MCIB
Marine Casualty Investigation Board

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www.mcib.ie

REPORT OF THE INVESTIGATION INTO THE LOSS OF A PERSON OVERBOARD FROM THE PASSENGER VESSEL "KU-EE-TU" ON LOUGH DERG NORTH OF BALLINA CO. TIPPERARY ON 9TH JULY 2005.

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

REPORT No. MCIB/113

Report MCIB/113 published by The Marine Casualty Investigation Board
2nd May 2008

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1. SYNOPSIS

1.1 On 9th July 2005 at approximately 17.00 hours, the Class V Passenger Vessel, "Ku-Ee-Tu" departed from Dromineer, Co. Tipperary carrying 36 passengers and 3 crew and proceeded out onto Lough Derg. At some time between 18.30 hours and 18.45 hours whilst in the vicinity of Ryneduff Point Co. Tipperary, Mr. Thomas Dalton fell overboard from the vessel. Despite efforts by those onboard the vessel to assist Mr. Dalton, he was seen to sink from view shortly after. The body of Mr. Dalton was recovered from the Lough in the same vicinity on 15th July 2005.

2. FACTUAL INFORMATION

2.1 **History.**

The "Ku-Ee-Tu" was built in 1968 and was originally carried onboard the United Kingdom passenger ship "Queen Elizabeth 2" as a tender for ferrying passengers from the ship to shore. She was subsequently sold and put to use as a passenger ship Class V and Class VI in Scotland. In 1990 the vessel was purchased by Shannon Sailing Limited and brought to Ireland where, following satisfactory completion of survey procedures, a Class V passenger certificate was issued for the vessel to operate on the Shannon navigation including all lakes above Killaloe Bridge. The vessel was surveyed by the Department of Marine's surveyors on an annual basis since for the purpose of renewing its Passenger Certificate.

Owner at the time of the incident	Shannon Sailing Limited. Callista, Dromineer Nenagh Co. Tipperary.
Number of Passengers allowed –	Maximum 53
Number of Crew –	Two (minimum)
Construction -	Glass Reinforced Plastic (GRP)
General Arrangement –	See Appendix (Original arrangement)
Length -	12.19 metres

Propulsion - Single screw – inboard diesel engine- Ford Lehman

2.2 **Lifesaving Equipment- Applicable Legislation – Merchant Shipping (Life-Saving Appliances) Rules, 1983. S.I. 302 of 1983 as amended.**

3 Buoyant Apparatus capable of supporting 48 persons.
8 Lifebuoys
61 Adult Lifejackets
6 Child Lifejackets
2 Smoke Flares

2.3 **Firefighting Equipment**

1 Fire Pump
1 Fire hose & nozzle
3 Fire Extinguishers
1 Fire Bucket
Sand box & scoop

2.4 **Other Equipment**

1 Sound Signal
1 Compass
1 Anchor & Cable
1 Public Address System
1 VHF Radio.
1 Painter
1 Heaving Line
Navigation Lights
2 Bilge Pumps
1 Bailer
1 Boat hook
1 Bucket

3. EVENTS PRIOR TO THE INCIDENT

3.1 The operators of the "Ku-Ee-Tu" accepted a booking for the 9th July 2005 for the carriage of a group of between 25 and 30 passengers on an evening lake cruise. The cruise was planned to commence from Dromineer at approximately 17.00 hours and to conclude in Garrykennedy at 19.30 hours, where the group were to disembark the vessel to enjoy an evening meal ashore.

3.2 Passengers arrived at the vessel at approximately 16.45 hours on 9th July 2005. A total of 36 passengers and 3 crewmembers were onboard when she departed from Dromineer. Weather at the time was fine with very light wind, near clear skies and virtually calm lake conditions. The passengers were in good spirits, enjoying their excursion. A bar and entertainment were provided onboard. Passengers were both seated and standing throughout the vessel and were able to walk around as they wished. Some passengers stayed in the midship area close to the manoeuvring position, occupied by the Master, Mr. Knight. The sides of the vessel in this area were open, being the embarkation / disembarkation points. These openings were fitted with chain guards, which were attached to brackets secured to the cabin structure. During the cruise some passengers were sitting next to the chain guard on the starboard side. At some time during the cruise Mr. Dalton decided to sit on the chain guard on the edge of the vessel. Mr. Knight did not see Mr. Dalton sitting on the chain. Passengers gathered in the area may have obstructed his view.

3.3 At approximately 18.30 hours the "Ku-Ee-Tu" passed another vessel, the "Marianne" on a reciprocal course on the starboard side. The owner of the "Marianne" could see a person sitting on a chain towards the middle of the "Ku-Ee-Tu" with his back to the "Marianne" and he observed this person adopting a swinging motion like he was sitting on a swinging chair. The owner of the "Marianne" could also see that the person sitting on the chain was surrounded by other people on the inboard side.

4. THE INCIDENT

4.1 At some time between 18.30 hours and 18.45 hours, whilst cruising at approximately 6 knots in the vicinity of Ryneduff Point, Mr. Dalton fell from the vessel. People in the vicinity recall seeing him falling backwards into the water. Mr. Knight, on glancing to his right, saw the feet, hands and top of the head of a male passenger disappearing over the starboard side.

4.2 Mr. Knight kept visual contact of the man until he was just clear of the stern and then put the engine into full astern with the rudder amidships. The boat stopped very quickly and the stern went to starboard. Mr. Dalton was then on the port side on the stern quarter approximately 20 feet away. People in the boat were shouting. Mr. Knight stepped out onto the cabin top and threw a lifebuoy to Mr. Dalton, which, landed approximately 1.5 – 2 metres away from him but Mr. Dalton did not react. At this stage he had been in the water for less than a minute. Mr. James McCarthy, the barman, went to the stern and threw a lifejacket towards Mr. Dalton, which landed within his grasp but he made no attempt to reach it. Mr. Dalton was then seen to slowly sink below the surface of the water. Some of the people on the boat wanted to jump in to the water but the crew and some of the passengers restrained everyone from doing so. Another vessel in the vicinity became aware of the situation and raised an alarm. Mr. Knight meanwhile donned a lifejacket and entered the water to search for Mr. Dalton but couldn't find him. On returning to the vessel Mr. Knight had to be assisted back onboard. The anchor was let go and another lifebuoy was tied to the anchor rope to mark the position.

4.3 The "Ku-Ee-Tu" then waited for assistance to arrive. Upon the arrival of a rescue helicopter from Shannon, the "Ku-Ee-Tu" proceeded to Killaloe. On arrival there the Gardai and a local priest met the vessel. Passengers then disembarked.

5. EVENTS FOLLOWING THE INCIDENT

5.1 A search operation was launched by the Irish Coast Guard, the local Lifeboat and other vessels in the vicinity to locate Mr. Dalton. The Garda Underwater Unit and a number of volunteer diving units conducted searches of the bottom of the lake.

5.2 An MCIB investigation was duly initiated.

5.3 On the 15th July 2005, a body, subsequently identified as being that of Mr. Dalton, was located in the vicinity and recovered from the water.

5.4 An autopsy report recorded the death of Mr. Dalton as death due to drowning.

6. FINDINGS

6.1 The "Ku-Ee-Tu" was inspected at Killaloe on the 10th July 2005. The results of this inspection are: -

(1) The guard chain arrangement at the embarkation position amidships on the starboard side had broken. One of the brackets, with the chain clipped to it, was detached from the cabin side and hanging off, being held on by the forward fixing bracket only. (See Photos in Appendices 9.2,9.3 & 9.4)

(2) The bracket had been secured with four screws. These screws passed through the g.r.p. cabin structure and then through a backing plate on the inboard side and were secured with nuts on the inner face of this backing plate. (See photo in Appendix 9.5). These screws had all broken just below the "head" under the load of Mr. Dalton as he sat on the chain. The screws were not recovered by the MCIB.

(3) The chain was fitted with a plastic protective hose over much of its length.

(4) There was a step underneath the chain at the side of the vessel to assist passengers embarking and disembarking. Mr. Knight stated that passengers were not supposed to sit on the chain or on this step and he would tell anybody he saw doing this to move to the proper seats. The general arrangement of the vessel (see Appendix 9.11) appears to show that the steps below the embarkation area were originally utilised as seats in the vessels previous role as a tender.

(5) Mr. Knight maintains that he had, on occasions, stopped the vessel during previous cruises of this type to insist that passengers did not hang out of the sides of the vessel or if he considered that activities onboard had become too boisterous.

(6) The vessel did not have a Passenger Ship Certificate on display as required by Section 10 (1) of the Merchant Shipping Act, 1992. The vessel had undergone a survey for renewal of its Passenger Ship Certificate, which was completed on 20th August 2004. At this time the Marine Surveyor's Office issued a "Notice of Clearance to Operate" to the owner, which was valid for 30 days (See Appendix 9.9). A "Declaration of Survey" was prepared and sent to the owner on the 24th August 2004 in compliance with Section 7 of the above Act (See Appendix 9.10). The owner mistook the declaration that he received for a Passenger Certificate and subsequently displayed it on the vessel. The same occured after the previous survey in 2003. As the owner did not sign and return the Declaration to the Marine Surveyor's Office on these two occasions, a Passenger Ship Certificate was not issued to the vessel.

(7) Equipment onboard was in compliance with the details stated on the declaration of survey although one of the smoke flares had passed its expiry date in May 2005.

(8) The vessel had a valid Passenger Liability Insurance Certificate displayed onboard.

(9) The owner had provided lifejackets (61 Adult & 6 Child) onboard at the survey in August 2004. The carriage of lifejackets on this type of vessel is not a statutory requirement of the Merchant Shipping (Life-Saving Appliances) Rules, 1983, but the owner had agreed to provide them following a request by the Marine Surveyor's Office in line with a policy of improving safety on “non subdivided” domestic vessels, which was adopted at that time.

(10) None of the passengers who were interviewed could recall hearing any safety instructions on boarding the vessel. Some of the passengers recalled seeing the lifejackets onboard. One of the crewmembers recalled hearing the Master give a safety announcement at the start of the cruise.

(11) Entertainment onboard consisted of a musician and a bar selling alcoholic and non-alcoholic drinks. The atmosphere onboard prior to the incident was good. Mr. Dalton consumed some alcoholic drinks but a number of the passengers were of the view that he had not drunk too much. The autopsy report stated that Mr Dalton’s blood contained 185mg% of alcohol.

7. CONCLUSIONS

7.1 Mr. Dalton fell overboard after the screws securing the chain guard on which he was sitting broke. The purpose of the chain was to act as a guard protecting people from falling out through the opening in the vessel's side at the embarkation position. It was not designed to take the full weight of a person sitting on it, although the presence of the plastic hose covering the chain and the presence of the step underneath did unfortunately make it more "comfortable" to sit on.
A number of passengers were gathered in the area and obscured Mr. Knight's view of where Mr. Dalton was sitting. Mr Knight, would have asked Mr. Dalton to move if he had spotted him sitting on this chain.

7.2 In spite of the efforts of the Master and crew to assist him, Mr. Dalton sank from view very quickly, probably in less than 90 seconds. The fact that Mr. Dalton was a non-swimmer and fell backwards, headfirst, fully clothed into cold water after consuming a quantity of alcohol probably contributed to this

7.3 Although the vessel did not have the required Passenger Ship Certificate on display it had undergone the required Marine survey and had been found to satisfy the conditions for the issuance of the certificate.

7.4 The Merchant Shipping (Emergency Information for Passengers) Rules 1992 require that an announcement be made at the commencement of voyages onboard vessels of Class IV, V & VI containing information regarding actions in case of an emergency, which could lead to the vessel being abandoned. There is no specific requirement for passengers to be informed of issues in relation to their safety onboard during a routine voyage.

8. RECOMMENDATIONS

8.1 Two of the passengers stated to the MCIB investigator that in their view all passengers on this type of vessel should be compelled to wear a lifejacket, so that if they fell overboard, they would stay afloat until rescued. Although a person wearing a properly donned lifejacket will stay afloat with their mouth clear of the surface of the water, the wearing of bulky lifejackets by passengers within a confined vessel is impractical and more importantly potentially dangerous as they may impede the escape of passengers in the event of a fire or other emergency onboard. The purpose of lifejackets onboard passenger vessels is to provide buoyancy to persons in the water in the event of the vessel being abandoned.
Notwithstanding the above, the Department of the Marine Surveyor's Office has introduced a policy that passengers carried aboard **open passenger vessels of Classes V and VI that are not in any way enclosed** should wear lifejackets whilst the vessel is underway.
The “Ku-Ee-Tu” is classified as an “Open” vessel but has closed-in saloon areas onboard. Therefore, for the reasons stated above passengers should not be required to wear lifejackets onboard and no further action is recommended in this regard.

8.2 In ensuring the safety of passengers in relation to “person overboard” incidents, the critical factor is that there should be adequate and effective measures in place, to ensure, as far as practically possible, that passengers cannot accidentally fall overboard. Owners of passenger vessels should be urged to carry out a risk assessment onboard their vessels, taking into account its particular layout and the nature of voyages being undertaken. A voyage where passengers onboard can consume alcohol may present an increased risk of a person falling overboard. Guards and railings onboard should be assessed for strength and design to ensure that persons would find it difficult and uncomfortable to either climb or sit on them. This is especially important for areas not in immediate view of the crew.
Securing brackets and fixing devices, screws, bolts nuts etc should be made of suitable material for use in the marine environment and be of adequate size. Fixing arrangements should be subject to periodic inspections. Protection arrangements for embarkation positions should be given special consideration. The number of these openings should be restricted to the minimum number required to provide for the safe evacuation of the vessel in an emergency. Owners should be advised of the above and should carry out any necessary improvements in consultation with the Department of the Marine Surveyor’s Office.
Since this incident the owners of “Ku-Ee-Tu” have carried out improvements to the vessel in respect of the guards across the embarkation openings.
(See photos in Appendices 9.6, 9.7 & 9.8).

8.3 Owners of domestic passenger vessels should be reminded of the importance of understanding and completing the "Declaration of Survey" at the conclusion of the annual survey, so that the necessary "Passenger Certificate" can be promptly issued and displayed.

8.4 Owners, masters and crews of domestic passenger vessels should be reminded of the importance of providing an effective safety announcement at the start of a voyage, which can be heard by all passengers. This announcement as well as satisfying the requirements of the Merchant Shipping (Emergency Information for Passengers) Regulations 1992 should also contain information and instructions relevant to the safety of the passengers onboard during a routine voyage.

9. LIST OF APPENDICES

9.1 View of embarkation area – starboard side.

9.2 View of vessel from quay on starboard side showing broken guard chain.

9.3 Close-up view of chain bracket location.

9.4 Close up of chain end and bracket.

9.5 View of inside of cabin structure showing backing plates for fixing to glass fibre.

9.6 New gate arrangement installed following incident.

9.7 Close up of the new gate bracket fixings with substantial through bolts fitted after the incident.

9.8 New warning sign placed on steps since incident.

9.9 Notice of Clearance to Operate 20th August 2004

9.10 Declaration of Survey from August 2004.

9.11 General Arrangement of "Ku-Ee-Tu" from 1968.

Appendix 9.1 View of embarkation area – starboard side.

Appendix 9.2 View looking into vessel from quay on starboard side showing broken guard chain.

Appendix 9.3 Close-up view of chain bracket location.

Appendix 9.4 Close up of the chain end and bracket.

Appendix 9.5 View of inside of cabin structure showing backing plates for fixing to glass fibre.

Appendix 9.6 New gate arrangement installed following incident.

Appendix 9.7 Close up of the new gate bracket fixings with substantial through bolts fitted after the incident.

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Appendix 9.8 New warning sign placed on steps since incident.

Appendix 9.9 Notice of Clearance to Operate 20th August 2004.

Department of Communications,
Marine & Natural Resources,
Floor 1,
Government Buildings,
Sullivan's Quay,
Cork.

Tel: 021-4968992
E-mail: dcmnrcork@eircom.net

An Rionn Cumarsáide, Mara
agus Acmhainní Nádurtha,
Urlar a hAon,
Tithe an Rialtais,
Ce O Suilleabháin,
Corcaigh.

Fax: 021-4968617

Ref No.

NOTICE OF CLEARANCE TO OPERATE

Re: "KU-EE-TU"

The above vessel has from the 20th day of August, 2004, been surveyed for the issue of:

A Class VI Passenger vessel certificate for 53 passengers and 2 crew.

A certificate will be issued as soon as possible by the Department of the Marine and the vessel may now go into service immediately.

The validity of this notice of clearance to operate is for a period of 30 days only from the date shown above at which time the passenger certificate, passenger boat licence or safety equipment certificate issued by the Department of the Marine is required to be displayed in a place on board the vessel/boat where it is available for inspection by passengers and authorised inspectors.

If a certificate/licence has not been received within a period of 30 days you should contact the Marine Surveyors Office.

Sean Foran
Engineer & Ship Surveyor

Appendix 9.10 Declaration of Survey from August 2004.

Survey 1 (Motor

DECLARATION
OF
SURVEY OF A PASSENGER MOTOR VESSEL

N.B. – Any person who fraudulently alters, assists in fraudulently altering, or procures to be fraudulently altered, anything contained in this declaration is guilty of a misdemeanour.

VESSEL

Name and Official Number	Single or Twin Screw, and Registered Power (KW)	Port of Registry or Ownership.	Tonnage		Length in Metres (1)
			Gross	Register	12.19
"KU-EE-TU"	Single 120 HP	Dromineer	21.52	20.09	Year built 1968

(2) Whether (a) open boat, (b) Fully decked boat, (c) fitted with a fore deck not less than 2.44 metres and A.W.C.

Name and Address of Owner	Name of Master, and Number of His Certificate (if any).
Shannon Sailing Ltd., Callista, Dromineer, Nenagh, Co. Tipperary.	Mr. T. Knight, Mr. C. Knight Mrs. V. Lynch

LIFE-SAVING APPLIANCES AND EQUIPMENT

- Boats capable of accommodating - persons
- Inflatable liferafts capable of accommodating - persons.

3 Buoyant apparatus capable of supporting 48 persons.
8 Life-buoys.
67 Lifejackets – 6 Child, 61 Adult
2 Buoyant smoke signals – 2 flares
1 Means of making sound signals
Compass. An anchor and cable.
Emergency steering.
P.A. System VHF Radio & Base Station

1 boat hook, painter and heaving line.
1 Fire Pump
1 Fire Hose and 1 Nozzle
3 Fire Extinguishers – (2 x DP, 1 x Foam & 1 x CO2 Forengine Room
1 Fire Buckets.
Fitted with Navigation Lights
Line Throwing Appliance –Type: None
A box containing sand and scoop
2 Bilge Pumps
1 Bailer 1 Bucket

MACHINERY

Engines				Cylinders		
Number	Type	Year when made	By whom made	Number	Diamter ins/mm	Length of Stroke ins/mm
One	I.C C.I Lehman – Ford 2715E	1983	Ford - Lehman	Six	107	115

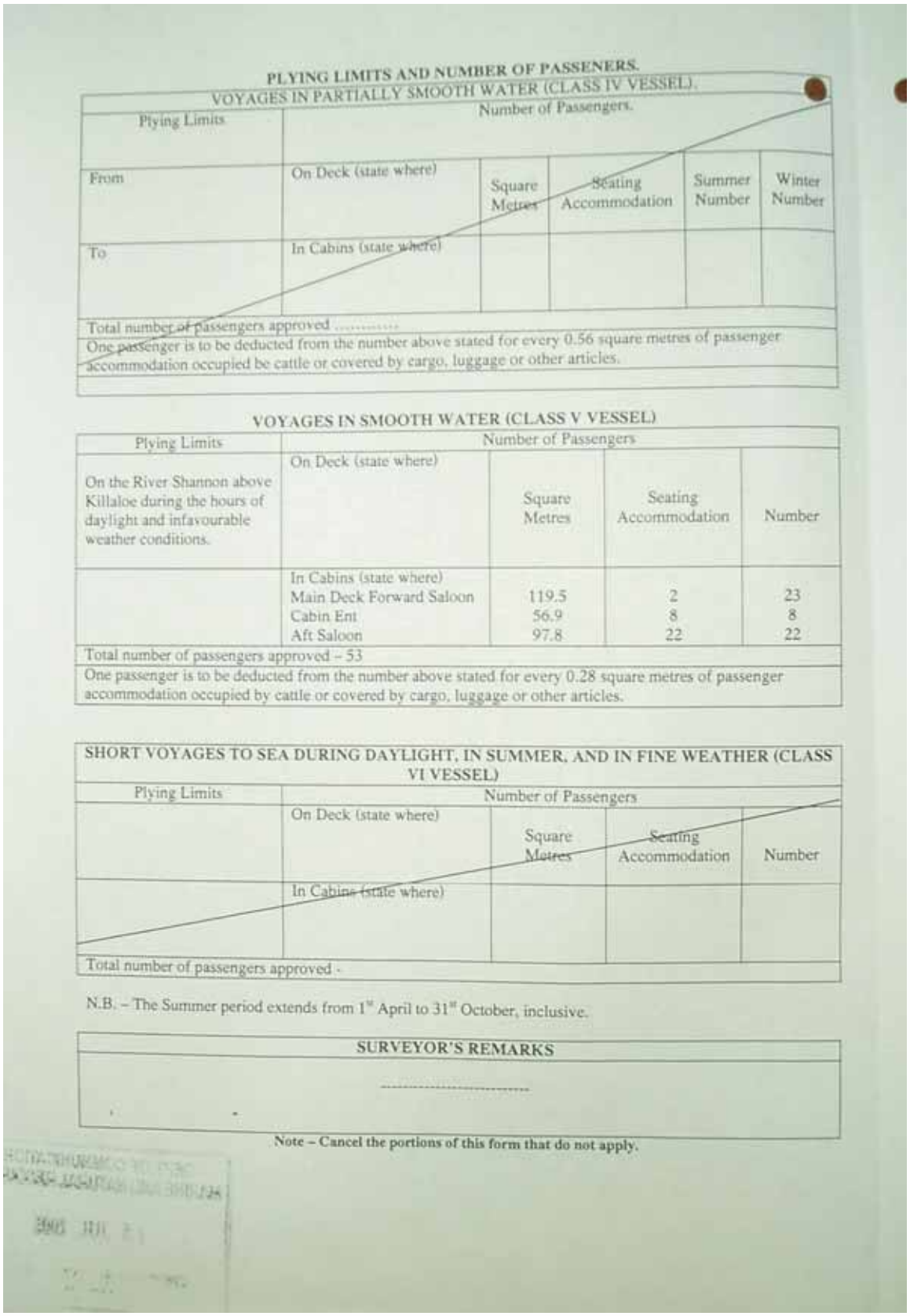
MISCELLANEOUS PARTICULARS

Date of last external examination of the bottom, and remarks (if any) relating thereto.		Clear height of side above water, when loaded.	Height of rails above deck or above flooring in open boats.	Date of inspection of ship's register.	Number of persons composing the crew.
Date	Remarks				
20th August 2004	Satisfactory	3'3"	3'3"	----	Two

NOTE – Cancel the portions of this form that do not apply.
(1) Length (in metres) from fore part of stem at head to aft side of sternpost or tra
(2) Delete the description not applicable.

DEPT. OF COMMUNICATIONS MARINE AND NATURAL RESOURCES
15 JUL 2005
RECEIVED AT M.S.O.

Appendix 9.10(Cont) Declaration of Survey from August 2004.



PLYING LIMITS AND NUMBER OF PASSENERS.

VOYAGES IN PARTIALLY SMOOTH WATER (CLASS IV VESSEL).

Plying Limits	Number of Passengers.				
From	On Deck (state where)	Square Metres	Seating Accommodation	Summer Number	Winter Number
To	In Cabins (state where)				
Total number of passengers approved					
One passenger is to be deducted from the number above stated for every 0.56 square metres of passenger accommodation occupied be cattle or covered by cargo, luggage or other articles.					

VOYAGES IN SMOOTH WATER (CLASS V VESSEL)

Plying Limits	Number of Passengers			
On the River Shannon above Killaloe during the hours of daylight and infavourable weather conditions.	On Deck (state where)	Square Metres	Seating Accommodation	Number
	In Cabins (state where)			
	Main Deck Forward Saloon	119.5	2	23
	Cabin Ent	56.9	8	8
	Aft Saloon	97.8	22	22
Total number of passengers approved – 53				
One passenger is to be deducted from the number above stated for every 0.28 square metres of passenger accommodation occupied by cattle or covered by cargo, luggage or other articles.				

SHORT VOYAGES TO SEA DURING DAYLIGHT, IN SUMMER, AND IN FINE WEATHER (CLASS VI VESSEL)

Plying Limits	Number of Passengers			
	On Deck (state where)	Square Metres	Seating Accommodation	Number
	In Cabins (state where)			
Total number of passengers approved -				

N.B. – The Summer period extends from 1st April to 31st October, inclusive.

SURVEYOR'S REMARKS

Note – Cancel the portions of this form that do not apply.

Appendix 9.10(Cont) Declaration of Survey from August 2004.

DECLARATION TO BE MADE BY THE SURVEYOR

I hereby Declare:-

1. That on the 20th day of August, 2004, I completed the inspection of (a) .....
   (a) If the survey was partial, state what parts were surveyed.
   the motor vessel "KU-EE-TU" Official Number or Port: Dromineer

2. That the hull, machinery and equipments are sufficient for the service intended and in good condition.

3. That the hull, bilge pumping arrangements, electrical installations, main and auxiliary machinery, compasses, anchors, cables, hawsers and warps, means of escape, guard rails, stanchions and bulwarks comply with the Merchant Shipping (Passenger Ship Construction) Rules 1983, as amended, or the Merchant Shipping (Passenger Ship Construction and Survey) Rules 1985, as amended, as applicable.

4. That the life-saving appliances comply with the Merchant Shipping (Life-saving Appliances) Rules 1983.

5. The fire protection arrangements comply with either:-
   5.1 The Merchant Shipping (Passenger Ship Construction) Rules 1983, and either:-
      a) The Merchant Shipping (Fire Appliances) Rules, 1967, as amended: or,
      b) The Merchant Shipping (Fire Appliances) (Post 1980 Ships) Rules, 1983, as amended as applicable: or:-
   5.2 The Merchant Shipping (Fire Protection) Rules, 1985, as amended, as applicable.

6. That the ship is provided with such navigation lights, shapes, and means of making sound, distress and lights signals are as required by the International Collision Regulations, the Rules for Distress Signals and the Merchant Shipping Acts.

7. The navigation equipment complies with the Merchant Shipping (Navigational Equipment) Rules, 1984, as amended, as applicable.

8. That the hull, machinery and equipments will in my judgment be sufficient until (b) 19th August 2005
   (b) Insert date or dates.

9. That the vessel is in my judgement fit to ply within the special limits stated on page 2 of this form.

10. That the vessel is in my judgement fit to carry the number of passengers stated on page 2 of this form under the conditions there indicated provided there is no encumbrance of the space measured for passenger accommodation.

11. (c) That there is a (d) GARDAI appointed by the (e) .....to control the plying of pleasure boats at the place at which this vessel is intended to ply (f).

(c) Only for vessels requiring Class V & VI Certificates and to be filled in only when the Local Authority has agreed to act.
(d) Title of Officer.
(e) Name of Local Authority.
(f) See note at foot of page.

Dated at Cork
On this the 24th day of August, 2004.

.....
Engineer and Ship Surveyor.

IRELAND

Particulars of fees paid.			
Amount	Date Paid	Port	Builder's Name and Number (in the case of new vessels).
€545.00	20th May 2004	Cork	....

NOTE – Cancel the portions of this form that do not apply.

Appendix 9.10(Cont) Declaration of Survey from August 2004.

UNDERTAKING TO BE GIVEN BY THE OWNER OF A VESSEL WHEN A CERTIFICATE IS REQUIRED.

I hereby undertake that, if the Minister for The Marine issues a passenger certificate for my motor vessel "KU-EE-TU".

1. The vessel will be used to carry passengers only when the weather is settled and the sea is calm;
2. The conditions stated on the certificate, and any regulations or instructions of the local authority will be at all times complied with;
3. The vessel will be kept clean and free from oil refuse, and the fire extinguishers will be kept in an efficient condition;
4. No loose can of petrol will, under any circumstances, be carried in the vessel;
5. The Surveyor will be notified if either, or both, of the men in charge are changed.
6. If any damage occurs or any defects become apparent the boat will not be used and a report will be sent to the Chief Surveyor's Office.
7. The boat will not be used for towing any other boat or craft except in cases of emergency.
8. No passenger will be allowed on board or in the immediate vicinity of the vessel during the transfer of fuel oil to the vessel.
9. A log is kept recording all voyages, number of passengers carried, times of departure and arrival, weather conditions etc.
10. I nominate the following person ashore _____ phone _____ to whom reference may be made in any emergency situation for accurate information as to the total number of passengers and crew on board during any voyage.
11. You will ensure that musters of the crew shall take place at intervals of not more than seven days to ensure that the crew understand and are drilled in the duties assigned to them in the event of an emergency.
12. Safety instructions concerning signals, life-saving appliances, means of escape etc. are announced to the passengers before the commencement of each voyage.

I understand that the certificate may be cancelled at any time by the Minister of The Marine if any of these conditions is infringed.

Signature .....
Address .....
Signature of Witness .....Date .....

NOTICE

When this Declaration has been completed by the Surveyor, it is to be given to the Owner, who is required by Section 273 of the Merchant Shipping Act, 1894, to transmit it to the Department of The Marine within *fourteen days* after the date of its receipt. The same Section provides that the Owner shall forfeit a sum not exceeding 50p for every day that the sending of the Declaration is delayed beyond this period of fourteen days.

This Declaration was sent by post Mr. T. Knight, Shannon Sailing Ltd., Callista, Dromineer, Nenagh, Co. Tipperary.
On the 24th day of August, 2004.

.....
Surveyor

This Declaration was received on .....day of .....20....., and is forwarded to the Department of The Marine this .....day of .....20.....

.....
(Owner) (Agent)

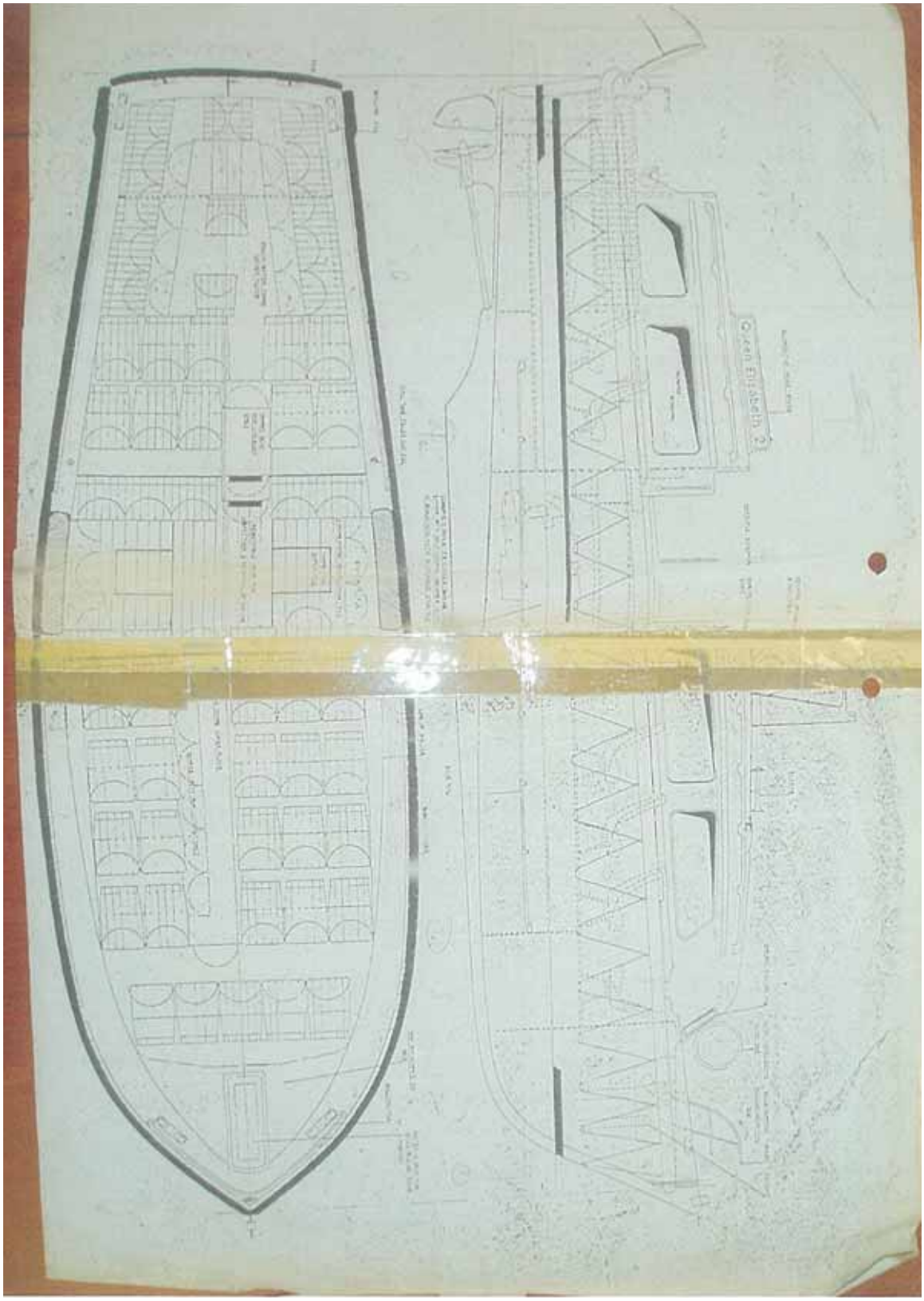
Port or Mercantile Marine Office to which the Certificate Is to be sent ..... } .....

Name and address of the Person to whom the Certificate is To be delivered on application ..... } Shannon Sailing, Callista, Dromineer, Nenagh, Co. Tipperary.

After the Owner or Agent has signed the above receipt for this Declaration, and the Undertaking (where necessary) and has filled in the name of the Port or Mercantile Marine Office to which he wishes the Certificate to be sent, and the name and address of the person to whom the Certificate is to be delivered on application, he should send the Declaration to The Secretary, Department of The Marine, Leeson Lane, Dublin 2.

When this Declaration has been received at the Department of The Marine and is found satisfactory, the Certificate in duplicated will be sent by post to the Mercantile Marine Office named above, at which Office the Owner, Agent, or Master named above for that purpose must apply for is and pay the necessary fee, expenses and forfeiture (if any) charged under Sections 273 and 276 of the Merchant Shipping Act, 1894.

Appendix 9.11 General Arrangement of "Ku-Ee-Tu" from 1968.



10. LIST OF CORRESPONDENCE RECEIVED

An Garda Síochána

Oifig an Choimisinéara,
An Garda Síochána,
Páirc an Fhionnuisce,
Baile Átha Cliath 8,
Éire.

Tel/Teileafón: (01) 666 0000 / 2026
Fax/Facs: (01) 666 2013
Please quote the following ref. number:

Office of the Commissioner,
Garda Headquarters,
Phoenix Park,
Dublin 8,
Ireland.

Web site: www.garda.ie
E-mail: comstaff@iol.ie
Date:

P.A. 2.1.
Your Ref: MCIB/113

Mr Jolin G. O'Donnell B.L.
Chairman
Marine Casualty Investigation Board
Leeson Lane
Dublin 2

Re: Draft Report of the Investigation into the loss of a person overboard from the Passenger vessel "Kuu-Ee-Tu" on Lough Derg, North of Ballina, Co. Tipperary on 9 July 2005.

Dear Chairman

I am directed by the Commissioner to reply to your letter of the 26 September 2006, and 20 October 2006, in the above.

Other than agreeing with the recommendations of the Marine Casualty Investigation Board that a risk assessment should be available to persons on future trips of this nature and that an audible safety announcement should be made to all persons on board at the commencement of each journey, there are no further observations.

Yours sincerely

B CORCORAN
CHIEF SUPERINTENDENT
PERSONAL ASSISTANT
TO COMMISSIONER

17 November 2006

MARINE CASUALTY INVESTIGATION BOARD
IRELAND
21 NOV 2006

Mission Statement:
To achieve the highest attainable level of Personal Protection, Community Commitment and State Security.

MCIB RESPONSE TO LETTER FROM AN GARDA SIOCHANA RECEIVED ON 21st NOVEMBER 2006

The MCIB notes the contents of this letter and would like to further add that all Risk assessments be made by the owner/ operator of vessel.

Shannon Sailing Ltd.

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Dromineer,
Nenagh,
Co. Tipperary,
Ireland.

MARINE CASUALTY INVESTIGATION BOARD
IRELAND
14 NOV 2006
EIRE

Ms Bridie Cullinane
MCIB
Leeson lane
Dublin 2

13/11/2006

Re Ku-Ee-Tu Draft Report

Dear Ms Cullinane

Thank you for your letter of 8th November attaching the above draft report.

At this stage Shannon Sailing does not intend to make any comments or observations.

Yours faithfully

Pat McCool
Managing Director

MCIB RESPONSE

The MCIB notes the contents of this letter.

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IN THE MATTER OF THE INVESTIGATION INTO THE LOSS OF MR. THOMAS DALTON DECEASED, OVERBOARD FROM THE PASSENGER VESSEL "KU-EE-TU" ON LOUGH DERG, NORTH OF BALLINA, CO. TIPPERARY on the 9th July, 2005.

Observations and Comments of the Dalton Family, being the siblings of the late Thomas Dalton deceased.

The family of Mr. Thomas Dalton (Junior), late of Ballyphilip, Ballingarry, Co. Tipperary have considered the contents of the draft Report of the Marine Casualty Investigation Board and wish to make the following comments and observations:-

1. **The Format of the Investigation and gathering of evidence.**

As stated in the Draft Report, Mr. Dalton, deceased, fell overboard from the passenger vessel, the KU-EE-TU, on Lough Derg, on the 9th day of July, 2005. His body was recovered from the waters of Lough Derg on the 15th July, 2005. Immediately following notification of the fatal accident, members of the Dalton family, being the late Mr. Dalton's siblings, attended at the scene and interacted with members of An Garda Siochana, the Killaloe/Ballina Search and Rescue Service, the Civil Defence and members of the Department of the Marine.

Following the recovery of their brother's body, the Dalton family were not informed by either the Marine Casualty Investigation Board or the Department of the Marine as to the nature of the investigation which would be undertaken, its format and the procedure, which would be followed in the course of the investigation.

At various times, following the death of their brother individual members of the family, had to contact either An Garda Siochana, in relation to the Garda Investigation or the Department of the Marine in order to ascertain developments in relation to the separate investigations into the death of their brother. The family were disappointed that no Liaison Officer, was appointed by either the Board or by the Department of the Marine, in order to ensure that the family were kept informed of all developments.

In particular, the family was not made aware of the procedure of the investigation and the draft Report does not set out, as a Preamble, the investigation procedure which was followed in compiling the Report.

Amongst the family's principal concerns in this regard are the following:-

1. It is not clear from the Report as to whether all of the surviving 35 passengers on board were interviewed.
2. Assessment of the facts, which are set forth in the draft Report would have been made easier, had the Report contained a Preamble stating the names of the passengers interviewed, those who were in a position to give Statements to the Investigating Team, the names of those officials who were appointed to conduct the investigation and the format which the investigation followed.
3. The family of the late Mr. Dalton understands that a meeting of the surviving passengers was convened at Ballysloe on Thursday the 22nd September. This information was communicated to the family by a third party. Whilst the family of the late Mr. Dalton fully accept that it would not have been appropriate for them to attend the meeting, it is respectfully submitted that they should have been informed that the meeting was being convened as this would have ensured that they were kept appraised of developments in the investigation as they occurred.
4. It remains a concern of the family that certain critical witnesses, who were on board the vessel at the time of the fatal accident were not interviewed by any member of the investigation team until at least 10 weeks after the 9th July. It may have been helpful to the investigation team for witnesses to have been interviewed on a date shortly after the fatal accident.

The family of the late Mr. Dalton would like the Board to take note of its observations in this regard and to consider amending the format of future Reports in order to clearly define the process of investigation and the details of how and when evidence was in fact collected.

The draft Report does not contain any reference to the Report of the North Tipperary Coroner, Dr. Louis Courtney, and the Record of Verdict which was recorded at the Inquest which took place the Courthouse, Nenagh, Co. Tipperary on the 12th July, 2006. It is felt that the Record of Verdict, the Reports and the Depositions contained within the Coroner's Report would be of assistance to the Investigating Team when considering the evidence of

the persons interviewed by the Investigating Team. The family of the late Mr. Dalton would therefore request the Board to consider the matters set forth in the Coroner's Report and Depositions, a copy of which is attached thereto.

Facts Recorded.

The family of the late Thomas Dalton were devastated by the tragic and sudden loss of their brother. Since his death they have endeavoured to come to terms with the circumstances of his death and have sought explanations as to how the tragedy could have occurred.

It is submitted that Paragraph 3.1 of the draft Report should be amended to record the exact number of passengers who were on board the vessel on the 9th July, namely 36.

Critical to their understanding is accuracy in the facts of the circumstances leading to their brother's fatal fall overboard from the passenger vessel The KU-EE-TU.

The Dalton family are concerned about the fact that the draft Report refers to different times and it does not therefore establish the time at which their late brother fell over board.

At Paragraph 1.1., Page 3 of the draft Report it is stated that:-

"At approximately 18.45 hours, whilst in the vicinity of Ryneduff Point, Co. Tipperary, Mr. Thomas Dalton fell overboard from the vessel".

It is stated at Paragraph 3.3, Page 5 that:

"at approximately 18.30 hours the KU-EE-TU passed another vessel "The Marianne" on a reciprocal course on the starboard side."

In his Deposition of the 12th July, 2006, Mr. John Purcell stated:-

"At 6.45 p.m. I was talking to Thomas Dalton of Ballyphilip, Thurles, I was standing holding onto a bar along the roof the Boat.".

In his Deposition of the 12th July, Mr. Jimmy McCarthy stated:-

"At around 6.45 p.m. on this trip I remember hearing a splash …….".

It is stated at Paragraph 4.1, Page 6 of the draft Report that:

"at some time shortly after 18.30 hours whilst cruising at approximately 6 knots in the vicinity of Ryneduff Point, Mr. Dalton fell from the vessel".

It is submitted that in the context of effecting a successful rescue, timings are critical and in particular the passage of minutes.

The Dalton family feel that the Draft Report needs to be amended before publication, in order to reflect that their late brother fell overboard at approximately 18.45 hours, as if it is accepted that he fell overboard at approximately 18.30 hours (Reference Paragraph 4.1 of the draft Report) then the Search & Rescue efforts could not have taken place within the time periods recorded throughout the draft Report.

Attention is drawn to the contents of Paragraph 3.3, Page 5 of the draft Report. It is stated:-

"At approximately 18.30 hours the KU-EE-TU passed another vessel "The Marianne" on a reciprocal course on the Starboard side. The owner of "The Marianne" could see a person sitting on a chain towards the middle of the KU-EE-TU with his back to "The Marianne" and he observed that the person was adopting a swinging motion like he was sitting on a swinging chair. The owner of "The Marianne" could also see that the person sitting on the chain was surrounded by other people on the inboard side".

The person observed by the owner of The Marianne remains to this day unidentified.

The Report continues to Paragraph 4 and immediately after Paragraph 3.3 it refers to Mr. Dalton's tragic fall from the vessel. Therefore the implication is that the person who was observed by the owner of "The Marianne" was in fact Mr. Dalton. However, no visual evidence has been adduced to support this implication and corroborative evidence has not been adduced to support the implication.

The Dalton family are satisfied from enquiries which they have made from other surviving passengers that their late brother was not sitting on the safety chain for a period of approximately 15 minutes – i.e. from 18.30 hours to 18.45 hours, when he fell overboard. They are therefore satisfied that the unidentified person observed by the owner of "The Marianne" was not in fact their brother. The Dalton family were informed by another passenger that their late brother had just moved into this particular area on the vessel. They would request the Board to ensure that it cannot be implied from the Report that the person observed by the owner of "The Marianne" was in fact Thomas Dalton deceased. It is reasonable to assume that it could have been any other passenger or indeed any other person who was on the vessel that evening. It is therefore requested that Paragraph 3.3. is clarified by way of a positive statement to the effect that no evidence has been adduced to suggest that the person observed by the owner of "The Marianne" was the late Mr. Thomas Dalton.

Please refer to Paragraph 4.2, Page 6 of the draft Report. The Statements of Fact contained in this Paragraph are inconsistent with the Depositions of Mr. Knight and Mr. McCarthy at the Coroner's Inquest. In particular, please refer to Mr. Knight's Deposition, a copy of which is appended hereto and to Mr. McCarthy's Deposition, a copy of which is also appended hereto.

In his Deposition of the 12th July, 2006, Mr. Jimmy McCarthy, a Barman on the KU-EE-TU stated:-

"I saw a body in the water. All that was above water was his head and shoulders. The buoy Teddy had thrown in was about 8 to 10 feet away from the person in the water. I tried to get to the outside of the boat to get closer to the person in the water. The person was approximately 30 feet from the rear of the boat. I could not do this easily because of the amount of people in the boat and in this area".

Mr. Knight has stated in his Deposition of the 12th July:-

"As I was looking toward the access point on the Starboard side of the vessel, aft of the hand bar structure, at the boarding point amid ships, I saw a member of the group's head, hands and the soles of his feet disappear over the side of the boat as he felt backwards off the vessel. Immediately I took the boat out of gear and waiting for the boat to clear the passenger/casualty (in the water) at the stern. Once I cleared the casualty at the stern I

then put the vessel into hard reverse and it paddled in anti-clockwise manner. Subsequently the casualty ended up on the port side of the vessel roughly 15 to 20 feet away. I then got hold a lifebelt/ring and threw it towards the casualty. The belt landed roughly 2 feet short of the casualty".

Both of these Statements are inconsistent with the Statement at Paragraph 4.2. of the draft Report which states:-

"The boat stopped very quickly and the stern went into Starboard and the casualty was then on the port side on the stern quarter approximately 20 feet away. Mr. Knight stepped out onto the Cabin top and threw a lifebuoy to the casualty, which, landed approximately 1.5 to 2 metres from him".

Given the importance of timing and distance in the context of the Rescue effort, the Board is now requested to re-visit these Statements and to seek clarification regarding the location of the late Mr. Dalton when he fell over board and his distance from the boat.

Furthermore, there would appear to be inconsistencies in the Depositions of Mr. Knight and Mr. McCarthy and the contents of Paragraph 4.2 of the draft Report. Mr. McCarthy in his Deposition stated:-

"The Lifejacket fell 3 to 5 feet from the person in the water. "

Mr. Knight stated:-

"At this point Mr. McCarthy who was at the stern threw a life jacket towards the casualty which landed within his grasp ..... The water was completely still and I noted that neither the lifejacket or belt had in fact removed from where they had landed once they had been thrown in the vessel".

It is stated at Paragraph 4.2 of the Draft Report that the lifebuoy thrown by Mr. Knight had landed approximately 1.5 to 2 metres (i.e. 5 feet 9 inches to 6 feet 6 inches) from the late Mr. Dalton.

The Board is referred to the Deposition of Mr. Jimmy McCarthy of the 12th July, 2006 in which he stated:-

"The person who fell was only in sight above the water for about 30 seconds maximum until he went under".

The Board is also referred to the Deposition of Mr. Knight of the 12th July, 2006 in which he stated:-

"The water was completely still, and I noticed that the neither the life jacket or belt had in fact moved from where they had landed once they had been thrown from the vessel".

It appears that the period of rescue of the late Mr. Dalton was approximately 90 seconds and during this time, by Mr. Knight's sworn Deposition the position of the lifesaving equipment in the water did not change. Therefore the question remains as to why a life jacket was thrown by Mr. McCarthy as opposed to a lifebuoy as clearly the first lifebuoy thrown by Mr. Knight could not possibly have been reached by the late Mr. Dalton in his efforts to save himself. It remains a question of the Dalton family as to whether there was a lifebuoy within Mr. McCarthy's reach, to be used by him in the rescue effort.

Paragraph 4.2 of the Draft Report is particularly important It is stated that:

"Mr. Knight stepped out onto the Cabin top and threw a lifebuoy to the casualty, which landed approximately 1.5 to 2 metres from him but Mr. Dalton, made no attempt to reach the lifebuoy. At this stage, he had been in the water for less than a minute. Mr. James McCarthy, the Barman, went to the stern and threw a life jacket towards the casualty, which landed within his grasp but he made no attempt to reach it. Mr. Dalton then seemed to slowly sink below the surface of the water".

This a clear Statement that Mr. Dalton did not attempt to save himself and the family of the late Mr. Dalton find this Statement particularly upsetting and offensive. It is not accepted that the late Mr. Dalton did not make any attempt to save himself and the Board is hereby requested to amend Paragraph 4.2 in order to clarify the following:-

(a) To adduce evidence from other passengers on board as to Mr. Dalton's actions in the water, in his effort to save himself.

(b) To state that in light of the Report's comment, "*although a person wearing a properly donned life jacket will stay afloat with their mouths clear of the surface*

of the water" that Mr. Dalton could not in these circumstances have donned a life jacket and therefore the life jacket was not an adequate life saving device at that point.

(c) It is possible, given the location of the late Mr. Dalton in the water, that he could not observe the location of either the lifebuoy or the life jacket in order to make an effort to catch hold of same for the purpose of his rescue.

(d) That it is not in way implied directly or otherwise that the late Mr. Dalton did not wish to be rescued but that his inability to reach life saving devices was a result of factors beyond his control.

(e) That significance is attached to the Statement of Mr. Jimmy McCarthy, written by Dr. Louis Courtney, Coroner for North Tipperary by way of affirmation, (Item No. 9) of the Coroner's Report:-

"Mr. McCarthy stated that he saw him splashing and grappling with his arms a couple of times before he submerged".

This Statement clearly indicates that the late Mr. Dalton made valiant efforts to save himself.

It is particularly distressing for the late Mr. Dalton's family to be left with the impression, either direct or implied, that their brother made no attempt to be rescued when, in fact, he was incapable of rescuing himself by reason of the fact that the lifesaving equipment which was thrown to him was either not adequate or did not land sufficiently close to him in order to enable to hold of same. The late Mr. Dalton was a vibrant young man, who lived life to the full and who would have made every possible effort to save himself.

Safety Equipment, Safety Procedure and Crew Training.

The Safety Equipment and the training of the Crew are critical to the rescue operation.

Please refer to Paragraphs 2.1, 2.2, 3.2 and Paragraphs 6.1 of the draft Report.

The family of the late Mr. Dalton wishes the Report to specifically state the nature of the "Marine Duties" of a Crew member on a passenger vessel such as the KU-EE-TU, during a voyage.

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The Safety Equipment and the training of the Crew are critical to the rescue operation.

Please refer to Paragraphs 2.1, 2.2, 3.2 and Paragraphs 6.1 of the draft Report.

The family of the late Mr. Dalton wishes the Report to specifically state the nature of the "Marine Duties" of a Crew member on a passenger vessel such as the KU-EE-TU, during a voyage.

The Report is silent as to whether any of the members of the Crew are required to possess life saving qualifications.

The draft Report states that it is a legal requirement that there must be a minimum of two crew members on the KU-EE-TU. Yet, it has been established, as a matter of fact, that three members of the Crew who were on the vessel on the 9th July were involved in the following duties:-

(a) Mr. Knight was Master of the vessel and charged with the responsibility of steering the vessel through the waters of Lough Derg.
(b) Mr. Jimmy McCarthy was the Barman and charged with the responsibility of managing and controlling the Bar area.
(c) The third Crew member, Mr. Dave Richardson was charged with the responsibility of playing music.

It is therefore evident that there was no member of the Crew charged with the responsibility of either attending to passenger needs, assisting passengers or indeed supervising the activities of passengers whilst on board. In particular, there was no Crew member who was specifically charged with ensuring that no passenger sat on a prohibited area and placed themselves in danger. It is accepted that Mr. Knight has stated that he was the only person charged with the responsibility of monitoring passengers. Please refer to Mr. Knight's Deposition, a copy of which is appended thereto. Mr. Knight has stated therein:-

"After about an hour and a half we approached Reinthoo Point, cruising at around to5 to 6 knots. At this time, as I always do throughout any trip, I was monitoring the deck area, the exists from the vessel onto the deck area, the bar area along with the bow and the stern and the access point amid ships. The passengers were continually passing up and down within the internal area of the boat from the bar at the stern to the seating area throughout the vessel."

The vessel had departed Dromineer at approximately 5. p.m. that evening. Therefore, one and a half hours later at 6.30 p.m. that evening Mr. Knight, by his own admission, was monitoring the deck area. However, at approximately 6.30 p.m. Mr. Knight did not notice the unidentified person who was in fact noticed by the Skipper of "The Marianne", as sitting on the chain in the middle of the KU-EE-TU with his back to "The Marianne".

Furthermore, it is stated at Paragraph 3.2 of the draft Report that Mr. Knight did not "*see Mr. Dalton sitting on the chain*". It is further stated:

"*the passengers gathered in the area may have obstructed his view in this respect*".

Mr. Knight further stated in the Deposition to the Coroner that:-

"As I was looking towards the access point on the starboard side of the vessel aft of the hand bar structure at the boarding point amid ship, I saw a member of the group's head, hands and soles of his feet disappear over the side of the boat as he fell backwards off the vessel".

Clearly, in being responsible for steering the vessel through the waters of Lough Derg, Mr. Knight could not have borne equal responsibility for monitoring the safety of the passengers on board.

It therefore appears that passengers were free to remain seated in this area without being checked and that no attempt was made to ensure that passengers were prevented from doing so by a member of the Crew. It also appears from the contents of the draft Report that there was no announcement made by any Crew member, during the trip, advising that it was strictly prohibited to sit on the said safety chain.

Paragraph 3.2 of the draft Report would appear to contradict Paragraph 6.1 (4) of the draft Report as Paragraph 3.2 and the Dalton family would request the Board to revisit both Paragraphs in order to avoid confusion created by this contradiction.

The family of the late Mr. Thomas Dalton wish the Board to recommend that vessels such as the KU-EE-TU, which are retained for the purpose of passenger pleasure trips, should be crewed by a minimum number of crew, one of whom should have sole responsibility for assisting and monitoring passengers and monitoring their safety on board.

The draft Report does not make any reference to a Safety Statement or Safety Announcement having been announced by way of a public address system and it is clear from paragraph 2.4 that the vessel was equipped with a public address system. In light of the importance of a Safety Statement being made to passengers on board, it is felt that the

Board should clarify whether the public address system was working and whether it was used by the Master of the vessel when he made the safety statement.

In his Deposition Mr. Knight specifically stated:

"*departure proceedings having been completed, the vessel eventually departed the Marina at 5 p.m. The weather conditions were superb, with excellent visibility and the lake was flat and calm, almost like "glass". Mr. McCarthy then began the normal mandatory safety demonstration, for all passengers, including demonstrating the appropriate procedure for putting on and security of a life jacket and an indication as to the emergency exists of the vessel. In addition, I made a general announcement that no member of the group was allowed either on deck, or to gain or tempt to gain access through the escape hatch to the deck area.*"

Mr. McCarthy makes no reference in his Deposition to the "Mandatory Safety Procedure" or to any announcement having being made by Mr. Knight. He states:-

"I was working behind the bar of the KU-EE-TU".

It is specifically stated at Paragraph 6 (10).1(10), Page 9 of the draft Report:-

"None of the passengers who were interviewed could recall hearing any safety instructions on joining the vessel. Some of the passengers recalled seeing the lifejackets on board. One of the Crew members recalled hearing the Master giving a Safety Announcement at the start of the cruise".

Which crew member had this recollection? The question remains as to whether the Master and the two members of his Crew were specifically questioned by the investigating team about the nature of the Mandatory Safety Procedure, which was allegedly followed prior to departure from Dromineer. The question also remains as to how the Safety Statement was communicated, i.e. whether by the public address system or simply by the Master speaking to the passengers, who numbered 36.

It is accepted that this vessel had a Bar on board and that the Master was entitled to serve alcohol to the passengers. The presence of alcohol on board only serves to underscore the necessity of having a member of the Crew dedicated to passenger assistance and passenger safety.

The safety equipment on board has been detailed at Paragraph 2.2, Page 4 of the draft Report. The family of the late Mr. Dalton would like the following points to be clarified:-

1. Did the Inspector count and check the number of lifebuoys on the vessel once the vessel was impounded?
2. How freely available were the lifebuoys and was this checked by the Inspector immediately following the impounding of the vessel?
3. It should be clarified as to how many life jackets were on the vessel at the time of the inspection, when the vessel was impounded, and this is particularly important as Mr. Knight stated in his Deposition:-

   "There are 68 life jackets and 10 children's life jackets on the boat.".

The draft Report specifies at Paragraph 2.2. that the vessel was equipped with 61 adult life jackets and 6 children's life jackets. This contradiction in a number of available life jackets should be clarified.

4. Was any member of the Crew trained in the use of the life jackets and use of the lifebuoys, with a specific life-saving training course having been completed?
5. Were any passengers interviewed by the Investigating Team in order to establish the life saving attempts made by the passengers and in particular whether any of the passengers had attempted to throw any further lifebuoys or life jackets to the late Mr. Dalton, which said life-saving equipment could possibly have landed closer to him and could possibly have been within his reach whilst he remained afloat on the water.
6. It is stated at Paragraph 4.2, Page 4 of the draft Report:

"*The Anchor was let go and another lifebuoy was tied to the anchor rope to mark the position.*"

Please clarify how many lifebuoys were found in the water when the inspection took place and please also clarify how many lifebuoys were found on the vessel when the inspection took place, given that at least one lifebuoy was tied to the Anchor Rope in order to mark the position where Mr. Dalton lost his life.

7. The draft Report concludes:

"*7.1. Mr. Dalton fell overboard after the Crew securing the chain guard on which he was sitting broke*".

The failure of a safety chain is fundamental to the circumstances of this tragic accident. The Dalton family wish to know whether the Inspector removed the bracket, (Reference Pictures 9.3, 9.6 and 9.7) in order to investigate how the bracket had in fact been attached, prior to the chain breaking free. Essentially, therefore, was it established by the Investigating Team or by the Inspector as to whether the bracket had been held in place by four screws or by two screws?

It appears to be incongruous that there were six holes in position for four bolts. Can it therefore be confirmed that the bolts of the correct dimension for the holes and whether suitable material had been used in order to secure the chain? (Please refer to Paragraph 8.2, Page 11 of the draft Report).

Photographs 9.5. clearly shows a previous (from the inside position on the vessel with four bolts secured with four nuts). The question remains as to whether this was the location of the earlier (?). Please clarify.

8. It is submitted that the new warning sign shown at Photograph 9.8, Page 17 of the draft Report, is not a sufficient warning for passengers. It is further submitted that a warning sign should be clear, precise in bold letters and displayed in a prominent position, preferably on the inside of the new gate arrangement for the vessel, as shown in Photograph 9.6 of the draft Report.

9. The recommendation described at Paragraph 8.1., Page 11 of the draft Report have been noted with interest by the Dalton family. However, it is submitted that there should be no differentiation made between an *open space* on a boat which is entirely open and open space on a boat such as the KU-EE-TU, which has a closed saloon area. Once a passenger departs the closed saloon area, they face the same dangers and risks in the open area of that vessel as if they were on an entirely open vessel and it is submitted that there should be a specific recommendation that passengers on board vessels such as the KU-EE-TU should be obliged to wear a life jacket when entering the open area of the vessel, but not when remaining in the closed area.

Recommendations

The family of the late Mr. Thomas Dalton welcome and endorse the recommendations described at Paragraph 8.2, Page 11 of the draft Report. However, they would respectfully submit that further recommendations are required in relation to the wearing of life jackets, as set forth above.

In particular the family would like the Board to make recommendations addressing the following:-

1. That at least one member of the Crew should be trained in life saving procedure.
2. That there should be at least one member of the Crew dedicated to assist the passengers, supervise the passengers and monitor their safety and that this Crew member should not be charged with any other duty whilst the vessel is on the water.
3. That there should be a clear and unambiguous safety announcement made prior to the departure of the vessel from port, outlining a guideline of the Crew's duties, identifying the Crew to the passengers, and advising passengers what procedures should be followed in the event of an emergency. This Safety Statement should be made by using the public address system and the public address system should be checked as being operational on each inspection of the vessel by the Department of Transport.
4. That all Notices for passengers should be prominently and clearly displayed and pointed out to passengers with passengers being requested to read the Notices prior to the departure of the vessel.
5. That the Board's Report should contain a Preamble, detailing the procedure which was followed in conducting the investigation, the names of persons who were interviewed, the names of persons who gave Statements to the Investigating Team and the names of those persons who interviewed witnesses.
6. In addition, the family of the deceased should be kept informed at all times of the investigation procedure and developments in relation to the investigation procedure and in order to facilitate this process of information, one member of the family of the deceased should be nominated as the person to whom information will be communicated by the Board.
7. Prior to preparing the draft Report, the Investigation Team should interview members of the family of the deceased in order to ascertain whether the family of

the deceased have any outstanding questions or concerns relating to the death of their loved one or the nature of the investigation which was undertaken. This would be of assistance to the Board in conducting its investigation.

8. The investigation team should have specific regard to the Depositions made by witnesses to the Coroner's Court and the contents of the said Depositions should be cross-referenced with statements given by such persons to the Board's investigating team.
9. That all Statements of Fact whether statements of the circumstances of the deceased's death or Statements of the time of the deceased's death should be accurate and consistent throughout the Report, and where possible should be independently corroborated and cross-referenced.
10. Furthermore, the family of the late Mr. Dalton feels that it would be of assistance and comfort to bereaved families to have a Liaison Officer appointed with whom they could make contact and who would in turn contact them in order to keep them informed of all developments in relation to the investigation.

Many of the matters referred to in the within Memorandum were alluded to and were referred to in the Statement of the Dalton family, which was read to the Coroner's Court at Nenagh Courthouse on the 12th July, 2006 and the Board is referred to a copy of that Statement, appended hereto.

Dated this 27th day of November, 2006.

Signed:_____

Patrick F. Treacy & Co.,
Solicitors,
29 Pearse Street,
Nenagh,
Co. Tipperary.

MCIB RESPONSE TO LETTER FROM PATRICK F. TREACY & CO. SOLICITORS ON BEHALF OF THE DALTON FAMILY RECEIVED 28th NOVEMBER 2006

Please note that it is against MCIB policy to include Coroner's Reports in the publishing of an incident.

The MCIB notes the contents of this letter and has the following comments to make:

1. **Format of the Investigation and gathering of Evidence.**

   The investigation was carried out in accordance with the Section 26 of the Merchant Shipping (Investigation of Marine Casualties) Act 2000.

   A member of the family made contact during the investigation and spoke with the MCIB investigator who appraised her of progress and took a contact address for forwarding of the draft report. The investigator did not get the impression that the family were unhappy with how the investigation was being undertaken at this time and would certainly have been concerned if such an opinion had been expressed and would have been keen to address any such concerns as best he could given the constraints of the Act.

   Whether all the "surviving" passengers were interviewed.

   In the Board's view, it is not appropriate to call the other passengers "survivors" after an incident where a single person has fallen overboard.

   The MCIB investigator received a list of names and addresses of persons onboard from An Garda Siochana. Our investigator wrote to all passengers on this list requesting them to get in contact and to provide any relevant information concerning the incident. Some information was gathered from these replies although some passengers had not witnessed Mr. Dalton falling into the water. One person claimed not to have been onboard as he was in the USA at the time. The Master and two crew were interviewed on the 13th July 2005. One of the passengers, Ms. Eimear Gaynor, contacted the MCIB around this time and spoke to the investigator. Ms. Gaynor had organised the "pub" day trip that took the passengers onboard the vessel and kindly offered a room for MCIB use on an evening at her premises at which she would ask all passengers to attend and give statements to our investigator. This was seen as the most practical method of facilitating the gathering of information from the passengers.

   The investigator duly attended on the evening of the 9th September 2005 and 18 persons were interviewed. The investigator is very appreciative of the time given up by people in attending that evening.

   In total, 20 passengers were either interviewed by or made statements to our investigator. Our investigator got a clear picture of the incident from his investigation.

Reference to the Coroner's Report

The MCIB investigation is independent of and separate from a coroners inquest and it is correct that this separation exists. A coroners inquest is to ascertain the cause of death wheras our function is to establish the probable cause of a marine casualty. Procedures for an MCIB investigation are set out in the Merchant Shipping (Investigation of Marine Casualties) Act 2000. Depositions in a coroners inquest are not included in an MCIB report.

2. Facts Recorded

Paragraph 3.1 does not state the number of people onboard. It states the nature of the booking that was made with the vessel operator and is correct.

Times. The exact time that Mr. Dalton fell into the water has not been established save that it was between 18.30 hrs and 18.45 hrs.
It is clear that Mr. Dalton was sitting on the chain. Passengers interviewed by the investigator did not recall any other person sitting on the chain prior to the incident.

The owner of the "Marianne" gave a statement to the MCIB confirming that a person was sitting on the chain when he passed by and it would be incorrect, given the information provided by the other passengers, to state in the report that this could have been any person onboard. The Board do not believe it is appropriate to state the name of the owner of the Marianne.

Paragraph 4.2

The details recorded are based on signed statements taken by the MCIB investigator. These amendments are made given Mr. Dalton's families concern that Mr. Dalton's observed actions may be misinterpreted as meaning that Mr. Dalton did not wish to be rescued. It was not the investigators intention that such an inference be drawn from this paragraph in our draft report.

Comments

a. The statements taken are entirely sufficient. The investigation did not seek to micro –analyse the struggle of Mr. Dalton in the water, as this would be of no added value in making recommendations for avoidance of similar actions in the future and may well be distressing to relatives and passengers. The conclusion of the report is, that even though Mr. Dalton was in the water for a very short time and life-saving appliances were deployed near him it was unfortunately too late.

b. *"Lifejacket not adequate lifesaving appliance"*. Mr. McCarthy was inside the vessel when the incident occurred. There were no lifebuoys located within the vessel as they were correctly located on the outside deck. It was quick thinking on his part to throw a lifejacket to Mr. Dalton. It is accepted that Mr. Dalton would not have been able to properly don a lifejacket in the water but it would have provided buoyancy to Mr. Dalton had he been able to grab hold of it.

c. Speculation regarding the reason that Mr. Dalton did not reach the life saving equipment is not appropriate.

d. The MCIB has not concluded that Mr. Dalton did not wish to be rescued nor is there any evidence to suggest this.

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The lifebuoy thrown by Mr. Knight was the most appropriate item of equipment for use in a man over board situation and was entirely adequate. The Lifejacket was thrown as it was to hand and this was a prudent and potentially lifesaving act and is to be commended.

3. <u>Safety Equipment, Safety Procedure and Crew Training.</u>

Paragraph 3.2 states that some passengers were sitting on the steps on the starboard side next to the chain. Para 6.1(4) states that Mr. Knight said that passengers were not supposed to sit on the steps or the chain. There is no contradiction as Paragraph 3.2 reports what actually happened. Paragraph 6.1(4) reports the policy, which in this case was not adhered to. The last two sentences in paragraph 3.2 and paragraph 3.3 clarify why this situation occurred.

Duties of Crew

It is accepted practice on passenger vessels that crewmembers have both operational and emergency duties. In this incident the barman upon hearing that a person had gone into the water threw a lifejacket towards Mr. Dalton. The Master is responsible for the safety of the vessel and those onboard and reacted appropriately in all the circumstances. It is not advisable that, during a formal training course, he should enter the water to effect a rescue attempt in any such circumstance.

Minimum Number of Crew

This is two for the vessel in question and is appropriate to her size.

Qualifications of Crew

At the time of the incident there were no statutory requirements regarding the training of crew. The Merchant Shipping (Passenger Shipping) Manning Regulations are expected to come into force and will require the Master of Class V passenger vessels to hold a "Certificate of Competency".

Safety Announcement

"No mention in report". See Paragraph 6.1(10). Although the passengers did not recall the announcement, one of the crewmembers did recall the announcement and included same in his signed statement. It is not appropriate for the report to identify which crewmember. The report is therefore balanced. The passengers did not recall hearing the announcement but this does not necessarily mean it was not made and the statement of the crewmember supports this conclusion.

Alcohol onboard

See duties of crew above.

Safety Equipment

1. See Paragraph 6.7 of draft report
2. Lifebuoys stowed on top of cabin in outside location as required. (They form part of the lifesaving equipment should the vessel sink and therefore cannot be stowed inside.)
3. See Paragraph 6.7 of draft report. As regards the MCIB report there was no contradiction in terms of the Lifejackets available.
4. At the time of the incident there were no Statutory Requirements regarding the training of crew. The crew held no relevant qualifications.

5. See paragraph 4.2. Some of the passengers wanted to enter the water to assist Mr. Dalton but were restrained from doing this. None of the passengers who were interviewed stated that they deployed any life saving equipment. One of the passengers stated in a letter that he saw a passenger – Mr. Dominic Mc Monagle throw a lifebuoy in to the water but it did not reach Mr. Dalton. Mr. Mc Monagle did not provide our investigator with such information nor did he attend the organised meeting to give a statement.
6. The Lifebuoy located on the lake was taken into account.
7. See paragraph 6.1(2) four screws. Photograph 9.5 shows the location where the inside fixings were located - above the new 4 bolt fixing plate.
8. The wording of the new notice is clear and precise. The Marine Survey Office should consider making recommendations to the owner regarding extra signs although there is no Statutory Requirement to carry signs warning people not to sit on bulwarks or guardrails on the sides of vessel.
9. This suggestion is noted but the wearing of lifejackets in some parts of the vessel but not others would be impractical and could hamper escape in the event of a fire or other emergency.

4. <u>Recommendations</u>

1. The manning regulations will require appropriate training for crews.
2. See Duties of Crew above. The MCIB does not support this recommendation as members of the crew going about their normal shipboard duties are already responsible for the safety of the passengers and this is accepted practice in shipping and other forms of transport.
3. See paragraph 8.4. All the vessels safety equipment including the public address system, if fitted, is checked at the annual survey for the passenger certificate.
4. Agreed recommendation for the safety-briefing announcement.
5. We do not agree that the names of all persons who gave statements should be published. Nor do we agree that our investigator should be named in the report. The report is that of the MCIB.
6. This was done although the family member may not recall that she was talking to the investigator.
7. Both our draft report and this, our final report,have allowed Mr. Dalton's family to have their input before publication.
8. We do not agree. All MCIB reports are independent of Coroner's Inquests.
9. Approximations of times are sometimes unavoidable, especially where there is no electronic warning device triggered (e.g. DSC) and a number of people are interviewed who have different recollections of the exact time. The statements in the report regarding events are based on these statements and are as accurate and consistent as the information provided to the investigator allows.
10. Noted.