MCIB
Marine Casualty Investigation Board
Bord Imscrúdú Taismí Muirí

REPORT OF AN INVESTIGATION INTO A MARINE CASUALTY INVOLVING THE FISHING VESSEL BREIZH ARVOR II IN OR AROUND 100 NAUTICAL MILES OFF THE BLASKET ISLANDS, CO. KERRY ON OR ABOUT 14 DECEMBER 2023

REPORT NO. MCIB/334
(No.1 OF 2025)

The Marine Casualty Investigation Board (MCIB) examines and investigates all types of marine casualties to, or on board, Irish registered vessels worldwide and other vessels in Irish territorial waters and inland waterways.

The MCIB objective in investigating a marine casualty is to determine its circumstances and its causes with a view to making recommendations for the avoidance of similar marine casualties in the future, thereby improving the safety of life at sea and inland waterways.

The MCIB is a non-prosecutorial body. We do not enforce laws or carry out prosecutions. It is not the purpose of an investigation carried out by the MCIB to apportion blame or fault.

The legislative framework for the operation of the MCIB, the reporting and investigating of marine casualties and the powers of MCIB investigators is set out in the Merchant Shipping (Investigation of Marine Casualties) Act, 2000.

In carrying out its functions the MCIB complies with the provisions of the International Maritime Organisation's Casualty Investigation Code and EU Directive 2009/18/EC governing the investigation of accidents in the maritime transport sector transposed into Irish law by the European Communities (Merchant Shipping) (Investigation of Accidents) Regulations 2011.

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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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Glossary of Abbreviations and Acronyms

AGS	An Garda Síochána
BIM	Bord Iascaigh Mhara
CPR	Cardiopulmonary Resuscitation
FV	Fishing Vessel
GMDSS	Global Maritime Distress and Safety System
HSA	Health and Safety Authority
ILO	International Labour Organisation
IMO	International Maritime Organisation
MCIB	Marine Casualty Investigation Board
MRSC	Maritime Rescue Sub Centre
MSO	Marine Survey Office
S.I.	Statutory Instrument
SITREP	Situation Report
STCW	International Convention on Standards of Training, Certification and Watchkeeping for Seafarers
UTC	Co-ordinated Universal Time

Hour	hr
Metre	m
Nautical mile	NM

Report MCIB/334 published by the Marine Casualty Investigation Board.
12th March 2025.

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1. SUMMARY

1.1 The fishing vessel (FV) Breizh Arvor II is a conventional stern trawler of 22.4 metre (m) in length and was fishing for prawns off the west coast of Ireland on 14 December 2023. The vessel was three days into an intended fishing trip of ten to 13 days when one of the crew suffered a fall in the accommodation. The vessel was trawling at the time of the incident and the catch from the previous haul was being processed by the crew on deck. The weather was Beaufort Force 5 with fresh breeze and moderate to rough seas with the vessel rolling moderately. The Casualty was found unresponsive lying on the deck in the sleeping area. Efforts were made to revive him but unfortunately were not successful. The vessel returned to the home fishing port of Castletownbere, Co.Cork and the Casualty was landed ashore.

Note: Times are local time = UTC +1 (Co-ordinated Universal Time + 1 hour).

Breizh Arvor II alongside in Kinsale, Co. Cork.

Approximate location of the vessel at the time of the casualty.

2. FACTUAL INFORMATION

2.1 Vessel Details

Vessel Name:	Breizh Arvor II.
Vessel Type:	Stern Trawler.
Flag:	Ireland.
Port of Registry:	Cork.
International Maritime Organisation (IMO) Number:	8228921.
Registration Number:	C436.
Call Sign:	EIRX3.
Classification Society:	None.
Registered Owners:	James Hurley Fisheries Ltd.
Gross Tonnage:	148.
Length Overall (LOA):	22.46 m.
Beam:	7.02 m.
Year Built:	1991.
Builder:	Chantiers de Bretange Sud.
Hull Material:	Steel.
Yard:	Belz, France.
Last Marine Survey Office (MSO) Survey:	18 September 2023.
Main Engines:	Mitsubishi S6R-23MPTAW.
Power:	324 Kilowatt.

2.2 Crew Details, Training, Certification, Employment Contracts, Working Hours

2.2.1 The crew onboard at the time of the casualty are shown in the table below:

	Rank/job	Qualification/Training	Issued	Time onboard	Years of experience
Skipper	Skipper	Bord Iascaigh Mhara (BIM) safety, Global Maritime Distress and Safety System (GMDSS) Long Range Radio Operators Certificate	2007 2008	7 years	21
Crewmember No. 1	Crew (Casualty)	GMDSS General Operators Certificate, BIM safety, STCW fire and Elementary first aid	2023 2013 2023	7 years	13
Crewmember No. 2	Crew	BIM safety	2022	3 years	29
Crewmember No. 3	Crew	BIM safety	2016	4 months	16
Crewmember No. 4	Crew	None provided		3 months	19
Crewmember No. 5	Crew	None provided		1.5 years	10
Crewmember No. 6	Crew	Spain safety cert, BIM safety	2017 2022	3 years	30

2.2.2 A crew list was required in accordance with Statutory Instrument (S.I.) No. 333 of 2020 European Union (International Labour Organisation Work in Fishing Convention) (Crew List and Fisherman's Work Agreement) Regulations 2020. An official crew list in accordance with Regulation 5(1) of S.I. No. 333[1] was not provided but a handwritten list of the crew onboard at the time of the incident was made available.

2.2.3 Work Agreements were required in accordance with S.I. No. 333 of 2020 European Union (International Labour Organisation Work in Fishing Convention) (Crew List and Fisherman's Work Agreement) Regulations 2020 because the regulation applies to all fishing vessels engaged in sea fishing (except single handed fishers) and protects the rights of the fishers. Work agreements in accordance with Regulation 6(1) of S.I. 333 were available onboard and signed by all of the employed fishers onboard at the time of the casualty.

1. S.I. No. 333 of 2020 European Union (International Labour Organisation Work in Fishing Convention) (Crew List and Fisherman's Work Agreement) Regulations 2020 - https://www.irishstatutebook.ie/eli/2020/si/333/made/en/print

2.2.4 A Safe Manning Document was required at the time of the incident in accordance with S.I. No. 315 of 2023 European Union (International Labour Organisation Work in Fishing Convention) (Safe Manning) Regulations 2023. These Regulations came into operation on 1 July 2023.

2.2.5 Regulation 2 of S.I. No. 315 of 2023 defines an "effective date" for different classes of fishing vessel by which they are required to have a Safe Manning Document. For vessels constructed before 19 December 1991 (as applies here) a Safe Manning Document should be onboard by *"the date of completion of the next survey for the grant of renewal of a fishing vessel safety certificate or the date of completion of the next intermediate or periodical survey, whichever occurs later from the date of 19 December 2019, under the Merchant Shipping (Safety of Fishing Vessels) (15-24 Metres) Regulations 2007 (S.I. No. 640 of 2007) in relation to fishing vessels of 15 metres Loa and over but less than 24 metres in length"*.

2.2.6 The renewal Fishing Vessel Safety Certificate was dated 12 February 2021, and a Periodical Survey Report was issued on 18 September 2023. Therefore, in accordance with 2.2.5 above, the Safe Manning Document should have been onboard by 17 September 2023. The MSO have advised the Marine Casualty Investigation Board (MCIB) there was no Safe Manning Document issued for this vessel at the time of the casualty and no other details were provided regarding this lapse.

2.2.7 Regulation 5(1) of S.I. No. 315[2] states that until such time that a Safe Manning Document is in place the vessel must carry the correct number of deck officers as detailed in the table (see Appendix 7.1 – Manning Levels Table). Based on this, with the vessel fishing in the limited area, this vessel was required to have onboard the following certified deck officers - one Skipper Limited <24m (or Second Hand Special) and one Second Hand Limited. It did not have the required officers.

2.2.8 Fishing vessel (Basic Safety Training) Regulations, 2001 S.I. No. 587/2001[3] - Regulation 4 states that *"every crew member of a fishing vessel shall undertake basic safety training as set out in this Regulation"*.

Regulation 5(1) states that *"on successful completion of the basic safety training defined in paragraph 4 (2) a Commercial Fishing Training Record Book shall be issued to each participant by BIM on completion of an application form signed by the applicant, the details of which are verified by an authorised BIM official"*.

Crewmembers No. 4 and No. 5 did not have the required basic safety training.

2. S.I. No. 315 of 2023 -European Union (International Labour Organisation Work in Fishing Convention) (Safe Manning) Regulations 2023 - https://www.irishstatutebook.ie/eli/2023/si/315/made/en/print

3. Fishing vessel (Basic Safety training) Regulations, 2001 S.I. No.587/2001 - https://www.irishstatutebook.ie/eli/2001/si/587/made/en/print

As the vessel was manned by share fishers, the Working Hours and Hours of Rest are to be maintained in accordance with S.I. No. 585 of 2020 European Union (Workers on board Seagoing Fishing Vessels) (Organisation of Working Time) (Share Fishermen) Regulations 2020. Hours of work and rest documents were provided and reviewed by the MCIB. As presented, they appeared to comply with the requirements. Determination of compliance is for the MSO.

2.3 Relevant Safety Requirements

The vessel was 22.46 m in length and therefore should comply with the Merchant Shipping (Safety of Fishing Vessels) (15-24 metres) Regulations 2007 S.I. No. 640 of 2007. The required surveys had been carried out and the Fishing Vessel Safety Certificate was valid at the time of the casualty. Regulation 152 (1) requires that:

"(a) Sleeping rooms shall be so planned and equipped as to ensure reasonable comfort for the occupants and to facilitate tidiness.

(b) The clear headroom shall, whenever possible, be not less than 2.0m."

2.4 Safety Equipment

2.4.1 The vessel was fully outfitted with the required safety and lifesaving equipment as required by the relevant regulations.

2.4.2 The failure or incorrect operation of safety equipment was not deemed to be a factor in this casualty.

2.5 Voyage Particulars

The vessel departed from Castletownbere, Co. Cork at 04.30 hours (hrs) on the 11 December 2023 and proceeded towards the Porcupine Bank fishing grounds. The plan was for ten to 13 days fishing. The first net was shot at 18.00 hrs on 11 December. The vessel fished all day on 12 December and the fishing was considered slack with no large catch. The vessel fished all day on 13 December and the fishing was still considered slack with no large catch. Nets were shot at around 22.00 hrs on 13 December and the casualty occurred at around 00.30 to 00.45 hrs on the 14 December 2023.The position of the fishing vessel at this time was approximately 52°16.50'N 013°06.00'W.

2.6 Marine Incident Information

Type: "Casualty" within the meaning of S.I. No. 276 of 2011 - European Communities (Merchant Shipping) (Investigation of Accidents) Regulations 2011 which apply to fishing vessels of greater than 15 m and where *"casualty" means "an event, or a sequence of events, that*

has resulted in any of the following which has occurred directly in connection with the operations of a ship:

(a) the death of, or serious injury to, a person;

(b) the loss of a person from a ship;

(c) the loss, presumed loss or abandonment of a ship;

(d) material damage to a ship;

(e) the stranding or disabling of a ship, or the involvement of a ship in a collision;

(f) material damage to marine infrastructure external to a ship that could seriously endanger the safety of the ship, another ship or an individual;

(g) severe damage to the environment, or the potential for severe damage to the environment, brought about by the damage of a ship or ships,

but does not include a deliberate act or omission, with the intention to cause harm to the safety of a ship, an individual or the environment;"

A Very Serious Casualty within the meaning of S.I. No.276 of 2011 *"means a casualty involving the total loss of the ship or a death or severe damage to the environment."*

Date: 14 December 2023.

Time: 00.30 – 00.45 hrs.

Position: 52°16.50'N 013°06.00'W.

Wind: Force 5 from the West.

Swell: 2.0 – 3.0 m.

Sea State: Moderate to Rough.

Visibility: Good.

Weather forecast and or weather warnings: No weather warnings were in place.

Human Factors: Moving in a confined space with flooring of different heights /lack of situational awareness.

Equipment/Location Factors: No equipment factors contributed to this casualty.

	The configuration of the confined space and the access/egress features were causal factors.
Consequences:	Fatality of one person onboard.

2.7 Emergency Response and/or Shore Authority Involvement

Marine Rescue Sub Centre (MRSC) Valentia was contacted by the Owner after the Casualty was deceased and therefore no units were tasked to attend the vessel on location.

See Appendix 7.2 – Irish Coast Guard SITREP.

2.8 Working Language

Regulation 9 of the European Union (International Labour Organisation Work in Fishing Convention) (Safe Manning) Regulations 2023 (S.I. No. 315 of 2023 is summarised in Marine Notice No. 43 of 2023,

"The owner or master of each applicable fishing vessel must ensure that there is a working language on board, that every fisher understands it and that, where necessary, fishers can give orders and instructions and report back in that language."

The working language on the vessel was English and there were no communication difficulties related to language that contributed to this casualty.

3. NARRATIVE

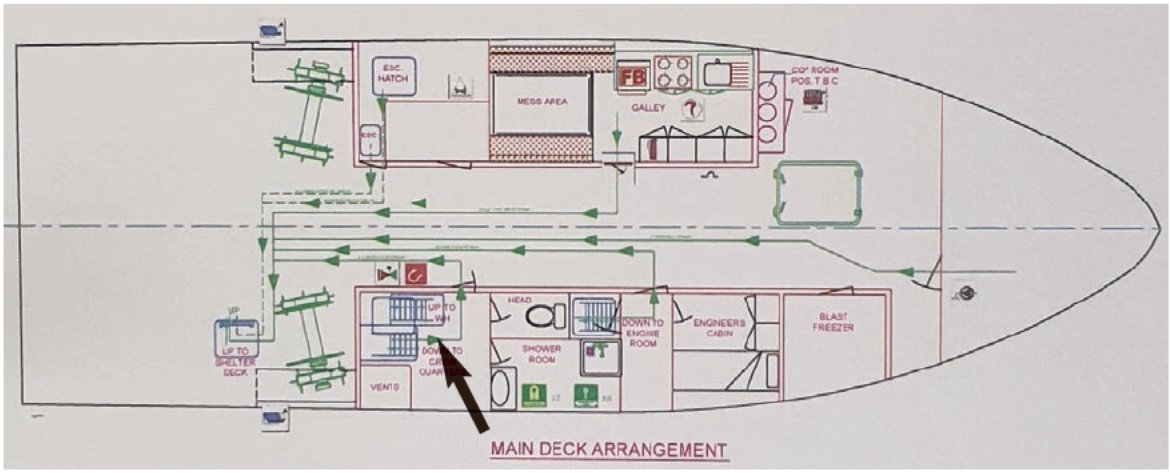
3.1 Type of Fishing

The FV Breizh Arvor II operates conventional nephrops trawl. This is a system designed to catch nephrops which are also known as langoustine but are commonly referred to as “prawns” within the industry. The trawl gear and equipment were not a factor in this incident.

3.2 Incident Details

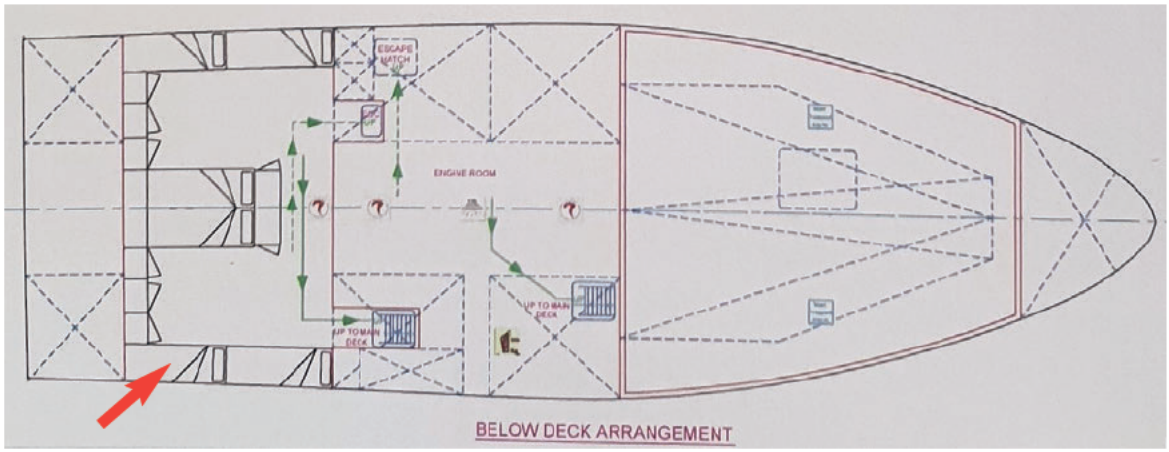
3.2.1 The vessel departed from Castletownbere at 04.30 hrs on 11 December 2023 and proceeded towards the Porcupine Bank fishing grounds. The plan was for ten to 13 days fishing. The first net was shot at 18.00 hrs on 11 December. The vessel fished all day on 12 December and the fishing was considered slack with no large catch. The vessel fished all day on 13 December and the fishing was still considered slack with no large catch. The vessel had heaved up the nets and emptied the catch at around 22.00 hrs on 13 December. The nets were shot again, and the vessel commenced trawling. The crew commenced cleaning, sorting, and packing the prawns that had been caught. The Skipper was in control in the wheelhouse and the remaining six crewmembers, including the Casualty (Crewmember No. 1), were on the main deck working on the catch.

3.2.2 At around midnight the Skipper came down to the deck and requested the Casualty to come to the wheelhouse to relieve him on watch. The Skipper returned to the wheelhouse waiting to be relieved on watch by the Casualty. The Casualty left the main deck, took off his oilskins and wellington boots, put on his Crocs, and went below to the accommodation deck to change his jumper to go to the wheelhouse to take the watch. It appears the Crocs were just used as a slip-on without use of the ankle strap which was folded forward when found later. The route from the main deck to the stairwell leading to the accommodation deck is clearly shown in the arrangement drawing below. There is only one door from the deck and a clear passage to the stairwell going below deck. There are no other obstructions in the passage to the stairwell. All the other five crewmembers continued working on the catch on the main deck.



Main Deck arrangement where the crewmembers were working with an arrow showing the ladder down to crew accommodation.

3.2.3 After around ten minutes the Skipper again came down to the deck and asked the crew where the Casualty was and they advised that he had gone to change his clothes for the watch. As the Casualty was never late for the watch, the Skipper checked the galley and bathroom and then proceeded below deck to check. He found the Casualty unresponsive on his back lying on the deck/cabin floor in the sleeping area adjacent to his bunk. The Skipper found no sign of life and called the crew to assist. The Skipper and one crewmember commenced Cardio-pulmonary Resuscitation (CPR) but got no response. The efforts to revive the Casualty continued for around half an hour. The Casualty was lifted off the floor and placed in the port side bunk in the nearest of the two partitioned bunk areas to the ladder to the deck. There were in total eight bunks in the accommodation area which were partly partitioned as shown in the plan below. As there was a spare bunk starboard aft, the Casualty used it to store his belongings and it is assumed that it was there he was coming from rather than from the bunk he slept in which was opposite.



Accommodation area where the Casualty was found on the deck on the starboard side (in green). His effects were stowed on the after starboard bunk shown with a red arrow. After the accident the Casualty was placed on his sleeping bunk on the port aft side.

Photograph No. 1 - Looking to starboard in the accommodation. Red arrow shows starboard aft bunk where effects were stowed.

Photograph No. 2 - Two steps on the deck in the space can be seen and green shape shows reported location of Casualty when discovered. The ladder to/from the accomodation area is located on the left hand side.

The Skipper called the Owner at home and advised the situation with the Casualty and then decided to immediately heave up the nets and sail the vessel back to port. The nets were heaved up which took approximately an hour. The vessel commenced the voyage back to Castletownbere.

3.2.4 The Owner had called the Coast Guard and advised them of the situation onboard the vessel. The Coast Guard attempted to call the vessel on the medium frequency/high frequency radio on 2182 MHz but received no reply. At this time the Skipper and crew were trying to revive the Casualty and there was no one in the wheelhouse. The Coast Guard contacted the vessel on WhatsApp to obtain the satellite phone number and then patched a call through to MEDICO Cork for medical advice but when checks were carried out as directed, MEDICO advised the Skipper that the Casualty had passed away and no further assistance could be offered.

3.2.5 The vessel returned to the port of Castletownbere and was met by an ambulance and An Garda Síochána (AGS) who had been contacted by the Coast Guard.

3.3 Emergency Services

The emergency services were contacted by the Owner ashore but at this stage the Casualty had passed away and no further assistance could be offered.

See Appendix 7.2 – Irish Coast Guard SITREP.

3.4 Safety, Health and Welfare at Work Act 2005[4]

3.4.1 Section 19 of the Act requires that employers and those who control workplaces to any extent must identify the hazards in the workplaces under their control and assess the risks to safety and health at work and complete Safety Statements, risk assessments.

"19.—(1) Every employer shall identify the hazards in the place of work under his or her control, assess the risks presented by those hazards and be in possession of a written assessment (to be known and referred to in this Act as a "risk assessment") of the risks to the safety, health and welfare at work of his or her employees, including the safety, health and welfare of any single employee or group or groups of employees who may be exposed to any unusual or other risks under the relevant statutory provisions."

3.4.2 The vessel did have a completed Fishing Vessel Safety Statement onboard, and this detailed all the normal hazards onboard with mitigating actions outlined.

3.4.3 In the safety statement there was no specific mention of spaces with restricted headroom and or use of specific footwear in the accommodation spaces. The accommodation spaces are not normally considered a high-risk area.

4. https://www.irishstatutebook.ie/eli/2005/act/10/enacted/en

3.5 Safety, Health and Welfare at Work (Fishing Vessels) Regulations 1999 S.I. No. 325/1999[5]

3.5.1 PART II General Safety and Health Provisions Safety, Health and Welfare at Work (Fishing Vessels) Regulations 1999 S.I. No. 325 /1999 provide as follows in respect of safety training for crew:

"6. It shall be the duty of every employer in providing training to his or her workers, in accordance with Part II of the Principal Regulations[6], to ensure that—

(a) such training includes adequate training on safety and health at work on board vessels and on accident prevention, firefighting, the use of lifesaving and survival equipment, and, in the case of the workers concerned, the use of fishing gear and hauling equipment, and the use of appropriate signs, including hand signals.

(b) such training contains appropriate precise and comprehensible instructions and is updated where this is required by changes in the activities on board.

(c) without prejudice to the provisions of the European Communities (Minimum Safety and Health Requirements for Improved Medical Treatment on Board Vessels) Regulations, 2021 (S.I. No. 591 of 2021), and to the Fishing Vessels S.I.313 of 2023 Fishing Vessels (Certification of Deck Officers and Engineer Officers) Regulations 2023 , any person likely to command a vessel shall be given training in relation to—

(i) the prevention of occupational illness and accidents on board the vessel and steps to be taken in the event of such an illness or accident,

(ii) the stability and the maintenance of the vessel under all foreseeable conditions of loading and during fishing operations, and

(iii) radio navigation and communication, including procedures related thereto."

Regulation 3 (3) of S.I. No. 325/1999 provides that the requirements of the Schedules to those Regulations *"shall apply whenever required by the features of the place of work, the work activity carried on and the circumstances or the hazards prevailing in relation to any such work activity."* This is a mandatory requirement.

3.5.2 The Skipper did not have the required certification as Skipper Limited or Second Hand Special and therefore would not have undergone the required training which would have included the BIM Guide to Safety Awareness which outlines possible causes of slip, trip and fall hazards. The Casualty also did not have the

5. https://www.irishstatutebook.ie/eli/1999/si/325/made/en/print

6. The Principal Regulations referred to means the Safety, Health and Welfare at Work (General Application) Regulations, 1993 (S.I. No. 44 of 1993).

required certification to take the watch from the Skipper as he did not hold a valid Second Hand Special Certificate (or higher) in accordance with the requirement in the table (see Appendix 7.1 – Manning Levels Table).

3.6 Working Hours and Hours of Rest

Working hours and hours of rest sheets were examined and the written records appeared to be in compliance with the Regulations.

3.7 Manning Levels and Certification

As stated above the vessel did not hold a Safe Manning Document or comply with the requirement in the table (see Appendix 7.1 – Manning Levels Table). Regulation 5(1) of the European Union (International Labour Organisation Work in Fishing Convention) (Safe Manning) Regulations 2023 S.I. No. 315 of 2023 provides that until such time that a Safe Manning Document is in place the vessel must carry the correct number of deck officers as detailed in the table (see Appendix 7.1 – Manning Levels Table). Based on this, with the vessel fishing in the limited area, this vessel was required to have onboard the following certified deck officers – one Skipper Limited <24m (or Second Hand Special) and one Second Hand Limited. It did not have the required officers, however this does not have any contributory role in the incident.

4. ANALYSIS

The Incident

4.1 At around midnight the Skipper came down to the deck and requested the Casualty to come to the wheelhouse to relieve him on watch. The Skipper returned to the wheelhouse waiting to be relieved on watch by the Casualty. The Casualty reportedly took off his oilskins and wellington boots, put on a pair of Crocs, and then left the main deck. He then went below deck to the accommodation space to change his jumper before proceeding to the wheelhouse to take the watch from the Skipper. There were no witnesses to these events or the events that followed.

4.2 It cannot be determined exactly what happened in the absence of any witness and given the lack of adequate corroborative evidence.

4.3 The accommodation space is quite small and confined and has two steps, changing the internal floor levels and height of the space going aft. The Casualty was found face up on the floor of the accommodation adjacent to the starboard aft bunk where he stowed his gear (and was moved post mortem on to his sleeping bunk on the port side). After descending the ladder to the accommodation area, he had to move aft and to step up two steps to get to his bunk area where he stowed his gear. He then had to crouch down or sit while he changed his clothes. He then had to stand in a crouched position to proceed forward and then had to step down two steps as he proceeded towards the ladder to return to the deck.

4.4 The stairwell is an enclosed type with the upper area surrounded by panelling and would be very difficult to fall forward into the lower accommodation. The ladder in the stairwell was around ten to 15 degrees off the vertical and had a handrail on the starboard side for the right hand to hold while going down the ladder. The person using the ladder should turn around and descend facing forward. The steps were non-slip type. Having descended the ladder, the Casualty would then be in a space with low ceilings of different height.

Photograph No. 3 - Looking down the stairwell from main deck.

Photograph No. 4 - Looking forward at the ladder from lower accommodation.

4.5 According to the investigating Garda at the inquest (held on 17 September 2024) the Casualty had retrieved his jumper. The Casualty therefore probably went aft to the spare bunk on the starboard side, where he stored his belongings and changed into his wheelhouse jumper. He was then in a space with a deck to ceiling height of 1.68 m whereas the Casualty was 1.88 m tall. This was also while the vessel was pitching and rolling in the sea. The evidence of the investigating Garda at the inquest seems to have been premised on the Casualty having gone to the port aft bunk as this is where he was found on the vessel's return to port rather than to the other bunk where he stowed his gear. This does not alter in any substantial way what then appears to have happened as the

Casualty moved away from where the bunks were and headed back towards the ladder with a view to taking over the watch.

Photograph No. 5 - Showing space with dimensions added.

Photograph No. 6 - Looking directly aft.

Photograph No. 7 - Looking aft to starboard at bunk with belongings.

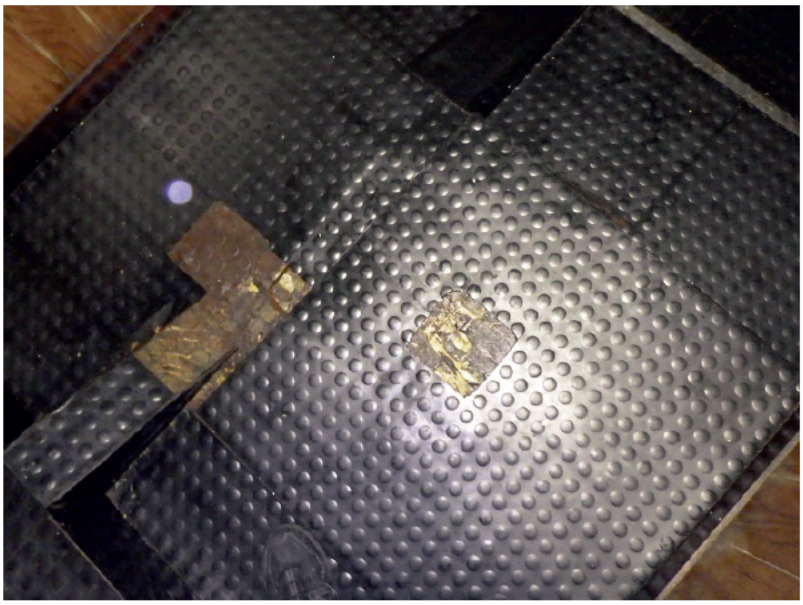
Photograph No. 8 - Looking at deck forward starboard.

Photograph No. 9 - Looking to starboard with the steps on deck visible.

4.6 Regulation 152(1)(b) of the Merchant Shipping (Safety of Fishing Vessels) (15-24 Metres) Regulations 2007, S.I. No. 640 of 2007 provides that in sleeping rooms *"(b) The clear headroom shall, whenever possible, be not less than 2.0m."* The Casualty was in a space with a deck to ceiling height of 1.68 m. The accommodation area in the vessel (built in 1991) did not have the minimum 2 m clear headroom in the sleeping room but according to the Regulations it is not compulsory but only where it is possible to have this. The Casualty was familiar with the vessel having been working on it for seven years.

4.7 The weather at the time of the casualty was Force 5. While this is not considered to be abnormal for this type of vessel fishing in that location, the rolling of the vessel could well have led to the Casualty being off balance and contributing to the fall. In Force 5 the vessel would be subjected to moderate waves of 2-3 m which would cause this vessel to lift and roll. In a vessel of this size the movement could be quite rapid, and seafarers are required to hold on for balance while moving around on the vessel. In addition, in order to meet the minimum criteria for acceptable stability, fishing vessels are regarded as "stiff", resulting in more rapid movement than a conventional vessel and subjecting personnel to higher accelerations requiring additional handholds. There are no obvious handholds in the photographs.

4.8 The deck covering in the accommodation space was rubber bubble-mat safety covering and this was generally in good condition with two small pieces missing (these pieces had been removed by AGS as a reference sample and were not damaged). This type of floor covering gives very good grip and is considered anti-slip. This part of the accommodation below deck is not normally wet and wellington boots are not worn below decks.



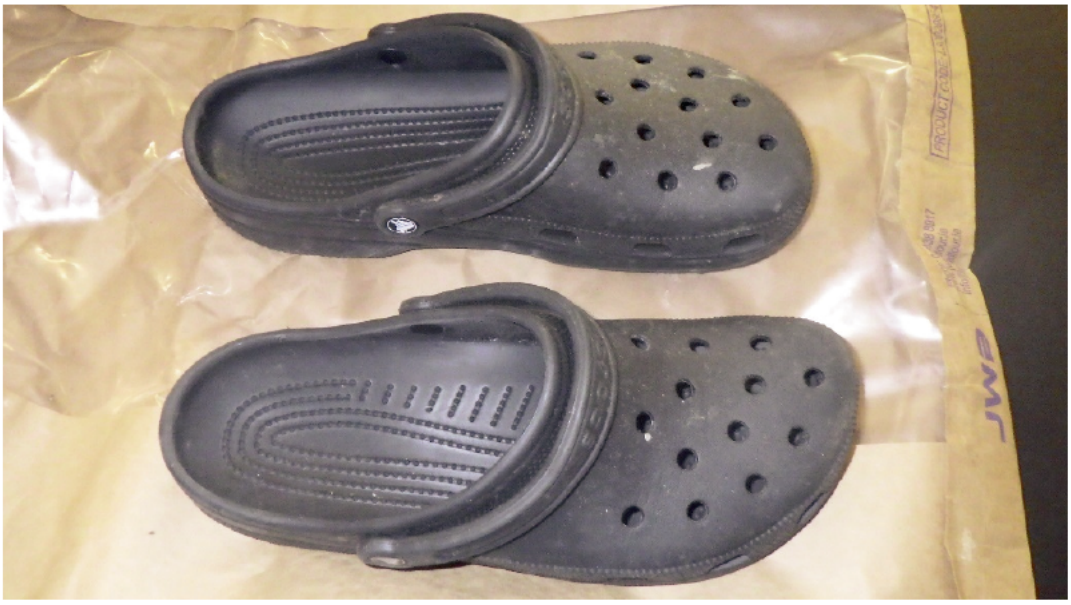
Photograph No. 10 - Looking down at deck aft.

Photograph No. 11 - Looking at deck aft to starboard.

4.9 The lighting was inspected and was traditional twin tube fluorescent type lighting and was considered good in the space.

4.10 The Casualty was wearing a pair of slip-on Crocs at the time of the fall (and from when he had been up on deck). The back securing straps were found by AGS in the forward position and do not appear to have been secured around the heels. The Crocs were taken by AGS who investigated the fatality. They confirmed that they were on the Casualty when found and that they were provided to the MCIB for inspection with the straps forward as they had been found. The condition of

the Crocs and the soles was very good. The accommodation space was not reported to have been wet at the time of the incident.

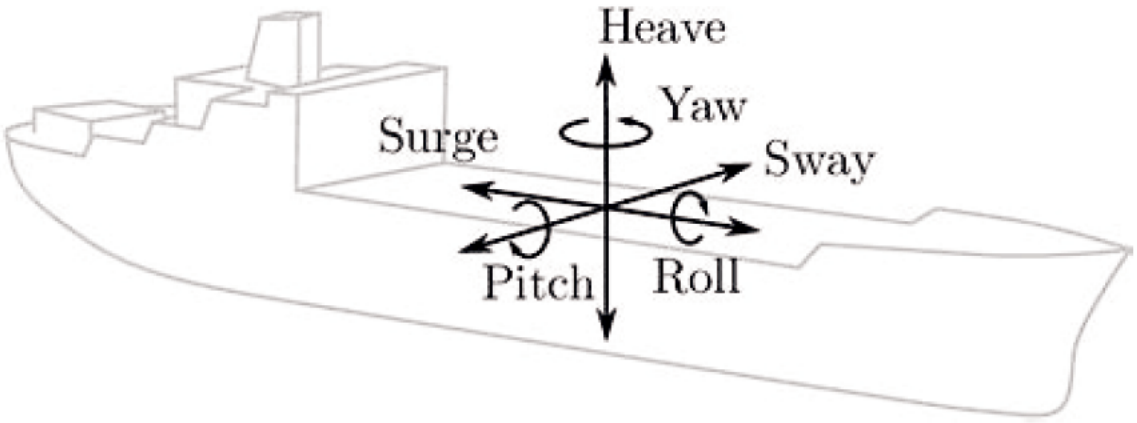


Photograph No. 12- The footwear found in good condition with the securing straps forward as shown.

4.11 The Casualty may have missed one of the two steps down from his berth in the accommodation area while moving forward in a crouched position, and heading towards the ladder, or, slipped as he stepped on to the ladder, thereby hitting his head and causing the fall. It also could have happened that the space configuration led him to misjudge the various heights and that he hit his head first. The vessel was also pitching and rolling, and this could have added to the possibility of unbalance and falling. A crewmember at the inquest gave evidence that carrying out CPR was difficult because of sea swells. It is also possible that irrespective of the condition of the Crocs, that they caused him to slip. The floor surface does not appear to have been a cause although the investigating Garda considered the floor surface material to be slippery. It is of note that the Health and Safety Authority (HSA) carried out an investigation and reported that there were no issues reported in and around the bunk space relating to flooring.

4.12 The accident appears to be the result of the Casualty falling and hitting his head, or a slip and then hitting his head and falling, in the restricted accommodation area where he was found while following instructions to go the wheelhouse to take over the watch from the Skipper. The heights of the space made it necessary for the Casualty to crouch down while, simultaneously, moving in the area and going down/up several steps at the same time. He may have missed one of the steps down, or slipped, and fell forward hitting his head in the small space, or conversely misjudged the heights and hit his head first. Loose footwear may also have contributed to the fall. There was no major damage on the deck surface that could be considered to have caused the fall.

4.13 Vessel movement and the lack of convenient hand-holds may have contributed to the incident. By vessel movement it should be noted that any vessel has six "degrees of freedom"- three axis each with linear movement in direction of the axis and rotation about each axis.



The weather is described as *"Weather on Scene Wind: 5, W / Sea: Rough / Swell: Low wave"*. Sea roughness is an average of the wave heights and large waves will occur in the wave pattern. Such a large wave would create an unexpected motion which, with the Casualty in the crouched position, could have caused him to lose his footing and fall.

See Appendix 7.2 – Irish Coast Guard SITREP.

4.14 The reported evidence of the investigating Garda at the inquest was that having accessed the scene, his opinion was that the Casualty probably slipped on a step as he made his way back towards the timber stairs of the accommodation deck, having retrieved his jumper. He considered it possible that he hit his head off the door frame of the room.

4.15 The Casualty was considered fit and healthy with his last Seafarers Medical Certificate being completed in April 2023 with no unusual findings.

4.16 The post mortem report recorded a large bruise on the front of the head as well as craniovertebral junction fracture in addition to C1 vertebrae fracture which is consistent with a heavy fall or falls hitting the head and neck causing the injuries. The Casualty was located on his back facing forward. The bruising on the front of his head, might indicate that he fell, or hit his head, while returning to, or stepping down from his storage bunk area, or stepping onto the ladder. It also cannot be determined absolutely why the Casualty fell or slipped, or whether he hit his head first and whether that caused the fall and a resultant neck injury. The reported evidence from the State Pathologist at the inquest, did not refer to any opinion of the medical evidence that was conclusively indicative of one or other of the aforementioned scenarios. The Coroner found that there

was *"strong circumstantial evidence"* that the Casualty lost his footing on the ladder, sustained a neck injury and suffered cardiorespiratory failure, as a result of *"extremely bad luck"*. He described the accident as a case *"of lightning striking"* leading to a *"one-in-a-million death"*.

4.17 Slips, trips and falls are a well-known hazard onboard fishing vessels and the section below is taken from HSA guidance document titled - Managing Health and Safety in fishing vessels Page 28 under the heading *"Slips, Trips and Falls"*. This part concentrates on areas of the working deck and does not refer specifically to the accommodation spaces.

"Fishermen constantly face the danger of slips, trips and falls and most of the time do not even notice them or think of the possible consequences. Incorrect footwear, rushing, slippery or wet and uneven surfaces are one of the main causes of slips, trips and falls. It is the responsibility of everyone on board to look out for their shipmates and themselves. Report any potential hazards, accidents or incidents to the skipper so that changes can be made and the risk of injury removed or reduced……".

5. CONCLUSIONS

5.1 This was a very unfortunate common slip or fall accident that very unusually resulted in a fatality to a young Fisher while he was carrying out his work.

5.2 The accident appears to be the result of the Casualty slipping or falling and hitting his head in, or departing from, the accommodation area while following instructions to go to the wheelhouse to take over the watch from the Skipper.

5.3 Circumstantial evidence would indicate that the Casualty may have missed one of the steps or slipped, and then fell forward hitting his head on any number of hard surfaces in the small space. Alternatively, he may have misjudged the heights in the accommodation area and hit his head first before falling to the deck floor. Loose footwear may also have contributed to an initial fall or hitting his head on the door frame. Vessel movement and the lack of convenient handholds may also have contributed to a slip or fall. There were no major features on the deck floor that could be considered to have caused the fall. Regard must be had to the findings of the Coroner that there was *"strong circumstantial evidence"* that the Casualty lost his footing on the ladder, thereby sustaining a neck injury and suffered cardiorespiratory failure.

6. SAFETY RECOMMENDATIONS

6.1 To the Minister for Transport:

The Minister for Transport should circulate a Marine Notice:

- highlighting the importance of wearing secure footwear at all times onboard fishing vessels.
- advising owners regarding the dangers of restricted headroom in vessels
- to include this hazard in their risk assessment
- to have suitable warning signage at the entrance/exit to spaces with restricted headroom, such as:

Bump or low deckhead

6.2 To the Owner:

The Owner should carry out a Risk Assessment of the accommodation area and access arrangements with regard to height and space restrictions and should ensure that all crewmembers are trained in relation to safe movement onboard.

6.3 To the Health and Safety Authority:

The Health and Safety Authority should review the content of their publication "Managing Health and Safety in Fishing Guidelines" in the light of this report and consider additional content with regard to all aspects of achieving safe movement on fishing vessels especially those <24m and with regard to footwear, and areas with height and space restrictions.

7. APPENDICES

Appendix 7.1 Manning Levels Table

Appendix 1: Minimum number of deck officers to be carried on board until a minimum safe manning document is secured

Column (1)	Column (2)	Column (3) Minimum Number of Qualified Deck Officers to be carried on a fishing vessel					Column (4)
Area	Length or Length Overall (L_{OA})	Skipper Full	Skipper Limited	Second Hand Full	Skipper Limited <24m	Second Hand Limited	Total Number of Deck Officers to be carried on a fishing vessel
Unlimited	100 metres in length and over	1	-	3	-	-	4
Unlimited	50 metres in length and over to less than 100 metres in length	1	-	2	-	-	3
Unlimited	Less than 50 metres in length	1	-	1	-	-	2
Limited	100 metres in length and over	1	-	-	-	2	3
Limited	50 metres in length and over to less than 100 metres in length	-	1	-	-	2	3 Limited
Limited	24 metres in length and over to less than 50 metres	-	1	-	-	1	2
Limited	15 metres in L_{OA} and over to less than 24 metres in length	-	-	-	1 (or Second Hand Special)	1	2

Appendix 7.2 Irish Coast Guard SITREP

SITREP1/UIIN2718/23

Transmission Routine
Entry Date 14 0344Z Dec 23
From MRSC Valentia
To MRSC VALENTIA SITREP GROUP
SITREP Number ONE
Incident UIIN2718/23 (T4 IFV BREIZH ARVOR 11 C/S EIRX3)
Reference Number SITREP1/UIIN2718/23
A. ID of Casualty 28 Y/O MALE
B. Position 52°16.50'N 013°06.00'W
C. Situation OWNER OF IFV BREIZH ARVOR 11 ADVZ [redacted] T4 ONBOARD VSL AFTER FALL ONBOARD/CAS FOUND AT BOTTOM OF LADDER IN BUNKSPACE.
D. Number of Persons 1
E. Assistance Required VSL CONNECTED WITH MEDICO CORK/CONFERENCE CALL SAT TFN.
F. Coordinating RCC MRSC Valentia
G. Description of Casualty 28 YO MALE
H. Weather On Scene Wind: 5, W / Sea: Rough / Swell: Low wave / Air Temp: 11.8°C / Water Temp: 11.6°C / Vis: Good / Precip: Slight / SITREP Weather-Time: 14 0209Z Dec 23
J. Initial Actions Taken LINK CALL ON MEDICO CORK / AGS & ON CALL UPDATED.
K. Search Area 100 NM WEST OF THE BLASKETS.
L. Coordinating Instructions MONITOR
M. Future Plans VSL ETA CTB APPROX 142200 Z DEC 2023
N. Additional Information 0209 OWNER OF IFV BREIZH ARVOR 11 ADVZ [redacted] ONBOARD VSL IS T4 AFTER SUFFERING FALL ONBOARD/SKIPPER & CREW CARRIED OUT CPR TO NO AVAIL/INCIDENT OCCOURED APPORX 0030/45 HRS.
0219/30 NUMEROUS CALLS TO VSL 2182/DSC/ WHATS APP & N/R
0237 CONNECTED TO THE VSL VIA WHATSAPP AND SAT TFN NO PASSED & UPDATED POSN RCVD.
0238/0246 CONFERENCE CALL ON WITH MEDICO CORK VIA SHIPS SAT TFN MEDICO DR ADVISES CAS T4 / VSL TO PROC TO PORT / VSL ADVZS CSE 123 DGS / SP 7/9 KNTS ETA CTB APPROX 2200 HRS TONIGHT.
ON CALL AND AGS UPDATED.

SITREP2/UIIN2718/23

Transmission Routine
Entry Date 14 1602Z Dec 23
From MRSC Valentia
To MRSC VALENTIA SITREP GROUP
SITREP Number TWO AND FINAL
Incident UIIN2718/23 (T4 IFV BREIZH ARVOR 11 C/S EIRX3)
Reference Number SITREP2/UIIN2718/23
A. ID of Casualty Unknown
B. Position 52°16.50'N 013°06.00'W
C. Situation OWNER OF IFV BREIZH ARVOR 11 ADVZ [redacted] T4 ONBOARD VSL AFTER FALL ONBOARD/CAS FOUND AT BOTTOM OF LADDER IN BUNKSPACE.
D. Number of Persons 1
E. Assistance Required VSL CONNECTED WITH MEDICO CORK/CONFERENCE CALL SAT TFN.
F. Coordinating RCC MRSC Valentia
G. Description of Casualty 28 YO MALE
H. Weather On Scene Wind: 5, W / Sea: High / Swell: High wave / Air Temp: 11.5°C / Water Temp: 11.6°C / Vis: Good / Precip: No rain / SITREP Weather-Time: 14 1602Z Dec 23
J. Initial Actions Taken LINK CALL ON MEDICO CORK / AGS & ON CALL UPDATED.
K. Search Area 100 NM WEST OF THE BLASKETS.
L. Coordinating Instructions MONITOR
M. Future Plans INCIDENT CLOSED
N. Additional Information 1017 AGS ADVISE THEY WILL MEET VESSEL ON ARRIVAL AT CTB AND ADVISE HSA.
1248 MRSC VALENTIA WELFARE CALL TO VESSEL. REVISED ETA 2100 AND NO ASSISTANCE REQUIRED ON ARRIVAL. CTB HRBR MASTER UPDATED.
1840 FV BREIZH ARVOR II OBSERVED ON AIS ALONGSIDE DINISH ISLAND. INCIDENT CLOSED

SECTION 36 PROCESS

Section 36 of the Merchant Shipping (Investigation of Marine Casualties) Act, 2000

It is a requirement under Section 36 that:

(1) Before publishing a report, the Board shall send a draft of the report or sections of the draft report to any person who, in its opinion, is likely to be adversely affected by the publishing of the report or sections or, if that person be deceased, then such person as appears to the Board best to represent that person's interest.

(2) A person to whom the Board sends a draft in accordance with subsection (1) may, within a period of 28 days commencing on the date on which the draft is sent to the person, or such further period not exceeding 28 days, as the Board in its absolute discretion thinks fit, submit to the Board in writing his or her observations on the draft.

(3) A person to whom a draft has been sent in accordance with subsection (1) may apply to the Board for an extension, in accordance with subsection (2), of the period in which to submit his or her observations on the draft.

(4) Observations submitted to the Board in accordance with subsection (2) shall be included in an appendix to the published report, unless the person submitting the observations requests in writing that the observations be not published.

(5) Where observations are submitted to the Board in accordance with subsection (2), the Board may, at its discretion -

(a) alter the draft before publication or decide not to do so, or

(b) include in the published report such comments on the observations as it thinks fit.

The Board reviews and considers all observations received whether published or not published in the final report. When the Board considers an observation requires amendments to the report, those amendments are made. When the Board is satisfied that the report has adequately addressed the issue in the observation, then no amendment is made to the report. The Board may also make comments on observations in the report.

Response(s) received following circulation of the draft report (excluding those where the Board has agreed to a request not to publish) are included in the following section.

The Board has noted the contents of all observations, and amendments have been made to the report where required.

8. MSA 2000 – SECTION 36 OBSERVATIONS RECEIVED

No correspondence was received on the draft of this report.

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