

MARINE CASUALTY INVESTIGATION BOARD

REPORT OF
INCIDENTS & INVESTIGATIONS



Reporting Period 1st January to 31st December 2022

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Chairperson's Statement



Claire Callanan,
Chairperson

Dear Minister,

In accordance with the requirements of Section 21 of the Merchant Shipping (Investigation of Marine Casualties) Act 2000, I present the twentieth Incidents & Investigations report of the Marine Casualty Investigation Board, covering the period 1 January – 31 December 2022.

The audited accounts of the Marine Casualty Investigation Board (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 2022, for publication on the MCIB website www.mcib.ie.

Overview of 2022

The MCIB commenced investigations into 11 marine casualties in 2022, of which eight occurred in 2022, two in 2021, and one in 2020. No lives were lost in any of the marine casualties under investigation.

A further 74 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 2022 the MCIB also assessed 14 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 20 years ago and to the end of December 2022 it has published 255 reports into incidents under its statutory remit. The Board published seven final marine casualty investigation reports and three interim reports in 2022.

Eleven investigations were commenced during the year, two of which concluded in 2022. At 31 December 2022 there were in total 13 ongoing investigations, nine of which commenced in 2022 (of which two have been published in 2023), one that occurred in November 2019, involving a fatality from a kayak on the Caragh River, Glencar, Co. Kerry, which was complex and was published in February 2023, and three that commenced in 2021, one of which was published in March 2023. Currently, there are in total 11 investigations ongoing including two which have commenced in 2023.

In the MCIB Annual Reports for 2020 and for 2021 we reported on incidents associated with water sports and water recreational activities. We focussed on the recommendations for organisations (especially clubs and commercial entities) aimed at improving their safety standards. In February 2023 we published a report following a lengthy investigation into a tragic fatality that focussed on the safety regime in kayaking in third level institutions. In my statement to the Minister in the 2021 Annual Report I referred to MCIB report No. 304, published in 2021, and a number of recommendations that the MCIB made in relation to the kayaking/canoeing sector. In April 2022 the MCIB commenced an investigation into another serious incident involving a commercial kayak provider and published its report No. 318 in May 2023. This incident involved six persons, two of whom narrowly escaped drowning. The MCIB has made extensive recommendations to the Minister, the organiser, Water Safety Ireland and to Canoeing Ireland and Sport Ireland, including:

That Canoeing Ireland, in conjunction with Sport Ireland, should consider the establishment, and promotion of a register of Canoeing Ireland qualified instructors with their qualifications that would be available to the public.

That Canoeing Ireland, in conjunction with Sport Ireland, should consider the establishment of a scheme for the audit of the safety policies and practises of entities affiliated with this national governing body.

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

That Water Safety Ireland should consider actions to further promote both public awareness of kayaking water safety and measures to prevent kayaking accidents.

The MCIB urges those bodies to whom recommendations have been addressed in these recent reports to take steps to improve much needed safety regimes.

In June 2022 the Department of Transport, following MCIB recommendations, published a specific Marine Notice No. 37 of 2022 entitled Important safety advice for those involved in Canoeing and Kayaking. The Marine Notice is designed to draw attention to Chapter 7 of the Code of Practice (CoP) for the Safe Operation of Recreational Craft in relation to Canoeing and Kayaking. The Notice also highlighted previous Marine Notice No. 30 of 2020 and Marine Notice No. 31 of 2019, and stated that canoeists, kayakers and kayaking and canoeing organisations are again encouraged to familiarise themselves with the contents of the CoP and to comply with its safety advice and recommendations.

In 2022, the MCIB continued to see incidents involving fatalities and injuries to crewmembers on fishing vessels where there are common themes of the lack of safety planning and regimes, lack of training, and contributory factors due to language barriers and poor communications, and fatigue. MCIB Report No. 307/2022 illustrates some of these issues, while Report No. 302/2022 arose from a sad fatality on a fishing vessel where it was not possible to determine exactly what occurred and where the death may have arisen from natural causes.

It is clear that many incidents on fishing vessels are not reported to the MCIB as required by legislation. Even from the limited information available to the MCIB from Coast Guard situation reports (SITREPs) it appears that many incidents could have been avoided by safety assessment and planning and by proper training of crew. As noted in MCIB Report No. 302/2022, the Maritime Safety Strategy identified that the fishing vessel sector accounts for a significant proportion of all maritime fatalities, and that fishing vessels less than 15 metres (m) in length make up 90% of the Irish fishing fleet in numbers. Fishing vessel safety, particularly in relation to the small and medium fishing vessels is a particular concern. Among the key factors contributing to loss of life in the fishing sector is working alone and fatigue.

Since April 2022 the MCIB has published three reports involving fire onboard vessels. While the circumstances of these incidents varied it illustrates the dangers and greater risks that can arise with fires in marine situations.

New legislation

As a result of the Court of Justice of the European Union (CJEU) decision in July 2020 which held that Ireland had not correctly implemented Article 8.1 of Directive 2009/18/EC, the Board of the MCIB had to operate with only three members. On the 16 May 2022, the President signed into law the Merchant Shipping (Investigation of Marine Casualties) (Amendment) Act 2022 to provide for an amendment to the composition of the Marine Casualty Investigation Board; to provide for notification of marine casualties to the Board; to provide for notification of marine casualties to the Marine Survey Office (MSO); to amend the definition of "Safety Convention" in the Merchant Shipping (Safety Convention) Act 1952; and to provide for related matters. Following that enactment, in August 2022, one new Board member was appointed. I am happy to report that shortly before publication of this report the Minister appointed three additional Board members. I extend a warm welcome to Mr Phil Murphy, Mr John Carlton and Ms Deirdre Lane to the Board of the MCIB.

Legislative Changes

The MCIB welcomed the announcement of the Minister in December 2022 of the drafting of a Merchant Shipping (Investigation of Marine Accidents) Bill to provide for a full-time Marine Accident Investigation Unit within the Department of Transport. The Board believes that the new proposed structure and the potential for greater synergy with other investigation units within the Department's remit will enhance future investigations of marine casualties and thereby contribute to greater marine safety.

The General Scheme provides for the establishment of the 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. The main focus of the Bill is to provide the MAIU with the necessary framework to ensure it can operate independently in its organisation, legal structure and decision-making of any party whose interests could conflict with the task entrusted to it. 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 draft legislation is making its way through the houses of the Oireachtas.

In April 2022 the Board completed a recruitment drive for additional investigators to the investigator panel which comprises independent persons with a high level of technical expertise.

In April 2023 the Board appointed an expert marine consultant for the MCIB. This initiative is in line with Recommendation 1 of the Review of the organisational structures underpinning marine accident investigations commissioned by the Department of Transport.

The Board has assured the Minister and the Department of its full support and co-operation to ensure continuity for ongoing and new investigations and to enable a smooth transition of the function of investigating marine casualties from the Board to the new Unit which will be established by the current Bill.

European Context and EMSA

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

In 2022 EMSA presented the first edition of the European Maritime Safety Report (EMSAFE); the first report of its kind, and one which reflects the paramount importance of safety to the maritime transport sector in the EU and worldwide. The report noted that there *"are more safety challenges ahead, as EMSAFE makes clear, and more work now and in the future. Passenger ship safety is firmly in our focus, as is fishing vessel safety, and we look ahead to three forthcoming important legislative revisions; those of the Port State, Flag State, and Accident Investigation Directives."* The Report notes emerging safety challenges, like those associated with alternative fuels and autonomous shipping. In its summary, it notes with regard to safety issues of particular interest to incidents that the MCIB is observing in respect of qualifications and training that *"Qualified seafarers are essential to ensuring the safety of ship operations and are vital for the future of the maritime sector."* With regard to fishing vessels, the Report continues to note previous statistics on safety: *"They present a high vulnerability to accidents, in that 50% of all the accidents involving fishing vessels are either very serious or serious, whereas the average for all ship categories is 27%. In addition, even though fishing vessels represent 17% of the total number of ships involved in accidents reported, the number of fishing vessels lost represents more than 55% of total number of lost vessels, a trend observed in recent years."* The EMSAFE report and any associated materials are available online at <http://emsa.europa.eu/emsa>

EMSA provides training services for EU accident investigators and announced in April 2022 the development of a training academy with a Core Curriculum Course for EU accident investigators which will come on stream in late 2023. The new EMSA Academy will deliver training on new or amended International Maritime Organisation (IMO)/EU acts and will provide operational training, using advanced tools and developing a Common Core Curricula. All trainings in EMSA Academy will comply with International Organisation for Standardisation (ISO) 9001:2015, ISO 21001:2018 and ISO 29993:2017 standards. This is a very welcome development which will contribute to the continued learning of MCIB accident investigators.

The European Commission has also initiated a review of EU legislation and a new Directive is expected within the next twelve months.

The Department of Transport published 85 Marine Notices in 2022.

The full list can be accessed here www.gov.ie - Marine Notices 2022 (www.gov.ie)

The following Marine Notices were published in 2022 following MCIB reports and investigations:

- | | |
|------------|--|
| 7 of 2022 | Reminder Fishing Vessel Safety – fatal incident involving a small fishing vessel (<15m). |
| 31 of 2022 | Importance of Voyage Planning for Fishing Vessels in Adverse Weather and Sea Conditions. |
| 37 of 2022 | Important safety advice for those involved in Canoeing and Kayaking. |
| 42 of 2022 | Important safety advice for those involved in Rowing. |
| 55 of 2022 | Incident Involving the Fire and Total Loss of a Fishing Vessel 15m – 24m in Length. |
| 61 of 2022 | Mandatory Requirement for all Fishing Vessel Crew Members – basic safety training. |

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.
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 2022

The Board published seven Final and three Interim Reports during 2022. The full details are provided at pages 16 to 22.

Investigations commenced in 2022

Investigations were initiated by the Board into 11 incidents during 2022. Summary details of the incidents are provided in the table below. Full details of all incidents are set out on pages 11 to 15.

Five of the 11 incidents which required investigation occurred in connection with fishing vessels. Two involved general cargo vessels, two recreational craft and two involved three passenger vessels.

Sector	Incidents	Sinkings	Fatalities	Injuries
Fishing	5	1	0	4
General Cargo	2	0	0	1
Recreational	2	0	0	0
Passenger	2	0	0	1
Total	11	1	0	6

Fishing Vessels

There were five incidents involving fishing vessels.

- Crewmember injured at Howth, Co. Dublin.
- Loss of vessel, Co. Cork.
- Crewmember injured, Co. Kerry.
- Two crewmembers injured, Co. Louth.
- Collision at Dingle, Co. Kerry.

General Cargo

- Crewmember injured on Irish cargo vessel, Aberdeen, Scotland, United Kingdom (UK) (Report Published 29/11/2022).

- Irish cargo vessel runs aground, Bristol Channel, UK.

Recreational Craft

There were two incidents involving recreational craft.

- Incident involving kayaks, Co. Donegal.
- Race Yacht grounding, Co. Cork.

Passenger Vessels

There were two incident involving passenger vessels.

- Incident involving two passenger ferries at Rosslare Harbour, Co. Wexford (Report published 22/12/2022).
- Crewmember injured on Fish Farm workboat (passenger vessel), Co. Galway.

Detailed tables of incidents investigated which occurred in the years 2013 to 2022 are at page 23 and 24 of this report. A summary of all incidents investigated occurring in these years is provided in the table below:

	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Fatalities	6	5	5	9	6	8	6	4	0	0
Injuries	Nil	1	0	14	Nil	Nil	1	2	2	6
Vessels Involved	6	7	7	15	5	5	7	8	8	21

Ethics in Public Office

During 2022, 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.

We had to say farewell to Mr Frank Cronin, our esteemed colleague as his term of office concluded and a further extension is not permitted under our legislation. Frank is a Chartered Insurer, a Fellow of the Chartered Insurance Institute, specializing in risk management and reinsurance, an Associate of the Chartered Insurance Institute 1986. He holds a Marine Engineer Class 1 steam & motor Certificate of Competency 1981 together with a National Diploma in Marine Engineering 1973 and a National Certificate in Mechanical Engineering 1972 along with extensive personal sailing experience worldwide. Aside from his academic and technical qualifications, Frank gave unstintingly of his time and expertise, and has been a major contributing factor to the increased depth and complexity of MCIB reports over the last few years.

In August 2022, we welcomed Mr Keith Patterson to the Board. Keith holds Chartered Engineer Status with The Engineering Council and a CEng CMarEng Member Institute of Marine Engineering, Science and Technology. He is a Chartered Engineer (CEng)/Chartered Marine Engineer (CMarEng) and holds the professional title of EUR ING (European Engineer awarded by FEANI (European Federation of National Engineering Associations)). Keith is retired from the Marine Safety Agency/Maritime and Coastguard Agency where he was Principal Consultant Surveyor for Fishing and Code Vessels, Examiner of Engineers and ISM Auditor.

None of that investigative work would have been possible without the dedication and expertise of our investigators whom I would also like to thank. We have welcomed new investigators to our panel in 2022 and their varied expertise is greatly appreciated.

I would also like to express my appreciation on behalf of the Board to our Board Secretary and her Secretariat and congratulate them on the work done during the year.

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 2022.

CLAIRE CALLANAN
CHAIRPERSON

Board Members and General Information



Ms. Claire Callanan,
Chairperson, Solicitor



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



Mr. Frank Cronin,
Marine Engineer Class 1
combined, FCII, Chartered
Insurer



Mr Keith Patterson,
(July-December 2022) CEng,
CMarENG, Marine Engineer
Class 1

Secretary: Ms. Margaret Bell
Secretariat: Mr. Paul Hallissey
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The following is some general information regarding the Marine Casualty Investigation Board (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 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 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 9th 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 Garda Síochána, etc.

Status

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

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

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

Incidents and Investigations 2022



Reporting Period 1st January to 31st December 2022

Introduction

Since establishment in 2002, and up to the end of 2022, the Board has published reports on 255 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 2022

1st January to 31st December 2022

Name of vessel/incident: Stena Europe - Connemara	
TYPE OF CRAFT	Two Passenger Ferries
TYPE OF INCIDENT	Close quarter situation
FATALITIES	None
SUMMARY	Two large passenger ferries engaged in a close quarter incident just outside the breakwater of Rosslare Harbour, Co. Wexford resulting in the ferries passing approximately 100 m apart. The inbound vessel Connemara arrived from Bilbao in Spain; it was scheduled to arrive at 08.15 hours (hrs). This vessel arrived early and was asked by Rosslare Port Control to wait outside the harbour in the vicinity of West Holdens buoy. The outbound vessel Stena Europe was scheduled to sail for Fishguard in the UK at 07.30 hrs. Connemara did not follow the instructions from Rosslare Harbour Control and instead of holding position proceeded towards the breakwater. Stena Europe was given permission to sail by Rosslare Port Control and departed its berth unaware that Connemara was approaching the breakwater. The two vessels met each other just off the breakwater. Both vessels had to take action to avoid collision resulting in a close quarter situation.

Name of vessel/incident: Donegal Kayaking Incident, Mulroy Bay, Co. Donegal	
TYPE OF CRAFT	Several Kayaks
TYPE OF INCIDENT	Kayaking incident
FATALITIES	None
SUMMARY	<p>A group of six kayakers set out on a morning's kayaking trip on Mulroy Bay, Co. Donegal. This is a tidal sea lough that extends 19 kilometres (km)/10 nautical miles (NM) inland from the north Atlantic coast. This was a commercial, guided trip consisting of the Trip Organiser and five clients. The clients were adults who typically had little or no kayaking experience. Only one client wore a wetsuit as thermal protection against the effects of cold water immersion, while the others wore clothing such as jeans and winter coats.</p> <p>The group got into difficulty when the wind speed increased and the sea state deteriorated. The double kayak capsized but its two clients were able to right the kayak and make their way to one side of the lough. Another two clients, in single kayaks, separately made their own way to the other side of the lough, after one of them capsized and swam for about 20 minutes to reach the shore. The remaining client and the Trip Organiser both capsized and lost contact with their kayaks. They drifted in the water for approximately one hour, isolated about mid-way across the lough, until they were rescued by the Coast Guard. They required hospital treatment before being released later that day. This rescue only became possible because of the diligent actions of a member of the public, who saw people in the water and notified the emergency services.</p>

Name of vessel/incident: **FV Anna Louise**

TYPE OF CRAFT	Fishing Vessel <15 m
TYPE OF INCIDENT	Sinking
FATALITIES	None
SUMMARY	<p>The fishing vessel (FV) Anna Louise was an open fishing boat of 5.35 m in length with an outboard engine and on a routine fishing trip to lift lobster pots in Bantry Bay, Co. Cork. The boat was operated by the owner's brother (the Skipper) and he was a qualified and experienced boat operator with valid certification. The Skipper had lifted two strings of lobster pots onboard with a total of ten pots and was retrieving the marker buoy when a wave came over the stern, flooding the boat. The Skipper tried to reach the bailing bucket, but a further wave swamped the boat, and the boat sank quickly. The Emergency Position Indicating Radio Beacon (EPIRB) floated free and was activated. The distress was received by Valentia Marine Rescue Sub-Centre (MRSC) who initiated rescue operations. Bantry Inshore Lifeboat was tasked as well as Castletownbere Lifeboat and Rescue Helicopter R115.</p> <p>The Skipper swam ashore and made his way through fields to a house from where he called to advise he was safe and well. The rescue operations were terminated. The boat was later salvaged from 12 m of water. There were no injuries and no pollution.</p>

Name of vessel/incident: **FV An Portán Óir**

TYPE OF CRAFT	Fishing Vessel <15 m
TYPE OF INCIDENT	Injured crewmember
FATALITIES	None
SUMMARY	<p>The FV An Portán Óir is a decked fishing boat of 9.9 m length with an inboard diesel engine. The vessel was on a routine fishing trip to lift, bait and shoot lobster pots in Dingle Bay, Co. Kerry. It was operated by the owner (the Skipper). He was a qualified and experienced boat operator with a valid certification. The Skipper was shooting the final string of 30 lobster pots with ten pots in the water when his leg became entangled in the pot ropes. The boat was in gear to stretch the string and the rope tightened around the Skipper's leg and he was pulled aft. He grabbed the rope between the pots and tied it to the handrail to avoid being pulled overboard. He was unable to free himself as the ropes around his leg were under tension and he remained stuck in this position until rescued around four hours later.</p> <p>Persons ashore noticed he had not returned as planned and raised the alarm. Several local boats as well as Dingle Lifeboat and Coast Guard Rescue Helicopters searched until the boat was located by a local boat and the Skipper was brought ashore where an ambulance was waiting to take him to hospital. The Skipper suffered serious injuries to his left leg.</p>

Name of vessel/incident: **FV John B**

TYPE OF CRAFT	Fishing Vessel >15m
TYPE OF INCIDENT	Injured crewmember
FATALITIES	None
SUMMARY	<p>An incident occurred onboard the FV John B, while engaged in fishing operations in the Irish sea approximately 20 miles East-North-East of Howth. Whilst hauling the nets and fishing gear onboard between 08.00-09.00 hrs a member of the crew was injured when his leg became trapped between the centre weight and the weight retaining cage at the stern of the vessel.</p> <p>The load was adjusted allowing the injured Crewmember to extricate his trapped foot from the grip of the centre weight. The other crewmembers provided first aid care to the injured Crewmember, and he was placed in the galley. The remaining crew retrieved the nets and fishing gear onboard. The vessel owners were informed of the incident and the vessel proceeded to Howth which was the closest port. No external medical or emergency assistance was requested.</p> <p>On arrival in Howth between 12.00-13.00 hrs the injured Crewmember was assisted from the vessel and was transferred to Beaumont Hospital where he received medical attention.</p>

Name of vessel/incident: **Arklow Clan**

TYPE OF CRAFT	Cargo Ship
TYPE OF INCIDENT	Injured crewmember
FATALITIES	None
SUMMARY	<p>The cargo vessel Arklow Clan, berthed alongside at the Port of Aberdeen. The vessel was in ballast condition and scheduled to commence loading a cargo of scrap metal in bulk the following morning. At around 17.49 hrs, three crewmembers commenced lowering the walkway handrails in preparation for loading operations. Whilst lowering the handrails, the Second Officer lost his footing, falling around 3.6 m from the walkway to the quay below. As a result of the impact the Second Officer sustained serious injuries to both his legs, necessitating an extensive period of hospitalisation, multiple surgeries and rehabilitation.</p>

Name of vessel/incident: **Jelly Baby**

TYPE OF CRAFT	Recreational Craft
TYPE OF INCIDENT	Sailing incident
FATALITIES	None
SUMMARY	<p>The yacht Jelly Baby, with nine persons onboard, was competing in the last race of the Autumn League series in Cork Harbour. On rounding the third mark of the racecourse the crew were preparing to change sails when they encountered difficulties rigging a gennaker type sail. During efforts to overcome these difficulties the gennaker sail and a Crewmember went overboard. The Crewmember was quickly recovered but the sail became entangled around the keel, rudder and propellor and disabled the yacht. The yacht lost motive power and went aground onto rocks at Weavers Point on the west side of the entrance to Cork Harbour. The crew were uninjured, but the yacht remained on the rocks until recovered on the following flood tide.</p>

Name of vessel/incident: FV Ardent	
TYPE OF CRAFT	Fishing Vessel >24m
TYPE OF INCIDENT	Injured crewmember
FATALITIES	None
SUMMARY	<p>The FV Ardent departed Port Oriel Harbour in Clogherhead, Co. Louth with four crew onboard, to commence fishing activities in the Irish sea. The vessel had moored in the harbour after discharging its catch in Ardglass Co. Down the previous day. At approximately 15.15 hrs the Skipper and Crewmember (A) 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 operated the tank discharge pump, expelling the water overboard. Crewmember (A) 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 was affected by the atmosphere and fell to the tank floor close to the ladder.</p> <p>An attempt to provide assistance to Crewmember (A) by the other crewmembers was discussed and a possible recovery plan was agreed. One crewmember donned a safety harness and attached a recovery line that was maned by another crewmember. Crewmember (B) entered the tank descending the ladder. While trying to assess the condition of Crewmember (A), Crewmember (B) was also 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 held aloft by Crewmember (C) via the line attached to the harness. The Skipper and Crewmember (C) recovered Crewmember (B) to the deck.</p> <p>The vessel returned to Port Oriel and rescue services with breathing apparatus recovered Crewmember (A) from the tank. At approximately 16.40 hrs both injured crewmembers were taken to hospital where medical treatment was administered.</p>

Name of vessel/incident: Simmerdim	
TYPE OF CRAFT	Passenger Vessel
TYPE OF INCIDENT	Injured crewmember
FATALITIES	None
SUMMARY	<p>The vessel Simmerdim departed Lettermullan, Connemara, Co. Galway with four personnel onboard and proceeded to the offshore Salmon Farm site located off Ardmore Pier. The Simmerdim arrived at the worksite and made fast alongside fixed-moored Feed Barge and all personnel transferred from the vessel to the Feed Barge.</p> <p>A smaller vessel (Polar boat) carrying five personnel to the Salmon Farm site rendezvoused at the site and moored outboard of Simmerdim to alight three personnel.</p> <p>The first of the three passengers from the Polar boat transited across Simmerdim to the Feed Barge. As the second person of the group was transiting across to the Feed Barge, there was a coming together of the vessels, which pinned the individual between both vessels causing crush injuries to the pelvic area. The injured Casualty was brought back onboard Simmerdim and was subsequently airlifted to Galway University Hospital where his injuries were assessed and included multiple fractures to the pelvis and fractured hip socket joints.</p>

Name of vessel/incident: **FV Bikain**

TYPE OF CRAFT	Fishing Vessel > 15 m
TYPE OF INCIDENT	Collision with marina and other vessels
FATALITIES	None
SUMMARY	<p>The French registered fishing trawler Bikain was alongside, at the end of the main finger pier, in Dingle Harbour, Co. Kerry and was preparing to go to sea to resume fishing. The main engine was started and checks for sailing were being carried out when the controllable pitch propeller went to the full astern position. The captain tried to stop the main engine with the emergency stops on the wheelhouse console, but this failed. The ropes holding the vessel parted and the vessel went quickly astern and made heavy contact with the southern boat marina pontoon causing extensive damage to the pontoon and to several boats that were secured there at the time.</p> <p>The main engine was eventually stopped by shutting off the fuel and the vessel drifted across the harbour basin. Another trawler, moored on the main jetty, saw the incident, and quickly went to assist and towed the Bikain back alongside the jetty.</p> <p>There were no injuries and no pollution but extensive damages to pontoon and moored boats.</p>

Name of vessel/incident: **Arklow Raider**

TYPE OF CRAFT	Cargo Ship
TYPE OF INCIDENT	Vessel ran aground
FATALITIES	None
SUMMARY	<p>The cargo vessel Arklow Raider, proceeded on a laden passage up the Bristol Channel towards her destination port of Sharpness, UK. At around 19.19 hrs the vessel passed under the Severn Bridge and the Pilot commenced a planned turn to port to round Lyde Rock. Despite the Pilot applying starboard helm to counter the anticipated currents and counter currents, the vessel rapidly sheered to port before grounding heavily by the bow on a mud and rock bottom at approximately 19.21 hrs. After sounding all compartments and determining no apparent water ingress, the vessel was re-floated under its own power on the still rising tide. The passage was aborted and successfully completed on the following tide with the same Pilot. The vessel sustained damage to the shell plating and framing in the forepeak ballast tank, with water ingress subsequently detected in the forepeak. The vessel was dry-docked for repairs. No persons were injured, and no pollution occurred.</p>

Summary of Reports Published 2022

1st January to 31st December 2022

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: Carrickcraft	
DATE OF PUBLICATION	17 January, 2022
TYPE OF CRAFT	Pleasure Craft
DATE OF INCIDENT	6 September, 2020
SUMMARY	On 6 September 2020 four clients of Carrickcraft (Shannon Leisure Development Co. Ltd), having rented a Linssen Grand Sturdy 35.0 motor cruiser on the previous day, departed Carrick-on-Shannon, Co. Leitrim heading south. Approximately 45 minutes into their journey, near Jamestown, a fire broke out in the engine compartment. The clients abandoned the vessel onto a passing charter boat. The fire brigade attended the scene and extinguished the fire. Soon afterwards the vessel sank in approximately 8 m of water.
INJURIES/FATALITIES	None
CAUSE OF INCIDENT	<p>Charter vessels are not considered passenger vessels and therefore are not subject to the requirements of the Merchant Shipping Act 1992. Instead, charter vessels come under the legislative requirements and recommendations detailed in the CoP. The CoP does not provide for the mandatory fitting of fire detection systems on recreational craft and hence there was no fire detection system fitted to the Carrickcraft vessel X4. If this fire had started while any of the party were asleep, then the consequences could have been more serious.</p> <p>The fire started as a result of one of a number of potential electrical issues onboard this Linssen Grand Sturdy 35.0. The extent of the fire means that the exact component at fault will never be definitely determined.</p>

Name of vessel/incident: FV Mirror of Justice	
DATE OF PUBLICATION	24 February, 2022
TYPE OF CRAFT	Fishing Vessel <15 m
DATE OF INCIDENT	26 August 2020
SUMMARY	On 26 August 2020 the FV Mirror of Justice drifted onto rocks west of Teelin Bay, Co. Donegal. An extensive search and rescue operation was implemented to try to find the lone Fisher who owned and operated the vessel. Due to an Atlantic swell the vessel broke up on the rocks on which it grounded. Shortly afterwards the Casualty was found floating nearby wearing flotation type oil skins but no Personal Flotation Device (PFD).
INJURIES/FATALITIES	1 Fatality
CAUSE OF INCIDENT	<p>It is likely that the Skipper of the FV Mirror of Justice became ill or got trapped shortly after stopping his vessel in an area he was known to fish at the end of the day. It would appear that this happened when he was either beneath the wheelhouse floor or in the fore peak compartment, as he was not visible to the winchman who was lowered from Rescue Helicopter R118. All those who knew the Skipper of the FV Mirror of Justice, described him as being a fit, competent, and experienced Fisher, with a sound understanding of the risks involved in all fishing operations and who would have implemented appropriate contingency actions in the event of a breakdown or a distress situation.</p> <p>The Skipper of the FV Mirror of Justice normally worked his vessel alone. He chose a type of fishing operation which could be considered less labour intensive than other types such as "potting". Had there been another crewmember onboard the FV Mirror of Justice on the day to raise the alarm or render assistance, the outcome could have been different. Fatigue may have been a contributing factor, but to what degree is impossible to quantify.</p>

Name of vessel/incident: FV Horizon	
DATE OF PUBLICATION	19 April, 2022
TYPE OF CRAFT	Fishing Vessel >15 m
DATE OF INCIDENT	14 May, 2021
SUMMARY	<p>Shortly before 02.00 hrs on the morning of Thursday 14 May 2021 the FV Horizon was fishing with four crew onboard, approximately 20 NM off the Old Head of Kinsale, Co. Cork, when the Skipper noticed large amounts of smoke coming from the accommodation of the vessel. Despite the crew's firefighting efforts, the fire took hold and spread. The Skipper broadcast a MAYDAY distress call by Very High Frequency (VHF) radio and the crew took to a life raft. The crew were recovered from their life raft by the offshore supply ship Pathfinder, but despite efforts to fight the fire by a responding offshore supply ship Maersk Maker, the fishing vessel sank at approximately 07.00 hrs, close to the position where it initially caught fire. There was some sea surface oil pollution reported which appears to have dissipated naturally.</p> <p>Weather and sea conditions at the time were good with light winds and a moderate sea. The crew were subsequently transferred to the Courtmacsherry Lifeboat and brought ashore. There were no injuries suffered by the crew.</p>
INJURIES/FATALITIES	None
CAUSE OF INCIDENT	<p>The vessel was materially fit for purpose and in a stable condition immediately prior to the incident and the vessel's condition was not a factor in the fire and loss of FV Horizon.</p> <p>The ignition source for the outbreak of the fire in the FV Horizon is not known with any certainty but it is reasonably deduced that an unattended mobile phone or other similar electronic device in the process of being charged and/or an electronic device battery charger into a 240 volt (V) alternating current (AC) circuit in the crew accommodation cabin may have been the source of ignition for this fire.</p> <p>The time delay (in fighting the fire) caused by the failure of the smoke detector alarm allowed the fire to take hold and spread before being spotted by the Skipper when he returned to the wheelhouse.</p> <p>The combustible materials commonly used onboard FV Horizon (a wood constructed fishing vessel), particularly the amounts of liquefied petroleum gas, oils and plastic onboard, provided adequate fuel for the fire. This enabled the fire to rapidly spread through the vessel.</p> <p>The exposure of the flexible plastic hose components of the vessel's machinery cooling systems to the fire in the engine room, allowing them to melt and lose their watertight integrity, thereby allowing seawater into the vessel to the extent that FV Horizon filled with seawater and sunk.</p> <p>The absence of fire proofing materials in the flexible hose components of the vessel's machinery cooling systems connecting to the through hull shipside valves allowed seawater to enter the vessel when the flexible hoses melted in the intense heat of the engine room fire. This allowed seawater to flood the vessel.</p> <p>Had the fire detection system onboard FV Horizon been more in-line with the more stringent requirements of the International Fire Safety Systems Code which requires the fire detection system to include both audible and visual fault signals, the fire in the accommodation cabin would likely have been detected earlier. However, FV Horizon was an 'existing vessel' in 2007 when Statutory Instrument (S.I.) No. 640 of 2007 was promulgated. Therefore, the lesser requirements of Regulation 80(17) of S.I. No. 640 of 2007 applied to the fire detection system on the FV Horizon and only audible smoke detector alarms were fitted.</p>

Name of vessel/incident: FV Marliona	
DATE OF PUBLICATION	19 October,2022
TYPE OF CRAFT	Fishing Vessel >15 m
DATE OF INCIDENT	3 February, 2021
SUMMARY	<p>At approximately 14.05 hrs on the afternoon of 3 February 2021, a serious marine casualty occurred on the FV Marliona while alongside Greencastle Harbour, Co. Donegal. During a repair process the Skipper's left arm became trapped by a trawl door causing severe damage to his arm.</p> <p>First aid was administered by another crewmember and the bleeding was stopped. The ambulance was called and arrived at 14.30 hrs, and the Casualty was transferred to the nearest hospital where he was treated for his injuries and they managed to save his arm. He was released the same day but continued to receive treatment and only returned to work in May 2021.</p>
INJURIES/FATALITIES	Crush injury to the Skipper's left arm.
CAUSE OF INCIDENT	<p>There was a failure to identify the consequences of the trawl door not being in the correct position. There was also a failure to take into account the possibility of additional vessel movement from the harbour. This operation should have been done on the quay wall, i.e., the door should have been landed onto the quay and the chain-link removed there. This would have been a quick operation to complete in a safe manner. The absence of a safety assessment and a method statement in the safety statement for this type of operation was a contributory factor to the incident.</p> <p>The time sheets were inspected, and inconsistencies were noted. The MCIB can make no finding about compliance or non-compliance with the Regulations as that is within the jurisdiction of the MSO. Irrespective of whether there was or was not compliance with the Regulations, it cannot be discounted that fatigue may have been a contributory human factor. It is likely that another human factor was that of time pressure to effect the repairs during a limited time in port before the next fishing trip.</p> <p>As Crewmember B had recently completed his first aid course in November, he was able to act appropriately to prevent the Casualty from bleeding out and dying.</p>

Name of vessel/incident: Arklow Clan	
DATE OF PUBLICATION	29 November, 2022
TYPE OF CRAFT	Cargo Ship
DATE OF INCIDENT	11 August, 2021
SUMMARY	The cargo vessel Arklow Clan, berthed alongside at the Port of Aberdeen, Scotland, UK during the afternoon of 11 August 2021, in ballast condition, and scheduled to commence loading a cargo of scrap metal in bulk the following morning. At around 17.49 hrs, three crewmembers commenced lowering the walkway handrails in preparation for loading operations. Whilst lowering the handrails, the Second Officer lost his footing, falling around 3.6 m from the walkway to the quay below. As a result of the impact the Second Officer sustained serious injuries to both his legs, necessitating an extensive period of hospitalisation, multiple surgeries, and rehabilitation.
INJURIES/FATALITIES	Serious injuries sustained
CAUSE OF INCIDENT	<p>At 17.49 hrs on 11 August 2021, while the Arklow Clan was moored alongside at the Port of Aberdeen, the Second Officer fell approximately 3.6 m from the walkway to the quay. In doing so he sustained serious and potentially fatal injuries.</p> <p>Environmental factors, such as weather and movement of the vessel are unlikely to have been contributing factors. The Second Officer was not suffering from excessive fatigue, but fatigue associated with working at night and keeping the 12 to four watch may have caused him to momentarily lose concentration.</p> <p>Full body harnesses were available onboard the vessel and had they been correctly used the incident would have been avoided. The root cause of the incident was a failure to follow safe systems of work applicable for working at height including adequate risk assessment, completion of a permit to work and "toolbox talks". These deficiencies were quickly identified post incident by Arklow Shipping and rectified.</p>

Name of vessel/incident: Stena Europe - Connemara	
DATE OF PUBLICATION	22 December 2022
TYPE OF CRAFT	Two Passenger Ferries
DATE OF INCIDENT	16 March, 2022
SUMMARY	On the morning of 16 March 2022, just outside the breakwater of Rosslare Harbour, Co. Wexford, two large passenger ferries engaged in a close quarter incident resulting in the ferries passing approximately 100 m apart. The inbound vessel Connemara arrived from Bilbao in Spain; it was scheduled to arrive at 08.15 hrs. This vessel arrived early and was asked by Rosslare Port Control to wait outside the harbour in the vicinity of West Holdens buoy. The outbound vessel Stena Europe was scheduled to sail for Fishguard in the UK at 07.30 hrs. Connemara did not follow the instructions from Rosslare Harbour Control and instead of holding position proceeded towards the breakwater. Stena Europe was given permission to sail by Rosslare Port Control and departed its berth unaware that Connemara was approaching the breakwater. The two vessels met each other just off the breakwater. Both vessels had to take action to avoid collision resulting in a close quarter situation.
INJURIES/FATALITIES	None
CAUSE OF INCIDENT	The bridge team of Connemara failed to follow instructions from Rosslare Port Control and instead proceeded directly towards the port knowing that another

vessel was outbound. Although it was the stand on vessel under the International Regulations for the Prevention of Collisions at Sea (IRPCS) and therefore obliged to maintain course and speed in a crossing situation where risk of collision existed, under IRPCS; Rule 17 (a) (ii) the option was available to Connemara at any time to alter course and/or speed. Rule 17 (a) (ii) states that as soon as it becomes apparent that the give way vessel, in this case the outbound vessel Stena Europe, was not taking appropriate action, the stand on vessel may take action. In his statement, the Master of the inbound vessel Connemara said he was unclear of the intentions of outbound vessel.

Given this uncertainty, the inbound vessel, Connemara, should have taken greater action, and taken it much earlier, in order to avoid this close quarter situation. Further to this, under the IRPCS; Rule 2 (b), the inbound vessel could have at any time, altered course and/or speed as necessary as the rule specifically allows for a departure from the rules to "avoid immediate danger". The inbound vessel could have avoided the situation entirely by utilising the deep water to the north of West Holdens buoy to manoeuvre while waiting for the outbound vessel to clear the channel, therefore, avoiding any possibility of a close quarter situation developing. This is also something that could have been communicated to the inbound vessel by Rosslare Port Control had the duty Port Controller noticed that the inbound vessel was not following his advice. It is evident from the Voyage Data Recorder (VDR) recording and conflicting statements received from the bridge team of Connemara that communication among the bridge team was extremely poor leading to a situation where there was uncertainty as to who was in control of the situation. It is further evident from the Connemara VDR recording and statements from the bridge team that planning, in particular contingency planning, among the bridge team was severely lacking.

The outbound vessel was in a position to have avoided this close quarter situation. It is evident from its VDR recording that it was concerned about its sailing time and not being held up by the early arrival of Connemara. This may have affected its decision making process and caused it to overlook the progress of the inbound vessel in its eagerness to sail on schedule. The final decision to depart the berth is up to the Master of the vessel. This is reflected in the Safety Management System (SMS) which states that the Master must ensure all statutory requirements are complied with. This includes the IRPCS which requires keeping a lookout at all times. The bridge team on Stena Europe did not comply with this. Rosslare Port Control should have been able to manage this situation and to ensure that arriving and departing vessel do not have to worry about close quarter situations off the entrance to the harbour. Arriving and departing vessels should not end up in a situation where they have to contact each other on VHF to arrange passing. The duty Port Controller was also engaged in other duties in addition to Vessel Traffic Service (VTS) duties. He could not have been completely focused on the vessels manoeuvring in and off the port. The Port Controller has no maritime qualifications or training and therefore cannot be expected to fully appreciate the manoeuvrability of the vessels operating in and out of the port. A lack of training and maritime experience meant that the Port Controller could not have anticipated the seriousness or potential consequences of allowing a situation such as this one to develop.

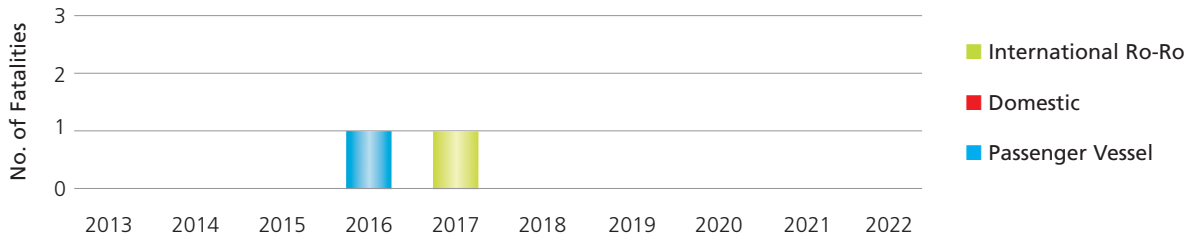
Name of vessel/incident: Frazer Tintern	
DATE OF PUBLICATION	29 December, 2022
TYPE OF CRAFT	Passenger Ferry
DATE OF INCIDENT	05 August, 2021
SUMMARY	<p>At approximately 18.05 hrs on 5 August 2021, when en route to Passage East, Co. Waterford the Master of the vessel Frazer Tintern detected a strong smell of diesel fuel. At that point, a crewmember called him to say that he could also get a strong smell of diesel and was going to investigate. When the crewmember got to the mesh door at the number one (No.1) engine compartment he was met with black smoke and flames. The crewmember notified the Master straight away that they had a fire onboard. The Master immediately shut down the No.1 engine and turned off the engine room fans. Two crewmembers then activated two portable fire extinguishers and rigged fire hoses to provide boundary cooling. The vessel continued to the Passage East slipway to get passengers off as quickly and safely as possible. As a precaution all passengers were summoned to the muster station and issued with lifejackets. On the way to the Passage East slipway the fire was brought under control. On arrival at Passage East all passengers and vehicles were disembarked in a safe manner. The vessel was then secured, and the remaining engines shut down. When the smoke dispersed fully the crew investigated the engine room to confirm the fire had been extinguished.</p>
INJURIES/FATALITIES	None
CAUSE OF INCIDENT	<p>The fire was most likely caused by a return line fuel leak on No.1 main engine providing fuel to the area. The volume and pressure of the fuel was greatly increased by the fuel return line being blocked or shut off. The ambient high temperature and swirling air flow in the vicinity assisted in the atomisation of the fuel. The fuel may have been ignited by arcing of the No.1 main engine alternator. It was more likely to have been from fuel spraying onto hot surfaces such as the engine exhaust manifold or turbocharger casing. Shutting down the engine removed the source of fuel from the fire and would have had a far greater effect in extinguishing it than the use of portable extinguishers. Due to the extent of the fire and subsequent damage to No.1 engine the exact location and cause of the fuel leak has been impossible to determine. It is hard to rule out the No. 1 engine fuel leak on the morning of the event having an association with the fire. The repair was carried out by using a hose clip to re-attach the return fuel line rather than a spring clip as used by the manufacturer. If the hose clip was over tightened it may have damaged the hose resulting in failure later in the day. Return fuel lines on this engine would have been new with the engine in 2016.</p> <p>Due to the airflow from No. 1 engine access door, the fire spread onto the car deck in an area open to the public. This also prevented access to the port side fire flaps and fan stops. Although the door has been modified to close on activation of the fire alarm, in this instance the fire would have spread to the public space prior to the door closing. The fuel systems on this vessel include a shut off valve on the return line. If this valve is closed while the engines are in operation this would lead to over pressurisation of the fuel system leading to component failure and considerable fuel leakage at pressure. The operators have stated that prior to the incident they carried out fire drills. There are no records of these being carried out or what was involved in the drills. Post incident, drills are carried out on a weekly basis, with at least one of each drill (Man Overboard/Fire in Accommodation, Car Deck or Engine Room/ Abandon Ship) carried out per month. The operators have also put in place a Domestic SMS to ensure daily checks are carried out and a smooth handover between shifts has been introduced. The Master of the vessel should have notified the Coast Guard of the fire by a VHF Pan-Pan call as soon as it was discovered.</p>

Comparisons of Marine Casualties 2013 - 2022

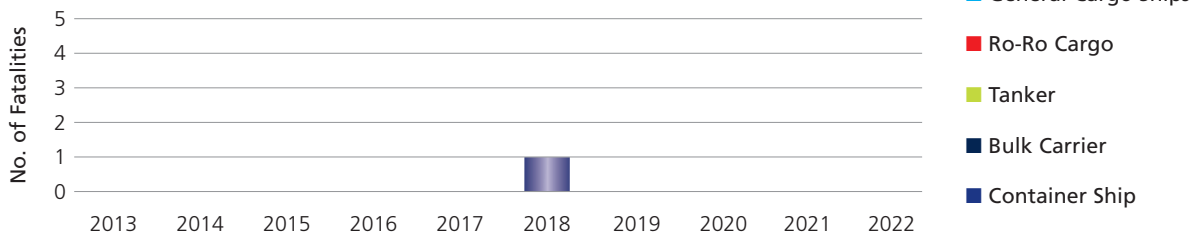
Type of Craft	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Passenger Ships/Vessels										
International Ro-Ro				10 injuries	1 Fatality					
Domestic				2 Injuries						
Passenger Vessel				1 Fatality 1 injury						1 Injury
Sub total	None	None	None	1 Fatality 13 Injuries	1 Fatality	None	None	None	None	1 Injury
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	None	None	1 Fatality	None	None	None	1 Injury
Fishing Vessels										
< 15 metres	2 Fatalities	1 Fatality	1 Fatality	2 Fatalities	2 Fatalities	2 Fatalities	2 Fatalities	3 Fatalities		1 Injury
15 - 24 metres	3 Fatalities							1 Fatality 1 Injury	1 Injury	1 Injury
> 24 metres			2 Fatalities	2 Fatalities					1 Injury	2 Injuries
Sub total	5 Fatalities	1 Fatality	3 Fatalities	4 Fatalities	2 Fatalities	2 Fatalities	2 Fatalities	4 Fatalities 1 Injury	2 Injuries	4 Injuries
Recreational Craft										
Jet Skis										
Open Boats/Canoe	1 Fatality	3 Fatalities/ 1 Injury		1 Fatality/ 1 Injury	1 Fatality	1 Fatality	3 Fatalities/ 1 Injury			
Motor (Decked)			2 Fatalities	3 Fatalities		1 Fatality	1 Fatality			
Sail		1 Fatality								
Fast Power Craft/RIB					2 Fatalities	3 Fatalities				
Sub totals	1 Fatality	4 Fatalities/ 1 Injury	2 Fatalities	4 Fatalities/ 1 Injury	3 Fatalities	5 Fatalities	4 Fatalities 1 Injury	None	None	None
Total Incidents	6	7	7	15	5	5	10	8	8	11
Total Fatalities	6	5	5	9	6	8	6	4	0	0
Total Injuries	0	1	0	14	0	0	1	1	2	6
Total No. of Vessels involved	6	7	7	15	5	5	11	8	8	21

Fatality Trends 2013 - 2022

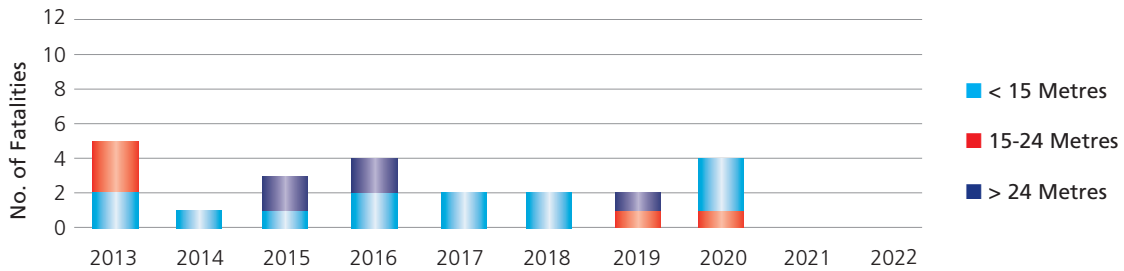
Passenger Ships/Vessels



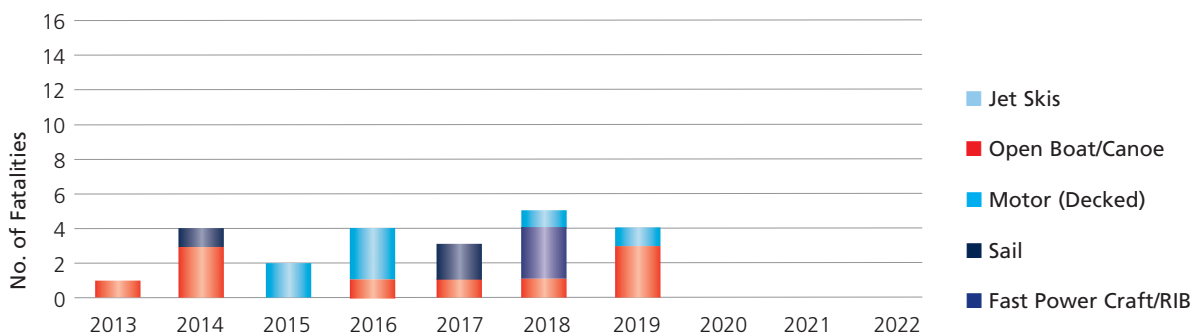
Cargo Ships



Fishing Vessels



Recreational Craft



Appendix A

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

MCIB Ref.	Vessel Name	Date	Incident details
MCIB/13/480	Wilson Hansa	19/01/2022	Engine problem
MCIB/13/481	FV Shauna Leon	20/01/2022	Fouled propeller
MCIB/13/482	FV Sceptre	06/02/2022	Sunken vessel
MCIB/13/483	SV Arruno	09/02/2022	Vessel adrift
MCIB/13/484	FV St. Alour	08/02/2022	Injured crewmember
MCIB/13/485	FV Mariscador	10/03/2022	Injured crewmember
MCIB/13/486	MV Alizee	12/03/2022	Fire onboard
MCIB/13/487	MV WB Yeats	13/03/2022	Vessel damaged
MCIB/13/488	Venture Luck	09/03/2022	Vessel not under command and grounded
MCIB/13/489	FV Le Stiff	20/03/2022	Injured crewmember
MCIB/13/492	FV Albelo Primero	31/03/2022	Injured crewmember
MCIB/13/493	MV Stena Estrid	04/04/2022	Missing passenger
MCIB/13/494	FV Hent Ar Mor	27/03/2022	Injured crewmember
MCIB/13/495	FV Slaatteroy	15/04/2022	Injured crewmember
MCIB/13/496	FV Nuevo San Juan	17/04/2022	Injured crewmember
MCIB/13/497	Malahide Estuary	13/03/2022	Kayakers capsized
MCIB/13/498	RNLI Lifeboat D815	21/04/2022	Injured crewmember
MCIB/13/499	MV Stena Estrid	21/04/2022	Power lost on main engine
MCIB/13/500	Kethi	15/04/2022	Loss of equipment
MCIB/13/501	Carrickcraft cruiser	01/05/2022	Vessel hit rocks and suffered water ingress
MCIB/13/502	FV Virtuous	28/05/2022	Injured crewmember
MCIB/13/503	FV Fertile	30/05/2022	Injured crewmember
MCIB/13/504	FV Piedras	01/06/2022	Sunken vessel
MCIB/13/505	Drum Derrig	14/06/2022	Sunken vessel
MCIB/13/506	Lady Breda	19/06/2022	Unplanned life raft launching
MCIB/13/507	FV Illunbe	26/06/2022	Crewmember overboard
MCIB/13/508	MV Katre	03/07/2022	Vessel aground
MCIB/13/510	Emerald Star Cruiser	28/06/2022	Vessel trapped against the bridge
MCIB/13/511	RIB Mr. B	08/07/2022	Vessel reported to be taking on water

MCIB Ref.	Vessel Name	Date	Incident details
MCIB/13/512	Houseboat Mollie	11/07/2022	Vessel took on water and ran aground
MCIB/13/513	Vessel (no name)	17/07/2022	Boating accident
MCIB/13/514	MV Delphine	17/07/2022	Engine failure
MCIB/13/515	RO-RO Dublin Swift	23/07/2022	Engine room incident
MCIB/13/516	FV Argonaut IV	24/07/2022	Vessel suffered water ingress
MCIB/13/517	Yacht Meridian II	09/07/2022	Engine problem/injured person
MCIB/13/518	MV Yassy	28/06/2022	Gearbox failure
MCIB/13/519	MV Roman Rebel	27/07/2022	Injured crewmember
MCIB/13/520	MV Arklow Spray	07/05/2022	Vessel aground
MCIB/13/521	FV Shauna Leon	04/08/2022	Fouled propeller
MCIB/13/522	Ballybunion Rescue Boat	02/08/2022	Vessel capsized
MCIB/13/523	Jean Spier	02/08/2022	Injured crewmember
MCIB/13/524	FV Carmona	10/08/2022	Injured crewmember
MCIB/13/525	Northern Maria	09/08/2022	Vessel aground
MCIB/13/526	Heulin Dispatch	14/08/2022	Injured crewmember
MCIB/13/527	Speedboat	13/08/2022	Sunken vessel
MCIB/13/528	FV Monica II	15/08/2022	Fire onboard
MCIB/13/529	SV Magoo	12/08/2022	Collision/injured person
MCIB/13/530	FV Clodagh O	21/08/2022	Propped and disabled
MCIB/13/531	FV Spica	01/09/2022	Injured crewmember
MCIB/13/532	Spirit of Adventure	01/09/2022	Injured crewmember
MCIB/13/533	Dinghies in difficulty	19/08/2022	Multiple dinghies in difficulty
MCIB/13/534	SV Polaris and FV Kate D	15/09/2022	Collision at sea
MCIB/13/535	FV Amethyst	17/09/2022	Sunken vessel
MCIB/13/536	Small fishing boat	17/09/2022	Vessel capsized
MCIB/13/537	FV Independence	21/09/2022	Engine failure
MCIB/13/538	MV Mirror	29/09/2022	Engine failure
MCIB/13/539	FV Dever Ar Mor	04/10/2022	Fouled propeller
MCIB/13/540	Arklow Cliff	06/10/2022	Engine failure
MCIB/13/541	FV Ocean Pioneer	12/10/2022	Fouled propeller
MCIB/13/542	CT Rotterdam	19/10/2022	Vessel not under command
MCIB/13/543	Clipper Point	18/10/2022	Injured crewmember

MCIB Ref.	Vessel Name	Date	Incident details
MCIB/13/544	FV Atlantic Drift	21/10/2022	Sunken vessel
MCIB/13/545	Austin Lidbury Lifeboat	29/10/2022	Injured crewmember
MCIB/13/548	FV Dawn Ross	31/10/2022	Injured crewmember
MCIB/13/549	FV Kristel Patrick	20/11/2022	Injured crewmember
MCIB/13/553	FV Danny Finn	02/12/2022	Injured crewmember
MCIB/13/554	FV Grand Saint Bernard	03/12/2022	Injured crewmember
MCIB/13/555	FV Mairi Maree	02/12/2022	Fouled propeller
MCIB/13/556	FV Mac Dara	02/12/2022	Collison with pier
MCIB/13/557	FV Carmona	05/12/2022	Engine failure
MCIB/13/558	MV Ocean Globe	14/12/2022	Injured crewmember
MCIB/13/559	Kayak	29/12/2022	Kayaking incident
MCIB/13/560	FV Gracefulmorn 2	23/12/2022	Injured crewmember
MCIB/13/561	MS Stena Horizon	31/12/2022	Blackout onboard



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