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.
INJURIES/FATALITIES	1 Fatality
CAUSE OF INCIDENT	The owner or master of any Irish registered fishing vessel has an obligation to ensure that there are sufficient qualified crew onboard, having regard to the type and duration of the voyage undertaken. This obligation was not observed by the Owner of FV Séimi. The Owner was unaware of which, if any, members of the crew held fishing or maritime qualifications and could not produce documentation to support qualifications or training for a single member of his current or former crew. Ensuring qualified crew were onboard was left to the Skipper who was only able to produce a Bord Iascaigh Mhara (BIM) safety training card for himself and one other crewmember. The Code of Practice (CoP) is very clear that the safe manning of the vessel is the owner's responsibility. The validity of a Declaration of Compliance (DoC) issued under the CoP is dependent upon the vessel being maintained, equipped and operated in accordance with the Code, and the Declaration. It is the owner's responsibility to ensure this. As only one of the BIM card numbers listed on the DoC was onboard the vessel at the time of the incident and three of the five crew held no BIM card, the vessel did not continue to comply with the requirements of the Code with respect to manning, training and certification. It is imperative that the owners, masters/skippers and employers of under 15 m fishing vessels take safety onboard seriously and operate their vessels in a professional manner. In this case, the absence of sufficiently qualified crew and the vessel's failure to comply with the CoP, coupled with the lack of drills, formal training, risk assessment, records and safety standards all indicate that the safety culture onboard FV Séimi was below the standards that should be expected onboard a commercially operated fishing vessel.

Name of vessel/incident: **Bruckless Pier**	
DATE OF PUBLICATION	22 August, 2024
TYPE OF CRAFT	Recreational Craft
DATE OF INCIDENT	28 September, 2023
SUMMARY	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 on Thursday, 28 September 2023. The vessel was at its mooring approximately 50 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 kts. A Small Craft Warning was in effect. The vessel was an older model of a recreational motor boat. The vessel had no means of unaided reboarding, either accessible to, or deployable by, a person in the water. 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.
INJURIES/FATALITIES	1 Fatality
CAUSE OF INCIDENT	The Casualty was operating alone in a recreational motor boat, in challenging weather conditions, when he fell overboard into cold water and drowned. He 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. The Casualty's situation was noticed by the owner of another recreational motor boat who had arrived on the shore and went afloat specifically to ascertain the situation. The Casualty's vessel had not been retrofitted with a means of unaided reboarding, either accessible to, or deployable by, a person in the water. The age of the Casualty's vessel meant that it predated the introduction of modern design requirements to both minimise the risk of falling overboard and to facilitate reboarding. There was no requirement for the Casualty, or the owner of any recreational vessel, to retrospectively assess their vessel against design standards introduced after the vessel's construction simply because new standards came into effect. The MCIB's analysis of the available information indicates that the Casualty's overboard situation is likely to have occurred in the course of his actions on the boat prior to untying the vessel's bowline from its mooring buoy. The circumstances of this incident mean that it has not been possible to determine exactly how the Casualty fell overboard and whether the Casualty's spinal cord stimulator medical device may have been a causal or contributory factor. This marine casualty occurred because of a combination of the following causal and contributory factors: 1. A fall overboard into cold water. 2. Operating alone, in challenging weather conditions. 3. Lack of formal training and planning of the voyage. 4. Inadequate safety and emergency equipment, being the omission of: a PFD; a means of raising the alarm, either in-person by VHF, PLB or mobile phone in waterproof pouch or via a shore contact; and a means of unaided reboarding of the vessel from the water.

Name of vessel/incident: **FV Ellie Adhamh**	
DATE OF PUBLICATION	31 October, 2024
TYPE OF CRAFT	Fishing Vessel >15 m
DATE OF INCIDENT	26 March, 2021
SUMMARY	The FV Ellie Adhamh with seven crew onboard was trawl fishing for prawns south of the Porcupine Bank off the west coast of Co. Cork, having started the trip on 13 March 2021. On 25 March 2021 at approximately 20.00 hrs the crew hauled the final trawl before returning to the vessel's home port of Castletownbere in Bantry Bay when the vessel experienced an electrical power failure affecting the vessel's main deck and wheelhouse deck lights and equipment. The vessel's emergency battery system activated and provided power to the vessel's emergency lighting system and other essential safety equipment. However, the Skipper was unable to restore the normal mains power supply. At approximately 06.00 hrs on Friday 26 March, the main emergency batteries had become exhausted causing controls to shut down. The crew were in darkness below decks. The weather and sea conditions were deteriorating. The Skipper of the FV Ellie Adhamh contacted the Owner to arrange a tug. Due to the weather conditions, FV Ellie Adhamh was rolling heavily and taking water into the main deck. The electrical supply to the bilge pumps in the factory deck drainage sumps was still operative, however the crew started to encounter difficulties in keeping the factory deck clear. After 06.00 hrs on Friday 26 March the electrical supply to the bilge pumps in the factory deck drainage sumps failed and the crew were unable to pump overboard the shipped seawater. The following morning, Saturday 27 March 2021, IRCG rescue helicopter R115 provided emergency salvage pumping equipment and handheld VHF radio sets to the vessel and the naval patrol vessel LÉ George Bernard Shaw established a towline. The fishing vessel developed a significant list during the towing operation and the safety of the crew became an increasing concern for the rescuers given the very difficult weather conditions. At 18.55 hrs on Saturday, the crew were airlifted from the listing vessel and brought to safety, ashore. At 10.55 hrs, Sunday 28 March, FV Ellie Adhamh sunk off the Bull Rock on the west coast of Co. Cork.
INJURIES/FATALITIES	None
CAUSE OF INCIDENT	The following factors led to the risk to the lives of the seven crew and the consequential exposure to the lives of the those involved in the extensive support and rescue operation, and ultimately, to the loss of the FV Ellie Adhamh: The electrical failure on the vessel and the failure to investigate the cause of the previous repeated electrical failures. The failure to provide the vessel with a properly qualified and trained skipper and the crews lack of emergency training and poor fluency in the English language. The Skipper and crews lack of knowledge or training in the emergency procedures to enable operation of the propulsion and controllable pitch propeller control systems when the power supply failed. The failure to establish a viable tow late on Thursday 25 March or early on the morning of Friday 26 March and the failure to assess and consider a back-up plan to relying solely on the tow from another vessel. Not closing all watertight and weathertight openings within and without the vessel when the electricity supply failed, allowed water ingress to flow to other compartments including the accommodation, increased the list, and contributed to the ultimate sinking of the vessel. The defective condition of the overboard waste discharge chute and the design of the chute cover combined with the design and stability characteristics which led to water ingress. The Owners apparent lack of appreciation of the stability characteristics of the vessel, their carrying out of changes that might affect stability.

	By omitting to apply to the Minister for approval(s) for the changes, and by failing also to notify the changes having made them, was likely to lead to their exclusion from an MSO examination for safety approval and the requisite periodic safety surveys. The failure of the vessel's towing bridle combined with the prevailing weather and sea conditions were also factors in this incident.

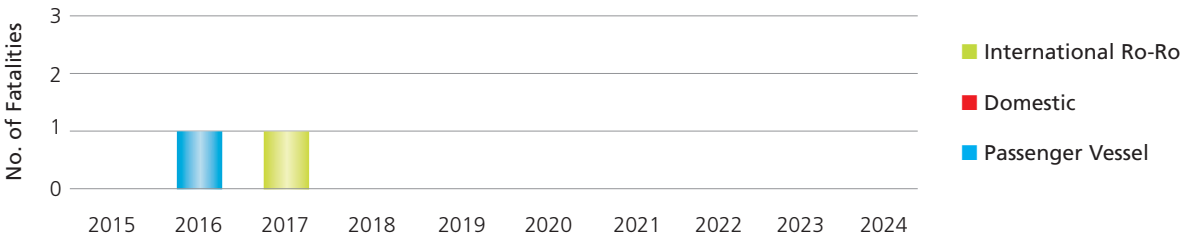
Name of vessel/incident: **FV Excel/MV Petrel Pacific**	
DATE OF PUBLICATION	20 December, 2024
TYPE OF CRAFT	Fishing Vessel >15 m & General Cargo Vessel
DATE OF INCIDENT	6 August, 2023
SUMMARY	At approximately 23.30 hrs on the 5 August 2023 the FV Excel departed Dunmore East, Co. Waterford. The vessel had four crew onboard and planned on fishing in the Irish Sea. After steaming overnight, the vessel arrived at the Smalls fishing grounds. Having completed a trawl and at around 22.00 hrs on 6 August, they were hauling gear from a second trawl when the Skipper observed the MV Petrel Pacific approximately 5 NM to the east of his position. MV Petrel Pacific was on laden passage from Milford Haven to the United States of America when at approximately 21.43 hrs the Third Officer plotted FV Excel on radar, with an initial Closest Point of Approach (CPA) of 0.77 NM. At around 22.05 hrs the Third Officer was called from the bridge by the Master to complete some paperwork in the chartroom, at this time the CPA with FV Excel was 0.06 NM. An Able Bodied Seaman (AB) was left alone on the bridge to keep watch. At approximately 22.18 hrs FV Excel increased speed to 7.0 kts in order to commence shooting nets. At around 22.21 hrs, the Third Officer returned to the bridge and observed that a close quarters situation had developed with FV Excel. Shortly after the vessels collided and the Skipper of FV Excel issued a VHF MAYDAY call. Both vessels stopped and conducted damage assessments. After determining no water ingress or crew injuries, FV Excel returned to Dunmore East and MV Petrel Pacific proceeded to anchor at Saint Brides Bay awaiting a classification society survey.
INJURIES/FATALITIES	None
CAUSE OF INCIDENT	Whilst the collision damage sustained by FV Excel was serious, had the Skipper increased his vessel's speed around one minute earlier, it may have crossed the bow of MV Petrel Pacific. Whilst it is only possible to speculate on the potential consequences, analysis of similar incidents is persuasive evidence that the outcomes for the fishing vessel crew would have been extremely serious, with potentially fatal consequences. The standard of look-out on both vessels was wholly inadequate and is the root cause of the collision. A collective departure on both vessels from the maintenance of a proper look-out led to a loss of situational awareness. Onboard MV Petrel Pacific, the Master prioritised completing documents over and above maintaining a proper look-out, with the Officer of the Watch leaving the bridge at C-17 when the CPA with FV Excel was already reduced to 0.06 NM. In addition, the AB look-out may have been distracted in conversation. Onboard FV Excel, from C-22 onwards, the Skipper and crew gave their full attention to fishing operations as opposed to maintaining a proper, or any, look-out. By increasing his speed at C-7 the Skipper set-up a collision, when otherwise there would potentially have been a near miss.

Comparisons of Marine Casualties 2015 - 2024

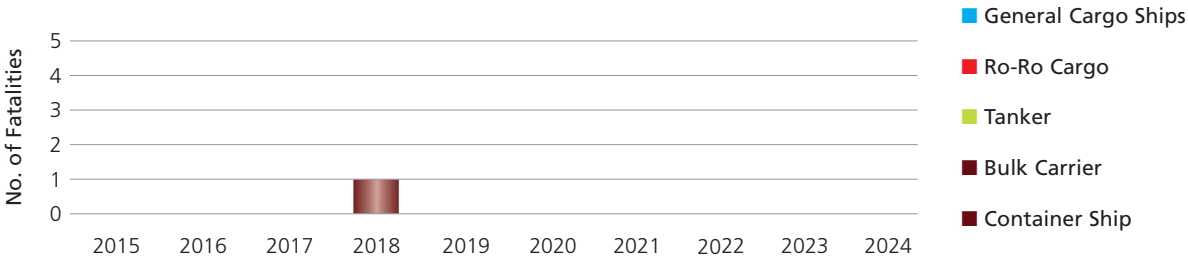
Type of Craft	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Passenger Ships/Vessels										
International Ro-Ro		10 Injuries	1 Fatality							
Domestic		2 Injuries								
Passenger Vessel		1 Fatality 1 Injury						1 Injury		
Sub total	**None**	**1 Fatality 13 Injuries**	**1 Fatality**	**None**	**None**	**None**	**None**	**1 Injury**	**None**	**None**
Cargo Ships										
General Cargo Ships								1 Injury		
Ro-Ro Cargo										
Tanker										
Bulk Carrier										
Container Ship				1 Fatality						
Car Carrier										
Work Boat Pilot/Barge										
Heavy Lift										
Sub total	**None**	**None**	**None**	**1 Fatality**	**None**	**None**	**None**	**1 Injury**	**None**	**None**
Fishing Vessels										
< 15 metres	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		
Sub total	**3 Fatalities**	**4 Fatalities**	**2 Fatalities**	**2 Fatalities**	**2 Fatalities**	**4 Fatalities 2 Injuries**	**2 Injuries**	**4 Injuries**	**3 Fatalities**	**None**
Recreational Craft										
Jet Skis									1 Fatality	
Open Boats/Canoe		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	1 Fatality
Sail										
Fast Power Craft/RIB			2 Fatalities	3 Fatalities						
Sub totals	**2 Fatalities**	**4 Fatalities 1 Injury**	**3 Fatalities**	**5 Fatalities**	**4 Fatalities 1 Injury**	**None**	**None**	**None**	**5 Fatalities**	**1 Fatality**
Total Incidents	**7**	**15**	**5**	**5**	**10**	**8**	**8**	**11**	**10**	**4**
Total Fatalities	**5**	**9**	**6**	**8**	**6**	**4**	**0**	**0**	**8**	**1**
Total Injuries	**0**	**14**	**0**	**0**	**1**	**1**	**2**	**6**	**0**	**0**
Total No. of Vessels involved	**7**	**15**	**5**	**5**	**11**	**8**	**8**	**21**	**11**	**4**

Fatality Trends 2015 - 2024

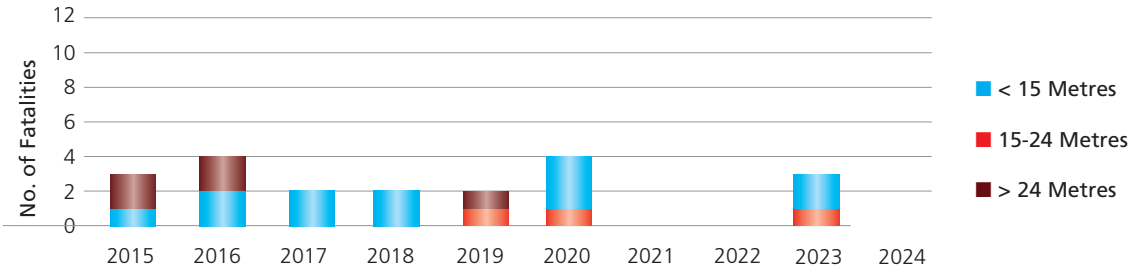
Passenger Ships/Vessels



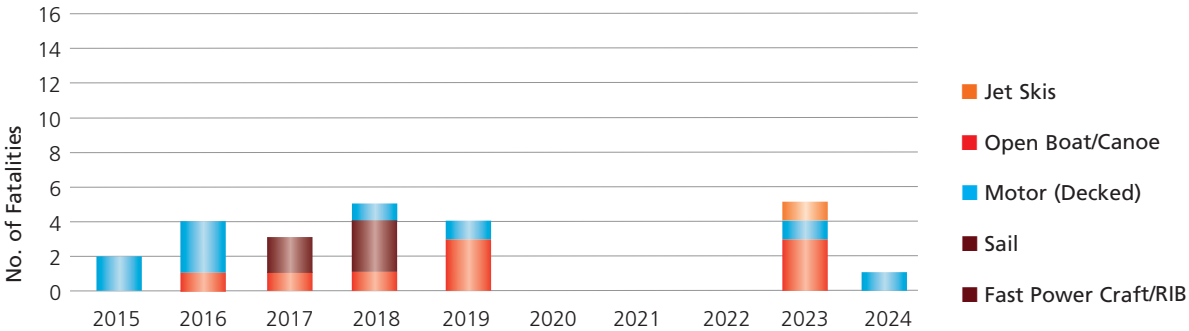
Cargo Ships



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 cases the uploading of key data onto the European Maritime Casualty Investigation Platform (EMCIP).

MCIB Ref.	Vessel Name	Date	Incident details
MCIB/13/622	FV Fr. McKee	06/01/2024	Injured crewmember
MCIB/13/623	MV Muros and Mv Erieborg	12/01/2024	Collision
MCIB/13/624	FV Green Isle	17/01/2024	Vessel aground
MCIB/13/625	FV Danny Finn	26/01/2024	Injured crewmember
MCIB/13/627	FV Aoibh Aine	31/01/2024	Vessel aground
MCIB/13/628	Ro-Ro Cargo ship Stena Nordica	25/02/2024	Injured crewmember
MCIB/13/629	FV Shauna Leon	08/03/2024	Water ingress
MCIB/13/630	MV Cuera	16/04/2024	Vessel aground
MCIB/13/631	FV Vision V	09/04/2024	Man overboard
MCIB/13/632	Yacht Marley	10/04/2024	Contact with harbour wall
MCIB/13/633	FV Vispon	18/04/2024	Injured crewmember
MCIB/13/634	DPC Dodder/ DPC Tolka	24/04/2024	Manoeuvring incident
MCIB/13/635	Wes Gesa	17/04/2024	Injured crewmember
MCIB/13/636	Stena Horizon Ro-Pax	27/04/2024	Vessel not under command
MCIB/13/637	Aran Island Ferry-Express Doolin	30/04/2024	Man overboard
MCIB/13/638	FV Vaya Con Dios	29/04/2024	Injured crewmember
MCIB/13/639	Pleasure Craft Lambay Island	02/05/2024	Vessel aground
MCIB/13/640	FV Lucinda Ann	08/05/2024	Injured crewmember
MCIB/13/641	MV Galicia	13/05/2024	Injured crewmember
MCIB/13/642	MV Larissa B	02/04/2024	Fouled propeller
MCIB/13/643	MV CT Rotterdam	20/05/2024	Allision with berth
MCIB/13/644	Annie B	16/05/2024	Boat mooring incident
MCIB/13/645	FV Silver Lining III	02/06/2024	Water ingress
MCIB/13/647	SV Corilla	29/06/2024	Vessel not under command
MCIB/13/649	Lida Suzanna	12/07/2024	Fuel pump issue
MCIB/13/650	FV Chloe B	13/07/2024	Engine failure
MCIB/13/651	L'Oursin	07/07/2024	Broken down
MCIB/13/652	Pride of the Lakes Waterbus	04/08/2024	Vessel aground
MCIB/13/653	FV Nausicaa and FV Custos Deus	31/07/2024	Allision between vessels

MCIB Ref.	Vessel Name	Date	Incident details
MCIB/13/654	Kayak	13/08/2024	One fatality
MCIB/13/655	FV Patrick C	07/08/2024	Fouled propeller
MCIB/13/656	FV Supreme II	11/08/2024	Fouled propeller
MCIB/13/657	An Foracha	23/07/2024	Man overboard
MCIB/13/658	FV Susa Uno	16/08/2024	Vessel aground
MCIB/13/659	FV Alana	17/08/2024	Close quarters encounter with another vessel
MCIB/13/700	Renaissance	23/08/2024	Passenger fell overboard
MCIB/13/701	Stena Adventurer	25/08/2024	Loss of power
MCIB/13/702	FV Kaiicobra	26/08/2024	Fouled propellor
MCIB/13/703	FV Ard Fionnbarr	04/09/2024	Fouled propellor
MCIB/13/704	Racing Yacht Kinsale	11/09/2024	Injured crewmember
MCIB/13/705	FV Maria Magdalen	13/09/2024	Two crewmembers injured
MCIB/13/706	Skellig Passenger Vessel	25/09/2024	Passenger in water
MCIB/13/707	Lagerta	05/09/2024	Vessel aground
MCIB/13/708	Kayaker Magheragallen	03/10/2024	Missing kayaker
MCIB/13/709	Seastruck Power	06/10/2024	Injured crewmember
MCIB/13/710	FV Breogan Tres	14/10/2024	Injured crewmember
MCIB/13/711	FV Bikain and FV Sauveur	18/11/2024	Collision
MCIB/13/712	Mary Jay and Glenbrooke Ferry	19/10/2024	Collision
MCIB/13/713	Ocean Battler	20/10/2024	Person in water between two vessels
MCIB/13/714	FV Blue Horizon	12/08/2024	Injured crewmember
MCIB/13/715	FV Bikain	24/10/2024	Injured crewmember
MCIB/13/716	FV Emerald Shore	30/10/2024	Fouled propellor
MCIB/13/717	MV Tacktow	29/10/2024	Injured crewmember
MCIB/13/718	FV Le Stiff	31/10/2024	Injured crewmember
MCIB/13/719	FV Armaven Tres	06/11/2024	Fire onboard
MCIB/13/720	MV Lucia B	13/11/2024	Vessel not under command
MCIB/13/721	FV Mar Mares	19/11/2024	Injured crewmember
MCIB/13/722	MS Seastruck Progress	23/11/2024	Damage to Cargo
MCIB/13/723	W.B. Yeats	23/11/2024	Damage to bridge window
MCIB/13/724	Celine	25/11/2024	Loss of port side anchor
MCIB/13/725	FV Sylvanna	27/11/2024	Injured crewmember
MCIB/13/726	FV Supreme II	1/12/2024	Injured crewmember
MCIB/13/727	FV Ard Fionnbar	9/12/2024	Fouled propellor
MCIB/13/728	Wilson Gdansk	11/12/2024	Collision
MCIB/13/729	FV Bridget Carmel	10/12/2024	Engine failure

MCIB Ref.	Vessel Name	Date	Incident details
MCIB/13/730	MV Fri Porsgrunn	20/12/2024	Injured crewmember
MCIB/13/731	FV Wings of the Morning	09/12/2024	One fatality

Financial Statements
2024

MCIB
Marine Casualty Investigation Board
Bord Imscrúdú Taismí Muirí

Reporting Period 1st January to 31st December 2024

Contents

Governance Statement and Board Members' Report

For the year ended 31 December 2024

Principal activities

The principal activity of the organisation continued to be the carrying out of investigations into marine casualties that take place to, or on board, Irish registered vessels worldwide and other vessels in Irish territorial waters and inland waterways.

Governance

The Board of Marine Casualty Investigation Board (MCIB) was established under Section 7(1) of the Merchant Shipping (Investigation of Marine Casualties) Act, 2000. The functions of the Board are set out in the Act of 2000 and the European Communities (Merchant Shipping) (Investigation of Accidents) Regulations 2011 and the European Communities Act 1972, European Communities (Merchant Shipping) (Investigation of Accidents) (Amendment) Regulations 2020 and the Merchant Shipping (Investigation of Marine Casualties) (Amendment) Act 2022. The Board is accountable to the Minister for Transport and is responsible for ensuring good governance and performs this task by setting strategic objectives and targets and taking strategic decisions on all key business issues. The regular day-to-day management, control and direction of MCIB are the responsibility of the Board Members and the Secretary to the Board.

Board Responsibilities

The work and responsibilities of the Board are set out in The Code of Conduct, which also contains the matters specifically reserved for Board decision. Standing items considered by the Board include:

- declaration of interests,
- risk register,
- financial reports/management accounts,
- investigation reports.

Section 20(1) of the Merchant Shipping (Investigation of Marine Casualties) Act, 2000, requires the Board to keep, in such form as may be approved by the Minister for Transport with the consent of the Minister for Public Expenditure and Reform, all proper and usual accounts of money received and expended by it.

In preparing these financial statements, the Board of the MCIB is required to:

- select suitable accounting policies and apply them consistently,
- make judgements and estimates that are reasonable and prudent,
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that it will continue in operation, and
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements.

The Board is responsible for keeping adequate accounting records which disclose, with reasonable accuracy at any time, its financial position and enables it to ensure that the financial statements comply with Section 20(1) of the

Merchant Shipping (Investigation of Marine Casualties) Act, 2000. The maintenance and integrity of the corporate and financial information on the MCIB website is the responsibility of the Board.

The Department of Transport (DoT) is responsible for allocating the annual budget. The MCIB profiles it's spending at the beginning of the year to the DoT. Due to the nature of the work undertaken by the MCIB, the Board is not in a position to plan and budget with certainty for the year ahead. As a result, the Board did not use a budget as a comparison for their review of the MCIB's performance in 2024.

The Board is also responsible for safeguarding its assets and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Board considers that the financial statements of MCIB give a true and fair view of the financial performance and the financial position of MCIB on 31 December 2024.

Implementation

Paragraph 1.19 of *Code of Practice for the Governance of State Bodies* ('the Code') requires the implementation of strategy by the management of each State body to be supported through an annual planning and budgeting cycle. Boards of State bodies are required to approve an annual plan and/or budget and to formally evaluate the actual performance by reference to the plan and/or budget on an annual basis. Due to the nature of work the MCIB undertakes, i.e. investigating marine casualties that take place to, or on board Irish registered vessels worldwide, and other vessels in Irish territorial waters and inland waterways it is not possible for the Board of the MCIB to plan with certainty for the year ahead.

Board Structure

The Board consists of not fewer than 5 members and not more than 7 members, who are appointed by the Minister.

BOARD MEMBER	ROLE	DATE APPOINTED / TERM COMPLETED
Claire Callanan	Chairperson	Appointed January 2019
Dorothea Dowling	Deputy Chairperson	Appointed April 2017 / Term Completed March 24
Keith Patterson	Ordinary Member	Appointed July 2022
John Carlton	Deputy Chairperson	Appointed May 2023
Phil Murphy	Ordinary Member	Appointed May 2023
Deirdre Lane	Ordinary Member	Appointed May 2023

Schedule of Attendance, Fees and Expenses

A schedule of attendance at the Board meetings for 2024 is set out at Note 5 to the financial statements and outlines details of the fees and expenses received by each member during the year.

Performance Review

The Board has engaged with an external accountant to assist in the reviewing of the system of internal control. The review was finalised and the report approved by the Board on 8th April 2025.

Key Personnel Changes

Dorothea Dowling term expired 31st March 2024.

John Carlton was appointed as Deputy Chair following Dr Dowling's, departure.

Diane Nesbitt Flood replaced Diptiben Bhatt as Secretariat in July 2024.

Committees

There are no committees in place. The MCIB was awarded a continued derogation regarding the Audit and Risk Committee based on the current structures and procedures in place within MCIB for financial oversight and risk management.

Disclosures Required by Code of Practice for the Governance of State Bodies (2016)

The Board is responsible for ensuring that the MCIB has complied with the requirements of The Code, as published by the Department of Public Expenditure and Reform in August 2016. The following disclosures are required by the Code:

Travel and Subsistence Expenditure

There were €14,735 of travel and subsistence costs incurred by staff and board members during the year ended 31 December 2024 (2023: €10,561).

Consultancy Costs

Consultancy costs include the cost of external advice to management and exclude outsourced 'business-as-usual' functions.

	2024	2023
Consultative advice on the legislative process and related	€7,566	€50,770
Total	€7,566	€50,770

Legal and professional fees of €15,688 (2023: €60,859) relate to expenditure on processes that have been outsourced under 'business as usual'. The MCIB was awarded their legal costs relating to judicial review proceedings which were successfully struck out.

Hospitality Expenditure

Hospitality expenditure during the year was €nil (2023: €348). Hospitality expenditure relates to costs incurred for training expenses.

Additional Disclosures

Employee' short-term benefits breakdown disclosure is included in Note 4 to the financial statements.

Other disclosures required by The Code in relation to legal costs and settlements, hospitality, and termination/severance payments and agreements are not disclosed as no expenditure was incurred in relation to these categories in the year ended 31 December 2024.

Statement of Compliance

The Board has adopted the Code of Practice for the Governance of State Bodies (2016) and has put procedures in place to ensure compliance with The Code. The MCIB was awarded a continued derogation regarding the Audit and Risk Committee based on the current structures and procedures in place within MCIB for financial oversight and risk management.

The derogations from certain provisions of The Code given to the MCIB due to its small size and nature of its activities are listed below:

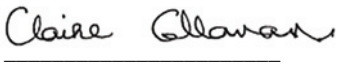
- Internal Audit, and Audit and Risk Committee[1]
- Property Acquisition and Disposal of Surplus Property
- Acquisition of Land, Buildings or other Material Assets
- Capital Investment Appraisal

- Diversification, Establishment of Subsidiaries and Acquisitions by State Bodies
- Disposal of State Assets
- Compliance with use of Auction or Tendering Requirements[2]
- Risk Appetite Statement

The MCIB engages a firm of accountants who prepare the Financial Statements each year and assist MCIB during the audit process. A separate team from the accounting firm is also engaged to conduct an annual review of MCIB's internal financial controls.

The MCIB reviews risk as a standing item at every Board meeting and maintains a risk register and risk policy which is reviewed on a quarterly basis.

The MCIB oversight agreement was finalised on 6th August 2024 after discussions and review with DoT.



Claire Callanan
Chairperson
17 June 2025

1. The MCIB maintains a risk register and a Risk Policy.
2. This derogation refers to 8.36 – 8.43 of the Code of Practice and does not extend to tendering for ongoing MCIB programme matters.

Statement on Internal Control

For the year ended 31 December 2024

Scope of Responsibility

On behalf of MCIB, I acknowledge the Board's responsibility for ensuring that an effective system of internal control is maintained and operated. This responsibility takes account of the requirements of The Code.

Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a tolerable level rather than to eliminate it. The system can therefore only provide reasonable and not absolute assurance that assets are safeguarded, transactions authorised and properly recorded, and that material errors or irregularities are either prevented or detected in a timely way.

The system of internal control, which accords with guidance issued by the Department of Public Expenditure and Reform has been in place in MCIB for the year ended 31 December 2024 and up to the date of approval of the financial statements.

Capacity to Handle Risk

Due to its small size the MCIB has received a derogation from the Department of Transport in respect of the Internal Audit function. The MCIB currently engages with its outsourced accountants to conduct an internal control review.

Risk and Control Framework

The MCIB has implemented a risk management system via a Risk Policy which identifies and reports key risks and the management actions being taken to address and, to the extent possible, to mitigate those risks.

A Risk Register is in place which identifies the key risks facing MCIB and these have been identified, evaluated and graded according to their significance. The register is reviewed on a quarterly basis. Risk is a standing item on the Board agenda should adjustments be required between reviews. The outcome of these assessments is used to plan and allocate resources to ensure risks are managed to an acceptable level.

The risk register details the controls and actions needed to mitigate risks and responsibility for operation of controls assigned to specific staff. I confirm that a control environment containing the following elements is in place:

- procedures for all key business processes have been documented,
- financial responsibilities have been assigned at management level with corresponding accountability,
- an annual non-pay budget of €598,000 is provided by DoT to the MCIB for investigations and other business expenditure. The budget is drawn down as the MCIB bank balance reaches approximately €50,000. If there is a sufficient bank balance at the year end and the MCIB can confirm that further funds will not be required, the remainder of the grant not drawn down is retained by the Department.
- there are systems in place to safeguard the assets.

Ongoing Monitoring and Review

Formal procedures have been established for monitoring control processes and control deficiencies are communicated to those responsible for taking corrective action and to management and the Board, where relevant, in a timely way. I confirm that the following ongoing monitoring systems are in place:

- business operational reporting can be used to derive assurance in relation to how risks are being managed,
- management activity is monitored and reviewed to determine that quality arrangements are being met in line with expectations for specific areas of risk, and
- internal control reviews are carried out by independent accountants on an annual basis.

Procurement

I confirm that the MCIB has procedures in place to ensure compliance with current procurement rules and guidelines and that during 2024 the MCIB complied with those procedures.

Review of Effectiveness

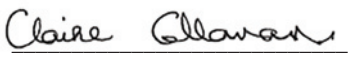
I confirm that the MCIB has procedures to monitor the effectiveness of its risk management and control procedures. All Board members have knowledge of all expenditure entered by the MCIB in the discharge of its statutory role and are updated by the Secretary to the Board, on an ongoing basis and at each monthly Board meeting, of all payments made and any issues likely to impact on the finances of the MCIB. All payments made require the approval of and authorisation by two members of the Board on the online AIB banking system.

The MCIB's monitoring and review of the effectiveness of the systems of internal control is further informed by the work of the external auditors, the external accountants who review the internal control function, and the senior management within the MCIB responsible for the development and maintenance of the internal control framework.

I confirm that the Board conducted an annual review of the effectiveness of the internal controls for 2024 informed by the MCIB procedures in place to monitor and control ongoing Board business and expenditure, and the report of the accountants engaged in February 2024 to undertake an external review of internal controls. The Internal Control Review report was considered and approved by the Board at the Board meeting on the 8th April 2025. The Board is satisfied that the controls in place are robust and effective.

Internal Control Issues

No weaknesses in internal control were identified in relation to 2024 that require disclosure in the financial statements.



Claire Callanan
Chairperson
17 June 2025

Report of the Comptroller and Auditor General

Report for presentation to the Houses of the Oireachtas
Marine Casualty Investigation Board

Opinion on financial statements

I have audited the financial statements of the Marine Casualty Investigation Board for the year ended 31 December 2024 as required under the provisions of section 20 of the Merchant Shipping (Investigation of Marine Casualties) Act 2000. The financial statements comprise

- the statement of income and expenditure and retained revenue reserves
- the statement of financial position
- the statement of cash flows and
- the related notes, including a summary of significant accounting policies.

In my opinion, the financial statements give a true and fair view of the assets, liabilities and financial position of the Marine Casualty Investigation Board at 31 December 2024 and of its income and expenditure for 2024 in accordance with Financial Reporting Standard (FRS) 102 - *The Financial Reporting Standard applicable in the UK and the Republic of Ireland.*

Basis of opinion

I conducted my audit of the financial statements in accordance with the International Standards on Auditing (ISAs) as promulgated by the International Organisation of Supreme Audit Institutions. My responsibilities under those standards are described in the appendix to this report. I am independent of the Marine Casualty Investigation Board and have fulfilled my other ethical responsibilities in accordance with the standards.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Report on information other than the financial statements, and on other matters

The Marine Casualty Investigation Board has presented certain other information together with the financial statements. This comprises the annual report, the governance statement and Board members' report and the statement on internal control. My responsibilities to report in relation to such information, and on certain other matters upon which I report by exception, are described in the appendix to this report.

I have nothing to report in that regard.

Mark Brady

For and on behalf of the Comptroller and Auditor General
18 June 2025

Appendix to the report

Responsibilities of Board members

As detailed in the governance statement and Board members' report, the Board members are responsible for

- the preparation of annual financial statements in the form prescribed under section 20 of the Merchant Shipping (Investigation of Marine Casualties) Act 2000
- ensuring that the financial statements give a true and fair view in accordance with FRS 102
- ensuring the regularity of transactions
- assessing whether the use of the going concern basis of accounting is appropriate, and
- such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Responsibilities of the Comptroller and Auditor General

I am required under section 20 of the Merchant Shipping (Investigation of Marine Casualties) Act 2000 to audit the financial statements of the Marine Casualty Investigation Board and to report thereon to the Houses of the Oireachtas.

My objective in carrying out the audit is to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement due to fraud or error. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with the ISAs will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with the ISAs, I exercise professional judgment and maintain professional scepticism throughout the audit. In doing so,

- I identify and assess the risks of material misstatement of the financial statements whether due to fraud or error; design and perform audit procedures responsive to those risks; and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- I obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the internal controls.
- I evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures.
- I conclude on the appropriateness of the use of the going concern basis of accounting and, based on the audit evidence obtained, on whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Marine Casualty Investigation Board's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my report. However, future events or conditions may cause the Marine Casualty Investigation Board to cease to continue as a going concern.
- I evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

I report by exception if, in my opinion,

- I have not received all the information and explanations I required for my audit, or
- the accounting records were not sufficient to permit the financial statements to be readily and properly audited, or
- the financial statements are not in agreement with the accounting records.

Information other than the financial statements

My opinion on the financial statements does not cover the other information presented with those statements, and I do not express any form of assurance conclusion thereon.

In connection with my audit of the financial statements, I am required under the ISAs to read the other information presented and, in doing so, consider whether the other information is materially inconsistent with the financial statements or with knowledge obtained during the audit, or if it otherwise appears to be materially misstated. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

Reporting on other matters

My audit is conducted by reference to the special considerations which attach to State bodies in relation to their management and operation. I report if I identify material matters relating to the manner in which public business has been conducted.

I seek to obtain evidence about the regularity of financial transactions in the course of audit. I report if I identify any material instance where public money has not been applied for the purposes intended or where transactions did not conform to the authorities governing them.

Statement of Income & Expenditure & Retained Revenue Reserves

For the year ended 31 December 2024

	Notes	YEAR ENDED 31 DEC 2024 €	YEAR ENDED 31 DEC 2023 €
Income			
Oireachtas Grants (Vote 31, subhead C3)		413,101	435,922
Other Income		-	30
		413,101	435,952
Expenditure			
Staff Salaries	4	170,852	141,718
Independent Contractor		27,338	23,871
Board Members Fees	5	37,179	36,995
Publishing		11,342	7,965
Website Design		8,779	861
Investigation	3	58,456	64,313
Translation		207	2,503
Maps/Charts		996	1,328
Legal & Professional Fees		15,688	60,859
Consultative advice on the legislative process and related		7,566	50,770
Accountancy		9,442	9,225
Audit Fees		10,637	9,600
Bank Charges		322	338
Training		28,760	12,232
Sundry Expenses		187	726
		387,751	423,304
Surplus/(Deficit) for the Year		25,350	12,648
Accumulated Deficit 1 January		(114,063)	(126,711)
Accumulated Deficit 31 December		(88,713)	(114,063)

The Statement of Cash Flows and notes 1 to 10 form part of these Financial Statements.

Claire Callanan
Chairman
17 June 2025

Margaret Bell
Secretary
17 June 2025

Statement of Financial Position

As at 31st December 2024

	Notes	31 DEC 2024 €	31 DEC 2023 €
Current Assets			
Prepayments		169	492
Cash and cash equivalents		2,081	12,134
		2,251	12,626
Creditors – amounts falling due within one year			
Payables	2	(90,964)	(126,689)
Net Current (Liabilities)		**(88,713)**	**(114,063)**
Representing			
Accumulated Deficit brought forward		(114,063)	(126,711)
Surplus/(Deficit) for the period		25,350	12,648
Retained Revenue Reserves		**(88,713)**	**(114,063)**

The Statement of Cash Flows and notes 1 to 10 form part of these Financial Statements.

Claire Callanan
Chairman
17 June 2025

Margaret Bell
Secretary
17 June 2025

Statement of Cash Flows

For the year ended 31 December 2024

	31 DEC 2024 €	31 DEC 2023 €
Cash flows from operating activities		
Cash (absorbed by) operations	25,350	12,648
Increase / (decrease) in receivables	323	-
Increase / (decrease) in payables	(35,727)	(12,267)
Net cash inflow/(outflow) from operating activities	(10,054)	381
Net cash used in investing activities	-	-
Net cash used in financing activities	-	-
Net increase/(decrease) in cash and cash equivalents	(10,054)	381
Cash and cash equivalents at beginning of year	12,134	11,753
Cash and cash equivalents at end of year	2,081	12,134

Notes to the Financial Statements

For the year ended 31 December 2024

Note 1. Accounting Policies

The basis of accounting and significant accounting policies adopted by the Marine Casualty Investigation Board are set out below. They have all been applied consistently throughout the year and for the preceding year.

a) General Information

The Marine Casualty Investigation Board was established under the Merchant Shipping (Investigation of Marine Casualties) Act, 2000. The Board commenced operations on 5 June 2002. It was formally established on 25 March 2003. The Board undertakes the independent investigation of marine casualties in Ireland and publishes the resulting reports.

b) Statement of Compliance

The financial statements of the Marine Casualty Investigation Board for the year ended 31 December 2024 have been prepared in accordance with FRS 102, the financial reporting standard applicable in the UK and Ireland issued by the Financial Reporting Council (FRC).

The Board of the entity who held office at the date of approval of these Financial Statements is responsible for securing the entity's compliance with its relevant obligations and we confirm the entity's compliance with the Code of Practice for Governance of State Bodies (August) 2016.

c) Going concern

The financial statements are prepared on a going concern basis.

In December 2022 Government approved the drafting of a Merchant Shipping (Investigation of Marine Accidents) Bill, to provide for the establishment of the MAIU within the Department of Transport. The General Scheme provides for the establishment of the Marine Accident Investigation Unit (MAIU) within the Department of Transport. The MAIU will replace the Marine Casualty Investigation Board as the permanent body responsible for marine accident investigation. The General Scheme also provides rule making power for the Minister for Transport to make the necessary secondary legislation for the regulation of offshore service vessels and industrial personnel.

The Merchant Shipping (Investigation of Marine Accidents) Bill was signed into law by the President on 14th April 2025. The MCIB will be dissolved once the MAIU Unit has been established, and the Act is commenced.

d) Basis of preparation

The financial statements have been prepared under the historical cost convention, except for certain assets and liabilities that are measured at fair values as explained in the accounting policies below. The financial statements are in the form approved by the Minister for Transport with the concurrence of the Minister for Public Expenditure and Reform under the Merchant Shipping (Investigation of Marine Casualties) Act, 2000. The following accounting policies have been applied consistently in dealing with items which are considered material in relation to the Marine Casualty Investigation Board's financial statements.

e) Period of Financial Statements

The financial statements cover the 12-month period to 31 December 2024.

f) Currency

The financial statements have been presented in Euro (€) which is also the functional currency of the board.

g) Oireachtas Grants

Income from Oireachtas Grants represent the cash and seconded staff salary costs received in the year from the

Department of Transport and payments made in the year by the Department of Transport on behalf of the Marine Casualty Investigation Board's staff*.

*Note: The MCIB Secretariat comprised three permanent staff assigned from the Department of Transport in 2024.

h) Recognition of Costs of Investigations

Costs relating to ongoing investigations are accrued for at the year end, based on estimated costs per investigation. Investigators invoice the MCIB on completion of investigations and the publication of the report. Interim expenses and travel expenses are paid as they are incurred.

i) Superannuation

Department staff assigned to act as the Secretariat to MCIB are covered by the relevant Department's pension arrangements. Accordingly, the Board has no liability for Pensions.

j) Cash and cash equivalents

Cash and cash equivalents include cash in hand, deposits held at call with banks, other short-term liquid investments with original maturities of three months or less, and bank overdrafts. Bank overdrafts are shown within borrowings in current liabilities.

Note 2. Creditors – amounts falling due within one year

	2024 €	2023 €
Accruals	88,724	118,016
Payables	-	-
PSWT	2,240	8,673
	90,964	126,689
Included in accrued expenses are amounts relating to: PAYE control account	-	-

Note 3. Accident Investigation Expenses

During year ended 31st December 2024, the Board completed 10 investigations and published reports on each investigation. The total cost of the investigations completed in 2024 was €58,456. 5 interim reports of ongoing investigations were published in 2024. As of 31st December 2024, 9 investigations were in progress and not finalised. The potential cost of this work is €65,500 and this has been included in the accrued expenses figure in note 2. Investigation costs are accrued in the year of occurrence of the incident.

Also included in investigation expenses are travel and subsistence costs incurred by investigators of €14,658 (2023: €8,363) - due to a decision taken by the Board in December 2020 that investigators will be reimbursed for agreed vouched T&S expenditure at Civil Service rates that are incurred in conducting investigations.

Note 4. Employees and Superannuation

Key management personnel

Key management personnel in MCIB consists of the members of the Board and the senior management team. The total value of employee benefits for key management personnel is set out at Note 5 to the Financial Statements.

A permanent Secretariat of three whole time staff was provided by the Department of Transport. Staff costs were recouped by the Department from the Board's grant allocation. The Board had 3 staff members assigned by DoT at the end of 2024 and 3 staff members assigned at the end of 2023.

During the year an independent contractor was required and this individual's fees of €27,338 were paid out of the funds available to the Marine Casualty Investigation Board.

The number of staff at each pay-band is detailed in the below table.

Short-term employee benefits** €	2024 No. of employees in band	2023 No. of employees in band
0 – 59,999	4	2
60,000 – 69,999	-	-
70,000 – 79,999	1	1
> 80,000	-	-

**Note: For the purposes of this disclosure, short term employee benefits in relation to services rendered during the reporting period include salary overtime allowances and other payments made on behalf of the employee but exclude employers PRSI.

Note 5. Board Members

The Board meets on a regular basis to review its operations and held 13 ordinary meetings in 2024.

As of 31st December 2024, the Board had a total of 5 members.

The fees payable to the Chairperson and the Board members for 2024 were at rates sanctioned and approved by the Minister for Public Expenditure and Reform. The Board members who retired or were appointed during a calendar year received a pro rata fee.

A schedule of 2024 Attendance and Fees is set out below:

Board member	Meetings Attended	2024 €	2023 €
Claire Callanan	13/13	8,978	8,978
Frank Cronin (retired March 2023)	-	-	1,496
Dorothea Dowling (Term expired March 2024)	3/13	1,496	5,985
Keith Patterson	12/13	5,985	5,985
John Carlton (appointed May 2023)	12/13	5,985	3,990
Deirdre Lane (appointed May 2023)	12/13	-	-
Phil Murphy (appointed May 2023)	12/13	-	-
Total Fees		**22,444**	**26,434**

Board members are paid an annual rate, on a one-off basis, not per attendance at meetings. The amounts disclosed above reflect the gross amounts payable to members.

€14,735 of travel expenses were paid to members of the Board in 2024 in respect of attendance at the Board Meetings during 2024. These were paid in accordance with approved Civil Service rates which the MCIB follows.

Note 6. Going concern

In the financial year ending 31 December 2024, the Board recorded an operating surplus of €25,350 and an accumulated deficit for 2002 – 2023 of €114,063. Funding has been received in 2024 and is expected to continue to be received to ensure that all liabilities can be met by the Board.

Note 7. Operating costs

The Department of Transport provides accommodation, including the use of fixed assets, to the Board free of charge in the Department's premises in Leeson Lane, Dublin 2.

The Board funds its own operating costs except for the following services which are provided by the Department of Transport free of charge:

- IT & Telephone
- Postage, stationary & internal printing costs (excluding costs relating to investigations)
- Cleaning
- Other office expenses including light and heating.

Note 8. Taxation

In accordance with Section 227 of the Taxes Consolidation Act, 1997 no taxation was paid or has to be provided for in the financial statements.

Note 9. Board Members: Disclosure of Interests

All Board members have adopted procedures in accordance with Section 17 and 18 of the Merchant Shipping (Investigation of Marine Casualties) Act, 2000.

The Board conducts its business in a manner which is both impartial and is seen to be impartial in accordance with the MCIB Code of Business Conduct (see www.mcib.ie). The Code is intended to establish an agreed set of ethical principles for the conduct of the Board's business; promote and maintain confidence and trust in the Board; and prevent the development or acceptance of unethical practices in the Board. Board members advise the Secretary to the Board of potential conflicts of interest and will absent themselves from a Board meeting where a conflict of interest arises.

In complying with the requirements of the Ethics in Public Office Acts 1995 and 2001 – Annual Statements of Interests, each Board member furnishes to the Secretary on an annual basis, no later than the 31 January, a completed Statement of Interests form. Nil responses are also submitted.

Note 10. Approval of Financial Statements

The financial statements were approved by the Board on 11th March 2025.

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