2024

MARINE CASUALTY INVESTIGATION BOARD

REPORT OF
INCIDENTS & INVESTIGATIONS

MCIB
Marine Casualty Investigation Board
Bord Imscrúdú Taismí Muirí

Reporting Period 1st January to 31st December 2024

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

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Chairperson's Statement

Claire Callanan,
Chairperson

Dear Minister,

In accordance with the requirements of Section 21 of the Merchant Shipping (Investigation of Marine Casualties) Act 2000 (as amended), I present the twenty-second Incidents & Investigations report of the Marine Casualty Investigation Board (MCIB), covering the period 1 January – 31 December 2024.

The audited accounts of the MCIB will be presented to you later in the year on completion of the annual audit by the Comptroller & Auditor General, following which, both this report and the MCIB Financial Statement will be combined to create the MCIB Annual Report 2024, for publication on the MCIB website www.mcib.ie.

Overview of 2024

The MCIB commenced investigations into four marine casualties in 2024, one of which was a fatal incident. In fatal cases the MCIB works with An Garda Síochána and I want to thank all the Gardaí who have assisted MCIB investigations in particular in the last year. Each fatality is a tragedy for family and friends and the community in which each person lived. The MCIB extends its condolences to all those affected by these deaths.

A further 67 incidents were considered by the Board which involved co-operation between the MCIB and the accident investigation bodies of other states. These incidents were in general considered to be minor in nature and not warranting investigation by either the flag state or the MCIB, or were incidents where investigations were being conducted by the flag state. Some cases required the uploading of data by Ireland onto the European Maritime Casualty Investigation Platform (EMCIP)[1].

During 2024 the MCIB also assessed 27 further incidents to determine whether an investigation should be carried out, and in these cases determined that they were either minor and/or that no useful safety recommendations were likely to be forthcoming from an investigation.

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

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

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

Included in the MCIB investigation reports published in 2024, is a report (MCIB Report No.325) into the investigation of a scheduled training session on the river Corrib for two competitive rowing boats which resulted in a marine casualty event that caused the loss of the two rowing boats and posed a threat of death or serious injury to persons who had been operating recreational vessels in Irish waters. Since this casualty event, many changes had been enacted in the operation of rowing activities in the boat club. The MCIB made safety recommendations addressed to the University of Galway Boat Club, Rowing Ireland and Sport Ireland, all rowing clubs operating on the River Corrib, Water Safety Ireland, and the Minister for Transport.

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

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

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

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

Legislative Changes

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

European Context and EMSA

In 2024 MCIB continued its involvement with the European Maritime Safety Agency (EMSA) in respect of maritime incidents that fall within the ambit of the European Union (EU) Directive 2009/18/EC (which establishes the fundamental principles governing the investigation of accidents in the maritime transport sector). EMSA is the EU agency that is tasked with providing technical expertise and operational assistance to improve maritime safety, pollution preparedness and response and maritime security throughout the EU.

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

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

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

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

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

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

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

The Department published 65 Marine Notices in 2024

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

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

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

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

29 of 2024 REMINDER - Safe Manning Document Fishing Vessels.

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

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

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

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

External Investigations of Casualties

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

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

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

Reports Published in 2024

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

Investigations commenced in 2024

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

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

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

Fishing Vessels

There were two incidents involving fishing vessels.

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

Passenger Vessel

There was one incident involving a passenger craft.

- Sunken vessel, Skellig Islands, Co. Kerry.

Recreational Craft

There was one incident involving a recreational craft.

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

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

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

Ethics in Public Office

During 2024, all Board members were in compliance with the applicable provisions and requirements of the Ethics Acts and the Standards in Public Office Act, 2001.

Acknowledgements

I want to thank my Board colleagues who have again given hugely of their time and very considerable expertise during this last year to the MCIB. I would also like to thank the diligent contribution and expertise of our investigators and our very dedicated Secretariat, and Board Secretary for all of the year's contribution.

Finally, I wish to record my appreciation for the assistance that you as Minister, and that of your officials in the Maritime Safety Policy Division, have afforded to the Board during 2024.

CLAIRE CALLANAN
CHAIRPERSON

Board Members and General Information

Ms. Claire Callanan,
Chairperson, Solicitor

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

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

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

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

Mr. Phil Murphy,
Class I Master Mariner

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

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The following is some general information regarding the MCIB.

Establishment of the Board

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

Function of the Board

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

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

(a) death or serious injury to a person;

(b) the loss of a person overboard;

(c) significant loss or stranding of, damage to, or collision with, a vessel or property; or

(d) significant damage to the environment,

in connection with the operation of:

(i) a vessel in Irish waters;

(ii) an Irish registered vessel, in waters anywhere; or

(iii) a vessel normally located or moored in Irish waters and under the control of a resident of the State, in international waters contiguous to Irish waters.

The purpose of each investigation is to:

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

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

Status

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

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

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

Incidents and Investigations 2024

MCIB
Marine Casualty Investigation Board
Bord Imscrúdú Taismí Muirí

Reporting Period 1st January to 31st December 2024

Introduction

Since establishment in 2002, and up to the end of 2024, the Board has published reports on 274 cases.

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

All reports are published on the Board's website, www.mcib.ie, and are available on application to the Secretariat.

Summary of Incidents Investigated which Occurred During 2024

1st January to 31st December 2024

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

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

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

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

Summary of Reports Published 2024

1st January to 31st December 2024

The following tables are summarised from published reports and are intended to give an overview. Full reports can be viewed on the MCIB website www.mcib.ie

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

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

Name of vessel/incident: **Sailing Vessel Inish Ceinn**	
DATE OF PUBLICATION	26 March, 2024
TYPE OF CRAFT	Recreational Craft
DATE OF INCIDENT	6 June, 2023
SUMMARY	The sailing yacht Inish Ceinn departed from Baltimore, Co. Cork on 6 June 2023 at 14.00 hrs, for a short voyage to Cape Clear Island. The Skipper was a well-qualified and experienced yacht master and diver. There were three other experienced persons onboard and one guest. The weather was moderate from the east and the yacht was taken out of Baltimore Harbour and then headed west on the planned course towards Cape Clear Island. The planned course was around 0.5 miles from the southern shore of Sherkin Island. At around 14.30 hrs the Skipper felt the yacht slow down rapidly and turn into the wind. Nothing could be seen in the water, so the engine was started, and propeller engaged. Vibration was felt and a burning smell was noticed. The engine was shut down and the yacht was immobilised. The wind and swell quickly pushed the yacht towards the rocks and the yacht went aground. Four of the persons onboard were able to get onto the rocks and the Skipper sent a MAYDAY message on the VHF radio. He also got onto the rocks. At this stage the Skipper noticed the hull was fouled with a large trawl net. Baltimore Lifeboat came to the rescue and the rescue helicopter R115 also attended the scene. All five persons were evacuated from the rocks by the lifeboat and taken back to Baltimore. The yacht broke up and was lost. There were no serious injuries and no pollution
INJURIES/FATALITIES	None
CAUSE OF INCIDENT	This casualty was caused by a floating trawl net that became entangled on the bottom of the yacht. This was a large net, and it completely immobilised the vessel. The wind and waves pushed the vessel quickly towards the rocks and there was very little that could be done to gain control. The experience and calm response of the Skipper ensured all five persons onboard were safely landed on the rocks in a very difficult situation and prevented a far more serious situation developing with potential loss of life. The vessel broke up due to the continuous hammering against the rocks. The discarded trawl net was the root cause of this casualty. Had this fishing gear been properly discharged ashore or had it been reported and recovered if accidentally lost, this incident could have been prevented. The source of the net cannot be established as it had no tags and there is no record of it having been reported to any Irish authority.

Name of vessel/incident: **Rowing Vessels River Corrib**	
DATE OF PUBLICATION	17 April, 2024
TYPE OF CRAFT	Rowing Vessels
DATE OF INCIDENT	14 January, 2023
SUMMARY	On the 14 January 2023, a scheduled training session on a river for two competitive rowing boats resulted in a marine casualty event that caused the loss of the two rowing boats and posed a threat of death or serious injury to persons who had been operating recreational vessels in Irish waters. A complex system and an issue of risk normalisation – in which risky behaviour gradually becoming acceptable over time – had developed around rowing activities in the vicinity of the river's Salmon Weir, especially during the river's high flow rates and low water temperatures during winter months. As a result, what may have initially appeared to be an innocuous meeting on the river of the rowing boats from two clubs – one setting out upriver and the other returning downriver – set in motion a final sequence of events that resulted in the loss of two rowing boats and posed a threat of death or serious injury to the crews of these two boats
INJURIES/FATALITIES	None
CAUSE OF INCIDENT	A complex system had developed around rowing activities on the River Corrib, with safety contingent on an interplay between the disperse factors. An issue of risk normalisation had developed around rowing activities in the vicinity of the weir, especially during the river's high flow rates and low water temperatures during winter months. The omission of PFDs had the potential to have been a causal factor in this marine casualty event. The University of Galway Boat Club had three club members afloat who were not wearing the PFD required of them by the relevant legislation. None of the eight rowers in the two rowing boats were wearing a PFD, nor were they required by the relevant legislation to do so because of the exemption pertaining to rowers in this type of competitive rowing boat.

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

Name of vessel/incident: **Lacken Pier**	
DATE OF PUBLICATION	3 July, 2024
TYPE OF CRAFT	Recreational Craft
DATE OF INCIDENT	16 July, 2023
SUMMARY	On the morning of the 16 July 2023 at around 10.20 hrs, a recreational boat was launched from Lacken Pier, Beltra Co. Mayo to facilitate a day of sea angling for two people. The boat was launched from a trailer towed by a tractor. The Casualty (the owner of the boat) was driving the tractor, and the Survivor was in the boat which was on the trailer. After launching, the Survivor made an unsuccessful effort to hold the boat alongside the pier while the Casualty parked the launch tractor and trailer. When the tractor and trailer were parked, the Casualty attempted to board the drifting boat and entered the water at the East Pier steps. He got into difficulty and was swept out to sea. The boat with the Survivor onboard drifted out to sea. Emergency services were alerted to the incident by a member of the public (MOP) and Killala CGU and Sligo rescue helicopter R118 were mobilised. The drifting boat came ashore at Lacken Strand with the Survivor still onboard. Shortly after, the Casualty was recovered from the water by R118 and transferred to Sligo University Hospital where he was pronounced dead. The Survivor was recovered by R118 from the beach at Lacken Strand and transferred to Sligo University Hospital for treatment, and subsequently released and returned to Germany where he resided.
INJURIES/FATALITIES	1 Fatality
CAUSE OF INCIDENT	This incident resulted in a fatality, which was likely caused by drowning. The Casualty got into difficulty after he entered the water whilst attempting to wade and/or swim to the boat, which was drifting out to sea. The failure to secure a line or painter to the shore, as well as lowering and having the engine ready for use during the boat launching procedure was the immediate causal factor in this incident. Had the Casualty been wearing a PFD/lifejacket his chances of survival would have been greatly improved. Had the Survivor been wearing a PFD/lifejacket, a) the Casualty may have assessed the risk to his companion differently and may not have felt the need to enter the water, and b) the Survivor might have exited the boat before it was out of his control and/or before it got too far from the pier while still in water he could wade in. Had the boat been equipped with a foghorn or distress flares, the Survivor may have been able to alert the Casualty at an earlier stage to the fact that he was drifting with no control over the boat. He might also have been able to alert a MOP, which might have resulted in either an earlier call to the emergency services or one that alerted the latter to there being someone in the water. The Survivor also had no mobile phone although he may not have been aware how to call the emergency services. The lack of communications facilities was a contributing factor. The presence of signage requiring wearing of lifejackets by persons on the pier may have prompted the Casualty and Survivor to don the lifejackets that were available to them. While the boat was adequately prepared for sea angling in Killala Bay, there was a lapse in detailed planning for the launch and especially concerning actions in emergencies and the prevailing conditions. The Survivor's inability to assist in boat operations was due to a deficiency in knowledge, training, experience, and a lack of pre-departure briefing on engine controls and operation. Inadequate planning was the root cause of this incident.

Name of vessel/incident: **FV Séimi**	
DATE OF PUBLICATION	22 August, 2024
TYPE OF CRAFT	Fishing Vessel 14.9 m
DATE OF INCIDENT	4 February, 2023
SUMMARY	On the evening of 4 February 2023 at approximately 20.00 hrs, the FV Séimi was shooting a string of crab pots approximately 60 NM north northwest of Arranmore Island off the northwest coast of Ireland. The operation of shooting the pots required one crewmember to be on deck ensuring the pots ran freely off the deck while another crewmember manoeuvred the vessel. The size and construction of the vessel allowed the crewmember in the wheelhouse to communicate verbally with the crewmember on deck. In addition, the crewmember in the wheelhouse was able to visually monitor the deck via a camera on deck and a monitor in the wheelhouse. On this occasion a third crewmember was sitting at the entrance to the wheelhouse. As the last pot was leaving the deck, the crewmember on deck became entangled in the rope connected to the pot and was dragged over the side and into the water. The vessel was stopped immediately, and an attempt was made to retrieve the MOB. This proved unsuccessful and contact was lost with the MOB. By this time the alarm had been raised onboard and the remaining two crew assisted in searching for the MOB. He was not wearing a PFD. The MOB was sighted a short distance from the vessel and was successfully recovered onboard. The crew estimate that the Casualty was in the water for no longer than 15 minutes. Cardiopulmonary Resuscitation (CPR) was administered and advice was received via satellite phone from MEDICO Cork, the 24-hour Emergency Telemedical Support Unit, via Malin Head Coast Guard. Despite the crew's efforts the Casualty did not survive.
INJURIES/FATALITIES	1 Fatality
CAUSE OF INCIDENT	The owner or master of any Irish registered fishing vessel has an obligation to ensure that there are sufficient qualified crew onboard, having regard to the type and duration of the voyage undertaken. This obligation was not observed by the Owner of FV Séimi. The Owner was unaware of which, if any, members of the crew held fishing or maritime qualifications and could not produce documentation to support qualifications or training for a single member of his current or former crew. Ensuring qualified crew were onboard was left to the Skipper who was only able to produce a Bord Iascaigh Mhara (BIM) safety training card for himself and one other crewmember. The Code of Practice (CoP) is very clear that the safe manning of the vessel is the owner's responsibility. The validity of a Declaration of Compliance (DoC) issued under the CoP is dependent upon the vessel being maintained, equipped and operated in accordance with the Code, and the Declaration. It is the owner's responsibility to ensure this. As only one of the BIM card numbers listed on the DoC was onboard the vessel at the time of the incident and three of the five crew held no BIM card, the vessel did not continue to comply with the requirements of the Code with respect to manning, training and certification. It is imperative that the owners, masters/skippers and employers of under 15 m fishing vessels take safety onboard seriously and operate their vessels in a professional manner. In this case, the absence of sufficiently qualified crew and the vessel's failure to comply with the CoP, coupled with the lack of drills, formal training, risk assessment, records and safety standards all indicate that the safety culture onboard FV Séimi was below the standards that should be expected onboard a commercially operated fishing vessel.

Name of vessel/incident: **Bruckless Pier**	
DATE OF PUBLICATION	22 August, 2024
TYPE OF CRAFT	Recreational Craft
DATE OF INCIDENT	28 September, 2023
SUMMARY	The owner of a recreational motor boat was alone aboard his vessel when he fell overboard and subsequently drowned. This occurred between 15.30 hrs and 16.30 hrs on Thursday, 28 September 2023. The vessel was at its mooring approximately 50 m from the shore, in a rural area near Bruckless Pier, Co. Donegal. The weather conditions were poor, with winds of force 6 and gusts of up to 35 kts. A Small Craft Warning was in effect. The vessel was an older model of a recreational motor boat. The vessel had no means of unaided reboarding, either accessible to, or deployable by, a person in the water. The Casualty was not wearing a PFD, he had no means of contacting the emergency services, and he had not left notice of his intentions with a shore contact.
INJURIES/FATALITIES	1 Fatality
CAUSE OF INCIDENT	The Casualty was operating alone in a recreational motor boat, in challenging weather conditions, when he fell overboard into cold water and drowned. He was not wearing a PFD, he had no means of contacting the emergency services, and he had not left notice of his intentions with a shore contact. The Casualty's situation was noticed by the owner of another recreational motor boat who had arrived on the shore and went afloat specifically to ascertain the situation. The Casualty's vessel had not been retrofitted with a means of unaided reboarding, either accessible to, or deployable by, a person in the water. The age of the Casualty's vessel meant that it predated the introduction of modern design requirements to both minimise the risk of falling overboard and to facilitate reboarding. There was no requirement for the Casualty, or the owner of any recreational vessel, to retrospectively assess their vessel against design standards introduced after the vessel's construction simply because new standards came into effect. The MCIB's analysis of the available information indicates that the Casualty's overboard situation is likely to have occurred in the course of his actions on the boat prior to untying the vessel's bowline from its mooring buoy. The circumstances of this incident mean that it has not been possible to determine exactly how the Casualty fell overboard and whether the Casualty's spinal cord stimulator medical device may have been a causal or contributory factor. This marine casualty occurred because of a combination of the following causal and contributory factors: 1. A fall overboard into cold water. 2. Operating alone, in challenging weather conditions. 3. Lack of formal training and planning of the voyage. 4. Inadequate safety and emergency equipment, being the omission of: a PFD; a means of raising the alarm, either in-person by VHF, PLB or mobile phone in waterproof pouch or via a shore contact; and a means of unaided reboarding of the vessel from the water.

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

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

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

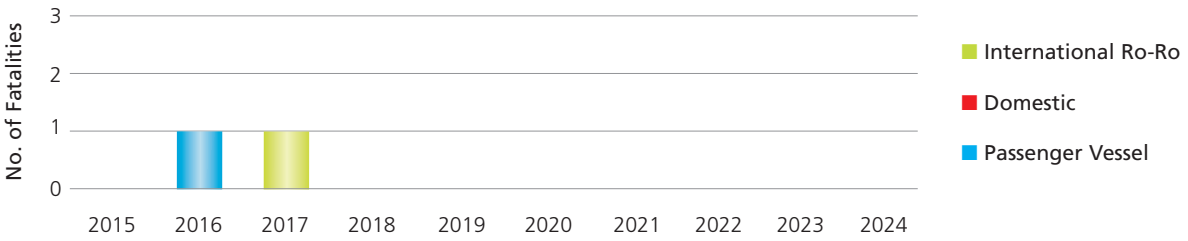
Comparisons of Marine Casualties 2015 - 2024

Type of Craft	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Passenger Ships/Vessels										
International Ro-Ro		10 Injuries	1 Fatality							
Domestic		2 Injuries								
Passenger Vessel		1 Fatality 1 Injury						1 Injury		
Sub total	**None**	**1 Fatality 13 Injuries**	**1 Fatality**	**None**	**None**	**None**	**None**	**1 Injury**	**None**	**None**
Cargo Ships										
General Cargo Ships								1 Injury		
Ro-Ro Cargo										
Tanker										
Bulk Carrier										
Container Ship				1 Fatality						
Car Carrier										
Work Boat Pilot/Barge										
Heavy Lift										
Sub total	**None**	**None**	**None**	**1 Fatality**	**None**	**None**	**None**	**1 Injury**	**None**	**None**
Fishing Vessels										
< 15 metres	1 Fatality	2 Fatalities	2 Fatalities	2 Fatalities	2 Fatalities	3 Fatalities 2 Injuries		1 Injury	2 Fatalities	
15 - 24 metres						1 Fatality	1 Injury	1 Injury	1 Fatality	
> 24 metres	2 Fatalities	2 Fatalities					1 Injury	2 Injuries		
Sub total	**3 Fatalities**	**4 Fatalities**	**2 Fatalities**	**2 Fatalities**	**2 Fatalities**	**4 Fatalities 2 Injuries**	**2 Injuries**	**4 Injuries**	**3 Fatalities**	**None**
Recreational Craft										
Jet Skis									1 Fatality	
Open Boats/Canoe		1 Fatality 1 Injury	1 Fatality	1 Fatality	3 Fatalities 1 Injury				3 Fatalities	
Motor (Decked)	2 Fatalities	3 Fatalities		1 Fatality	1 Fatality				1 Fatality	1 Fatality
Sail										
Fast Power Craft/RIB			2 Fatalities	3 Fatalities						
Sub totals	**2 Fatalities**	**4 Fatalities 1 Injury**	**3 Fatalities**	**5 Fatalities**	**4 Fatalities 1 Injury**	**None**	**None**	**None**	**5 Fatalities**	**1 Fatality**

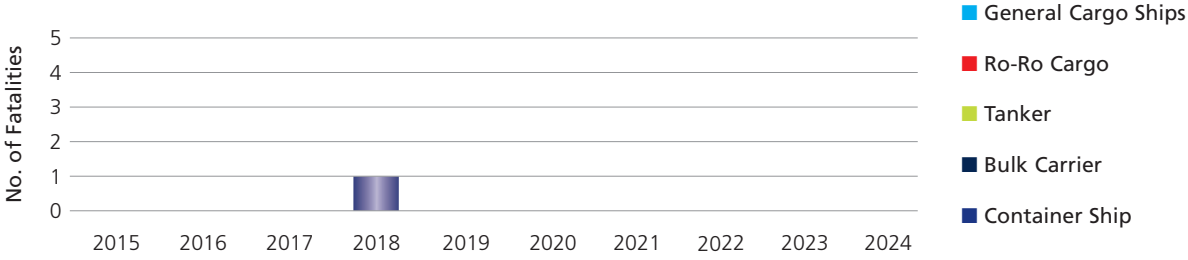
Total Incidents	**7**	**15**	**5**	**5**	**10**	**8**	**8**	**11**	**10**	**4**
Total Fatalities	**5**	**9**	**6**	**8**	**6**	**4**	**0**	**0**	**8**	**1**
Total Injuries	**0**	**14**	**0**	**0**	**1**	**1**	**2**	**6**	**0**	**0**
Total No. of Vessels involved	**7**	**15**	**5**	**5**	**11**	**8**	**8**	**21**	**11**	**4**

Fatality Trends 2015 - 2024

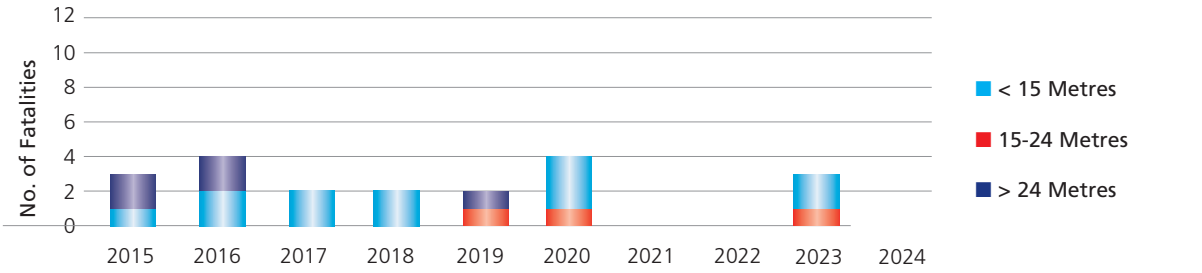
Passenger Ships/Vessels



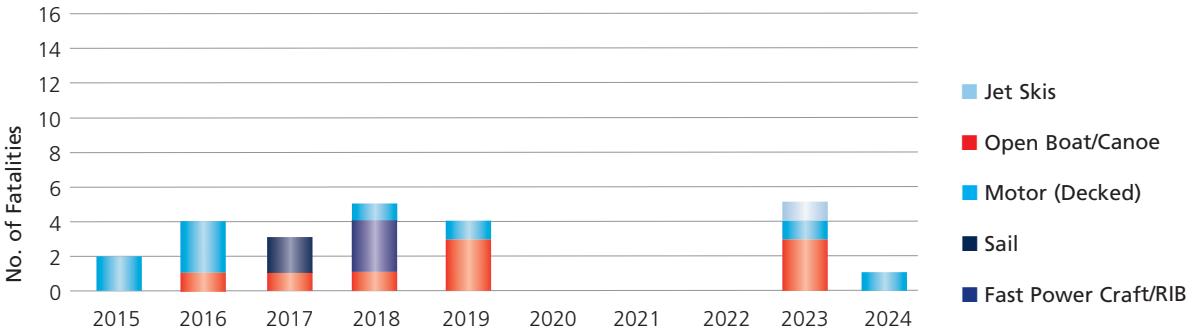
Cargo Ships



Fishing Vessels



Recreational Craft



Appendix A

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

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

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

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

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