

# MARINE INQUIRIES: BALANCING THE 'NO-BLAME' INVESTIGATION WITH THE REGULATORY INVESTIGATION TO ACHIEVE MARINE SAFETY OUTCOMES

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*In recent years a new style of incident investigation has emerged to challenge the continued relevance of the marine inquiry jurisdiction. Known colloquially as 'no-blame safety investigation', safety investigation agencies exercise an investigative response to serious marine incidents. Safety investigation is fundamentally concerned with finding the causes of the incident in order to prevent its recurrence, and the attribution of blame is expressly not one of its functions. By contrast, the marine inquiry jurisdiction requires a consideration of fault as well as causation, and sometimes results in criminal, civil and administrative liability consequences. The legal regimes associated with each style of maritime incident response are compared and contrasted and it is suggested that the marine inquiry regime, whilst it has presently fallen out of favour, has characteristics that offer greater utility and possibly superior marine safety outcomes than the safety investigation regime alone.*

## 1. Introduction

Marine Inquiries<sup>1</sup> are a traditional response to serious marine incidents with a centuries-long heritage. A marine inquiry generally consists of a judicial-style of investigation into the circumstances of an incident, with a view to making findings of fact and attributing blame, often assisted by nautical experts or assessors. In times past, marine inquiries also had a disciplinary function, with the ability to cancel or suspend the certificates of mariners concerned.

In recent years a new style of incident investigation has emerged to challenge the continued relevance of the marine inquiry jurisdiction. Known colloquially as 'no-blame safety investigation', safety investigation agencies, such as the Australian Transport Safety Bureau, have been established to exercise an investigative response to serious marine incidents. The essential characteristics of no-blame safety investigation include the abrogation of the privilege against self-incrimination and the isolation of the evidence collected and the final report from any other use aside from safety purposes. Safety investigation is fundamentally concerned with finding the causes of the incident in order to prevent its recurrence, and the attribution of blame is expressly not one of its functions.

Notwithstanding the emergence of the no-blame safety investigation agency in a number of Australian jurisdictions, the marine inquiry continues to exist in marine safety legislation, at least at state level, and the marine inquiry remains an important element in the administration of marine safety in Australia.

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<sup>1</sup> A short note on usage: a reference to a 'board of inquiry' means a board of inquiry established under part 12 of the *Transport Operations (Marine Safety) Act 1994* (Qld); a reference to a 'court of marine inquiry' means a Court of Marine Inquiry established under the *Navigation Act 1912* (Cth); whereas a reference to 'marine inquiry(ies)' is a reference to marine inquiries generally, not necessarily a particular inquiry established under a particular Act.

Part 12 of the *Transport Operations (Marine Safety) Act 1994* (Qld) ('TOMSA') provides for the establishment and conduct of boards of inquiry into marine incidents. Since the introduction of TOMSA in 1994, two boards of inquiry have been established to investigate marine incidents in Queensland.<sup>2</sup> In each case, the terms of reference for the inquiry included consideration of systemic and regulatory issues, rather than simply focussing on the proximate causes of the marine incidents themselves.

Boards of inquiry are established by the Queensland Minister responsible for maritime safety and are tasked to inquire into the circumstances and probable causes of a marine incident and to give the Minister a written report of the Board's findings.

The conduct of boards of inquiry is contrasted with the establishment of 'no-blame' safety investigation agencies at Commonwealth level by the *Transport Safety Investigation Act 2003* (Cth) and State level<sup>3</sup> in Australia in the maritime jurisdiction. To facilitate the discussion, no-blame safety investigation reports are compared to reports prepared by regulatory agencies using traditional investigative methods. The most recent board of inquiry into the marine incident concerning the ship *Wunma* is also considered, and in particular, how the board approached its consideration of systemic and regulatory issues.

It is argued that the powers and limitations created by the *Transport Safety Investigation Act 2003* (Cth) exceed what is necessary to achieve an appropriate safety outcome. Further, the powers and limitations created by the no-blame safety investigation regime unnecessarily interfere with the marine safety regulator's ability to perform their legislative responsibilities, such as by denying access to crucial evidence. Finally, the no-blame safety investigation regime can only report on substantially untested findings of fact and circumstances and make recommendations. Those whose role it is to implement such recommendations, such as marine safety regulators, must make independent inquiries to support any action taken in relation to a recommendation because of the limitations imposed by the no-blame safety investigation regime.

These criticisms are considered in the context of three main themes: first, the tension between the dual objectives of an inquiry, that is, to investigate into the facts and circumstances of an incident to prevent its recurrence and also the possibility for the attribution of blame to participants in the incident where appropriate; second, the evolving use of nautical expertise to inform the inquiry by the use of assessors and expert investigators; and third, the development of the safety investigation agency and its attendant characteristics of no-blame attribution, confidentiality of evidence, and the removal of legal protections such as self-incrimination, procedural fairness and rights to representation.

## 2. Marine Inquiries

### 2.1. What is a Marine Inquiry?

The starting point is a consideration of the common characteristics associated with marine inquiries. According to Ogilvie<sup>4</sup>:

Courts of marine inquiry occupy a unique place in the Australian legal system as do shipping courts in the British legal system, in that their jurisdiction over national ships and seamen is worldwide. They are administrative courts of a special character. They are a compromise between administration within the discretion of a government department unaccustomed to judicial procedures and an ordinary court of justice, which may not possess the special knowledge which is desirable for matters of nautical inquiry. They are entirely independent of the department for whose assistance they were created.

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<sup>2</sup> The reports of both boards of inquiry are available on the Maritime Safety Queensland web site at: [http://www.msq.qld.gov.au/Home/Publications/Reports\\_of\\_boards\\_of\\_inquiry/](http://www.msq.qld.gov.au/Home/Publications/Reports_of_boards_of_inquiry/)

<sup>3</sup> New South Wales has established a safety investigation body, The Office of Transport Safety Investigations (OTSI), which is responsible for, amongst other things, investigating incidents involving Passenger Ferries in NSW. The OTSI has similar powers and responsibilities to the ATSB, but a detailed examination of that agency lies outside the scope of this paper. For more, see [www.otsi.nsw.gov.au](http://www.otsi.nsw.gov.au). Victoria also has a no-blame safety investigator: see <http://www.transport.vic.gov.au/chiefinvestigator> accessed 4 July 2008.

<sup>4</sup> AG Ogilvie *Courts of Marine Inquiry in Australia* (1979) 53 ALJ 129 at 132.

White<sup>5</sup> quotes with approval an extract from a 1929 English book entitled '*Shipping Inquiries and Courts*',<sup>6</sup> as encapsulating the principal characteristics of a marine inquiry. Marine inquiries, it is said, are:

- administrative in character but whose decisions can have consequences for the private rights of individuals;<sup>7</sup>
- effectively created by the relevant regulatory body (such as the Ministry for Transport in the United Kingdom or previously the Australian Maritime Safety Authority in Australia) or the relevant Minister or other appropriate authority;
- vested with a specific jurisdiction relating to the investigation of certain kinds of maritime casualty; often specific questions are asked of the inquiry by the establishing authority; in later years the jurisdiction of the inquiry may be described by 'terms of reference';<sup>8</sup>
- the inquiry is assisted by the relevant government department representing the public interest and also as the holder of expert knowledge in relation to shipping and marine matters;
- the inquiry is usually constituted by a person or persons of legal training and so the proceedings of the inquiry are usually conducted in accordance with the usual legal formalities;
- such legally qualified persons are often assisted by assessors who have the skills appropriate to the subject matter of the inquiry;
- the inquiry makes a formal report of its decision, including reasons, together with such recommendations as are appropriate;
- at least originally, marine inquiries also had a disciplinary component, with the ability to suspend or cancel the certificates of masters, mates and engineers;<sup>9</sup> and
- the inquiry is independent, impartial and entirely distinct from the government for whose assistance the inquiry was created.<sup>10</sup>

A marine inquiry therefore is a specially constituted administrative 'court' or tribunal, created for a specific purpose; that is, to investigate the facts and circumstances of particular maritime incident; using a peculiar combination of legal and nautical expertise; in some cases able to take disciplinary action against the participants in the marine casualty; and to deliver a report on the incident to the government of the day.

The marine inquiry fills an important niche role in achieving marine safety whilst balancing the regulatory role; it is independent of the regulatory agency, enabling it to exercise its inquirial functions independent of any influence of government, whether perceived or actual; and it also allows an independent examination of culpability that is unaffected by the prevailing views of the regulator.

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<sup>5</sup> M White *Marine Inquiries* (1993) 9 *QUEENSLAND UNIVERSITY OF TECHNOLOGY LAW JOURNAL* 61.

<sup>6</sup> ARG McMillan *Shipping Inquiries and Courts*, Stevens and Sons Ltd London 1929.

<sup>7</sup> In *Marine Board; Ex parte Dalton* (1876) 14 SCR (NSW) 277, Sir James Martin CJ said (at 281) that the NSW Marine Board '...has all the elements of a Court-the power of summoning parties and witnesses, and punishing them if they disobeyed the summons-of hearing evidence on oath administered, and of deciding questions which might deprive persons of civil rights.'

<sup>8</sup> See for instance the Formal Investigation Notice for the *Marchioness-Bowbelle* Formal Investigation available from <http://www.marchioness-bowbelle.org.uk/> accessed 14 May 2008.

<sup>9</sup> See for example *Robbie v Director of Navigation* (1944) 44 SR (NSW) 407.

<sup>10</sup> See for example paragraph 2.4 of the *Report of the Board of Inquiry into the Marine Incident Involving the Ship Wunma in the Waters of the Gulf of Carpentaria on 6 and 7 February 2007*, at [http://www.msq.qld.gov.au/Home/Publications/Reports\\_of\\_boards\\_of\\_inquiry/](http://www.msq.qld.gov.au/Home/Publications/Reports_of_boards_of_inquiry/) accessed 14 May 2008

## 2.2. Assessors

One distinctive feature of the marine inquiry worthy of additional comment is the use of the assessor as, in effect, a court-appointed expert. Assessors are generally persons with specific skill or knowledge within the area under consideration by the marine inquiry. The concept of a person with special nautical or technical skill is also relevant to a consideration of the investigators appointed under the safety investigation agencies that are considered later in this paper.

The use of assessors has a long tradition in the English Admiralty Court, dating back to the 14th century.<sup>11</sup> The use of assessors survived the absorption of Courts of Admiralty by the common law courts in the 19<sup>th</sup> Century.<sup>12</sup>

In Australia, the practice of using assessors in the Admiralty jurisdiction fell out of favour in the 20<sup>th</sup> century, although there are some 19<sup>th</sup> Century examples of Colonial Courts appointing assessors to assist in Admiralty matters.<sup>13</sup>

Dickey describes the use of the Assessor as follows:

Assessors... are not called by the parties, are not sworn, and cannot be cross-examined. Indeed their advice is both sought by and given to the court in private and is disclosed to the parties at the court's discretion and then usually at the end of the case in the judgment.<sup>14</sup>

Further, the ordinary rule was "that expert evidence relating to matters of nautical skill within the competence of the marine assessors was not admitted",<sup>15</sup> except in extraordinary circumstances,<sup>16</sup> such as where the assessors themselves felt they would benefit from hearing that evidence.

The usual justification for the use of an assessor is that the assessor possesses special nautical skill that the judicial officer does not possess, in order to allow the judicial officer to properly interpret the evidence and form legal judgments. Expressed differently, 'to provide the judge with such general information as will enable him to take judicial notice of facts which are notorious to those experienced in seamanship'.<sup>17</sup>

There are some persuasive efficiency arguments associated with using assessors, permitting the judge to have "the advantage of experts who sat with the judge and heard all of the evidence".<sup>18</sup> Further, the advantage of using such well-informed persons:

... is that the court can obtain such assistance as it needs on nautical matters without the necessity of hearing long and conflicting and often unpersuasive opinion evidence on such matters. Moreover, the court can obtain such assistance from assessors right up to the time when judgment is pronounced.<sup>19</sup>

But the use of assessors has not been without controversy, with suggestions that the judicial decision-makers were perhaps abdicating their responsibility, and instead relying upon the opinion of the assessor. The tension inherent between the two roles is encapsulated in the judgment of the Master of the Rolls, Sir Baliol Brett in *The Beryl*:

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<sup>11</sup> New South Wales Law Reform Commission, *Report 109 - Expert Witnesses*, Sydney 2005 at chapter 2.

<sup>12</sup> By operation of the *Supreme Court Judicature Act 1873* 36 and 37 Vict c 66; as to the development of Admiralty jurisdiction and the jurisdiction of the courts generally both in the United Kingdom and in the Australian colonies see M White (ed), 'Australian Maritime Law' second edition, The Federation Press, Sydney 2000 at chapter 1.

<sup>13</sup> See Australian Law Reform Commission, *Civil Admiralty Jurisdiction* (Report 33, 1986) at para 290; *Peters Slip Pty Ltd v Commonwealth of Australia* [1979] Qd R 123.

<sup>14</sup> A. Dickey, 'The Province and Function of Assessors in English Courts' (1970) 33 *Modern Law Review* 494.

<sup>15</sup> AG Ogilvie 'Courts of Marine Inquiry in Australia' (1979) 53 *Australian Law Journal* 129 at 137.

<sup>16</sup> Australian Law Reform Commission, *Civil Admiralty Jurisdiction* (Report 33, 1986) at para 288.

<sup>17</sup> *Egmont Towing & Sorting Ltd v The Ship 'Telendos'* (1982) 43 NR 147, 165 (Thurlow CJ), leave to appeal dismissed by S Ct, id, 446.

<sup>18</sup> M White *Marine Inquiries* (1993) 9 *Queensland University of Technology Law Journal* 61 at 63.

<sup>19</sup> *Egmont Towing & Sorting Ltd v The Ship 'Telendos'* (1982) 43 NR 147, 165 (Thurlow CJ), leave to appeal dismissed by S Ct, id, 446.

In the Court of Admiralty the application of the rules is to be made by a mixed tribunal. The tribunal which has to try the case is the judge himself, and the judgment is his and his alone. The assessors who assist the judge take no part in the judgment whatever; they are not responsible for it, and have nothing to do with it. They are there for the purpose of assisting the judge by answering any question, as to the facts which arise, of nautical skill...

Still, it would be impertinent in a judge not to consider as almost binding upon him the opinion of the nautical gentlemen who, having ten times his own skill, are called in to assist him.<sup>20</sup>

Assessors tread the fine line between advising the judicial officer appropriately in their area of special skill without venturing into opinions on the merits of the case; and equally, for the judicial officer to differentiate the assessor's opinion on technical matters from the ultimate legal issue.

Further, as what passed between the assessor and the judicial officer was not known to the parties in a case in Admiralty or to the participants in a marine inquiry, questions of procedural fairness arise. Thus, as Lord Justice Scrutton said in *The Tovarisch*:

The judge in Admiralty talks to them [assessors] and gets information from them. The parties do not know what the witnesses are telling the judge; they have no opportunity of cross-examining the so-called witnesses.<sup>21</sup>

White describes this wryly as 'a slight bending of one of the rules of natural justice but was the English system which had stood the test of time and was kept on in Australia'.<sup>22</sup> One could well understand the concern of some parties and their legal advisers about a system that allows specialist advice to be given to a judge without the opportunity of testing such advice in open court. As the learned authors of the Australian Law Reform Commission Report into Admiralty Jurisdiction comment 'It [cross examination] may be the only way of bringing out the fact that an assessor, while not partisan, belongs to a particular school of thought on a subject in issue'.<sup>23</sup>

Fully cognisant of such disadvantages, Mr Justice Neasey, a member of the Commonwealth Court of Marine Inquiry into the *Lake Illawarra* collision,<sup>24</sup> who had the benefit of four assessors sitting with the Court,<sup>25</sup> queried whether the ordinary English rule concerning the non-admission of expert evidence relating to matters of nautical skill within the competence of the marine assessors was appropriate. He also inquired whether the marine assessors were to advise the Court privately or in open Court, and what course the Court should take if independent expert evidence conflicted with advice from assessors.<sup>26</sup>

After hearing submissions on these questions, the Court allowed the admission of expert evidence without restriction, even on areas within the competence of the assessors. Ogilvie concludes that the approach adopted by the court was preferable to the English practice of not allowing such expert evidence, principally on the basis that the parties should have the opportunity to call all relevant testimony on the issues before the Court, and it is for the Court to decide whether to accept the opinions of the experts or not, whether in consultation with the assessors or independently of them.<sup>27</sup>

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<sup>20</sup> *The Beryl* (1884) 9 PD 137 at 141 cited in New South Wales Law Reform Commission, *Report 109 - Expert Witnesses*, Sydney 2005 at chapter 2.

<sup>21</sup> *The Tovarisch* [1930] P 1 at 7, cited in South Wales Law Reform Commission, *Report 109 - Expert Witnesses*, Sydney 2005 at chapter 2.

<sup>22</sup> M White 'Marine Inquiries' (1993) 9 *Queensland University of Technology Law Journal* 61 at 63.

<sup>23</sup> Australian Law Reform Commission, *Civil Admiralty Jurisdiction* (Report 33, 1986) at para 291.

<sup>24</sup> Constituted by the Governor-General on 16 January 1975 under Part IX of the *Navigation Act 1912* (Cth) (ss355A-377A) and the *Navigation (Courts of Marine Inquiry) Regulations* (Cth).

<sup>25</sup> 2 master mariners and 2 marine engineers.

<sup>26</sup> AG Ogilvie 'Courts of Marine Inquiry in Australia' (1979) 53 *Australian Law Journal* 129 at 137

<sup>27</sup> *Ibid.*

But with respect to the learned author, that position seems to be the worst of both worlds. That is, allowing expert evidence to be admitted on the areas of expertise of the nautical assessors, together with cross-examination, would inevitably extend the sittings of the inquiry, and therefore increase costs. But the use that was made of the expert evidence by the assessors, and the advice that the assessors gave to the court, was still concealed from the parties (until perhaps the final report was handed down) and was not tested by cross-examination. In other words, the efficiency and cost advantages associated with using nautical assessors had been lost without completely addressing the procedural fairness issues associated with undisclosed advice being given to the judicial decision-maker.

Having said that, the procedural fairness issues can largely be overcome if assessors have the opportunity to put questions to witnesses directly during the hearings. By asking questions, and permitting parties to cross-examine or re-examine on issues disclosed by such questioning, there should be no surprises in the final report.

It is submitted that the advantages associated with the use of assessors in marine inquiries, in terms of cost, time and availability of technical expertise to the inquiry on an ongoing basis, are very persuasive in the context of an administrative tribunal such as a marine inquiry, where the public interest is an important factor and it is desirable to conduct the inquiry and publish the findings in an expeditious manner as possible.

However, such advantages are much less persuasive in the wider Admiralty jurisdiction, where transparency and procedural fairness considerations assume greater importance; which probably explains why the use of assessors has persisted in the marine inquiry context and fallen away in the wider Admiralty jurisdiction, at least in Australia.

Considerations of cost, time and availability of nautical expertise remain relevant to the modern safety investigation agency jurisdiction, which will be discussed at greater length later in this paper. Suffice to say for present purposes that the investigators of such agencies are ordinarily technically skilled master mariners and marine engineers (in the marine context) who have received appropriate investigation training. In many ways, such investigators fulfil the same role as their nautical assessor ancestors; they review the evidence and form nautical opinions based on the evidence, which opinions are then documented in a written report. The principal distinction appears to be the removal of legal consequence or blame from such reports and therefore the corresponding removal of legal expertise from the preparation of such reports. This point will also be developed further later in this paper.

### 3. Commonwealth Marine Inquiries

In this section, the development of marine inquiries at Commonwealth level is considered.

The provisions for marine inquiries were originally contained in part IX of the *Navigation Act 1912* (Cth). These provisions were modelled upon the *Merchant Shipping Act 1894* (UK), and like that Act, provided for an inquiry into the 'circumstances of the casualty and also into the conduct of the master, mate, engineer or pilot whose licences or certificates were at risk as the Court had power to cancel or suspend them'.<sup>28</sup>

There were a number of inquiries conducted under Part IX; perhaps most memorably, a Commonwealth Court of Marine Inquiry set in Hobart on 30 January 1975 to inquire into the collision between the SS Lake Illawarra and the Tasman Bridge in the Derwent River at Hobart in Tasmania. The bridge collapsed, and 12 people were killed when cars fell from the bridge into the river and parts of the bridge collapsed onto the ship.<sup>29</sup>

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<sup>28</sup> M White 'Marine Inquiries' (1993) 9 *Queensland University Of Technology Law Journal* 61 at 62

<sup>29</sup> see <http://search.archives.tas.gov.au/default.aspx?detail=1&type=A&id=TA00241> for the Tasmanian government archives of the Court of Marine Inquiry. See also <http://www.ccc.tas.gov.au/site/page.cfm?u=424> for a news story on the collision.

A Commonwealth Court of Marine Inquiry was constituted by at least one judge (who could be from almost any court), assisted by not less than two assessors who, by section 359 of the *Navigation Act 1912* (Cth), 'shall advise the Court but shall not adjudicate on the matter before the court'.

A Commonwealth Court of Marine Inquiry was granted the jurisdiction to make inquiries as to casualties affecting ships '...and as to charges of incompetency or misconduct, or a failure of duty in regard to any collision or in any matter relating to the navigation, management or working of the ship, on the part of masters, mates or engineers of ships...'<sup>30</sup>

Immediately it should be observed that a Commonwealth Court of Marine Inquiry had a kind of duality to its role: an inquirial responsibility to investigate the facts and circumstances of a particular marine casualty; and also a role in determining whether a mariner should be charged with 'misconduct'; defined as 'careless navigation, drunkenness, tyranny, improper conduct or, without reasonable cause or excuse, failure of duty.'<sup>31</sup>

This dual jurisdiction has inherent tension; Ogilvie summarises the issue as follows:

Inherent in the conduct of a Court of Marine Inquiry where the issue of fault arises is the coupling of the inquiry as to the general circumstances and causes of the disaster, on the one hand, with a quasi-criminal proceeding vis-a-vis the 'accused', on the other. The result is a proceeding of the type which would arise if a Coroner's Inquest was combined with a prosecution.... the difficulties which arise from combining these two processes are an inevitable result of the clash between the public interest in ascertaining the circumstances of the casualty without the fetters of strict criminal and evidentiary procedure, and the protection of any individual's rights in so far as he is at risk of punishment as a result of the findings of the Court.<sup>32</sup>

The difficulties associated with such a fused procedure were evident in *Robbie v Director of Navigation*,<sup>33</sup> an appeal to the New South Wales Supreme Court by the master of a ship whose certificate had been suspended by a Court of Marine Inquiry established under the *Navigation Act 1912* (Cth). During the course of the inquiry, at the conclusion of the evidence called by the Director of Navigation, the Court of Marine Inquiry was called upon to show cause the master why his certificate should not be suspended. After giving the master the opportunity to make submissions and to call further evidence, the Court of Marine Inquiry suspended his certificate for three months.

The master, Captain Robbie, appealed, arguing amongst other things that he did not have a full opportunity of making a defence and that he did not have a copy of a report or statement before the commencement of the inquiry; both obvious procedural fairness points.

The Court agreed. In granting the master's appeal Halse Rogers J stated:<sup>34</sup>

I am of the opinion that it was clearly the duty of the representative of the Director of Navigation at the conclusion of the evidence to put the matter in order by formulating a charge, and I think it would have been proper for the Court, in calling upon the master to show cause to intimate to him, that an adjournment would be granted to him if he so desired. In that way only does it seem to me that effect can be given to the statutory direction contained in section 369 that 'every inquiry shall be so conducted that if a charge is made against any person, that person shall have full opportunity of making a defence.'

However, it is interesting to note that the court cited, with apparent approval, *The Carlisle*,<sup>35</sup> where Sir Gorell Barnes said:<sup>36</sup>

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<sup>30</sup> Section 364 *Navigation Act 1912*.

<sup>31</sup> Section 6C *Navigation Act 1912*.

<sup>32</sup> AG Ogilvie 'Courts of Marine Inquiry in Australia' (1979) 53 *Australian Law Journal* 129 at 139.

<sup>33</sup> (1944) 44 SR (NSW) 407.

<sup>34</sup> (1944) 44 SR (NSW) 407 at 414.

<sup>35</sup> [1906] P. 301.

<sup>36</sup> [1906] P. 301 at 314, 315.

If, on the other hand, the case is a strong one, showing gross negligence and impropriety of conduct on the part of the master... I think the Board of Trade is quite justified in the discharge of its duties in saying to the magistrate it is a case of that character, and the certificate should be dealt with... it seems to me desirable in the interest of all concerned that the Board of Trade should have the power I have indicated, and that it should be exercised.

In *Robbie*, it was noted that the 'fused' procedure, combining the inquirial and disciplinary jurisdictions, was a deliberate initiative of the Commonwealth Parliament to avoid holding two courts. The previous procedure was to hold the first Court of Marine Inquiry into the facts and circumstances of the incident and then to provide a charged person with 48 hours notice before holding a second court in relation to the disciplinary matter. There was considerable objection to that, and the regulations were amended to create the combined inquiry.<sup>37</sup>

It may be inferred that the public interest associated with the efficient holding of marine inquiries, and dealing with all matters arising out of them, including a disciplinary procedure where appropriate, was thought at the time to outweigh the almost inevitable procedural fairness issues that arise for a person whose certificate was at peril in the combined inquiry.

Nevertheless, in 1979, Ogilvie concluded by suggesting 'that separation of the two aspects of the inquiry, in accordance with orthodox legal tradition, would be preferable to the present fused procedure'.<sup>38</sup>

A *Commission of Inquiry into the Maritime Industry into Australian Maritime Legislation*<sup>39</sup> came to a similar conclusion, recommending that the power to cancel or suspend certificates should be exercised by a delegate of the Minister, with the Court of Marine Inquiry's only function to be inquirial. Such recommendations were adopted in the *Navigation Amendment Act 1979*, with the repeal of section 372, which effectively removed the power for Courts of Marine Inquiry to cancel or suspend certificates.

However, as observed by Sheppard J in the *TNT Alltrans*,<sup>40</sup> the repeal of section 372 'did not make any difference to the way in which it [the Court of Marine Inquiry] should conduct an inquiry. Section 364 remains in force and empowers the court to inquire into charges of misconduct. Furthermore, it remains expressly bound to afford a person charged with misconduct the opportunity of making a defence.'

In that case, His Honour was also concerned about the form of the questions put to the inquiry for answering, which, in His Honour's words 'are designed to implicate the officers of the TNT Alltrans'.<sup>41</sup> It appears that even though the express power to suspend or cancel an officer's certificate had been removed from the court, the tension between the dual purposes of the inquiry remained.

Part IX was subsequently repealed in 1990,<sup>42</sup> and provision was made for Courts of Marine Inquiry in the *Navigation (Marine Casualty) Regulations*.<sup>43</sup> The new regulations introduced a two-step process; a preliminary inquiry conducted by an 'Inspector of Marine Accidents'; followed, where appropriate, by a Board of Marine Inquiry appointed by the Minister. The Board was constituted by a judge, who was assisted by a secretary and at least two 'technical advisers', who appear to fulfil the same role as assessors, as they were required to possess 'suitable qualifications and experience in navigation, marine engineering or other fields relevant to the investigation of the incident'.<sup>44</sup>

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<sup>37</sup> *Navigation Act 1942* (Cth) and the *Navigation (Courts of Marine Inquiry) Regulations 1943*.

<sup>38</sup> AG Ogilvie 'Courts of Marine Inquiry in Australia' (1979) 53 *Australian Law Journal* 129 at 139.

<sup>39</sup> published in June 1976 and referred to in *Re Grounding of MV 'TNT Alltrans'* 67 ALR 106 at 108.

<sup>40</sup> *Re Grounding of MV 'TNT Alltrans'* 67 ALR 106 at 111.

<sup>41</sup> *Ibid.*

<sup>42</sup> *Transport and Communications Legislation Amendment Act 1990* (Cth), section 45.

<sup>43</sup> Statutory rules 1990, number 257, made on 2 August 1990 under the *Navigation Act 1912* (Cth).

<sup>44</sup> *Ibid.*, regulation 20.



Importantly, the functions of the Board were confined to identifying the circumstances of the incident and to determine its cause.<sup>45</sup> The new regulations had no power to deal in any way with persons by way of disciplinary procedure (except by failing to comply with the directions given by the investigator or the judge or making a misleading or false statement.)<sup>46</sup> The separation of the inquirial and disciplinary jurisdictions was clear.

As White notes,<sup>47</sup> the amendments were 'more in line with modern concepts of administrative law than was the former procedure of having an inquiry into circumstances surrounding the incident combined with allegations concerning the conduct of persons concerned with it'. Such allegations were dealt with separately, by means of suspending or cancelling certificates, under the *Navigation (Orders) Regulations*, also made under the *Navigation Act 1912* (Cth).

Another important change was the introduction of confidentiality. Regulation 15 obliged the Inspector of Marine Accidents not to divulge any evidence obtained in relation to the inquiry other than to the person who provided the evidence, a subsequent Board of Inquiry appointed to investigate the incident, the secretary to such a Board, or the Minister. Further, the Board was not required to conduct hearings in public<sup>48</sup> and the ultimate report was to be provided only to the Minister,<sup>49</sup> who could release the findings at the Minister's discretion.

These amendments present a seismic shift in the way marine inquiries were to be conducted at Commonwealth level; from a publicly held inquiry combining inquirial and disciplinary objectives, marine inquiries were now solely inquirial, were not required to be held in public, and the subsequent reports were confidential and may or may not be disclosed at the Minister's discretion. It can be inferred that the principal driver for this change was an overriding drive for better marine safety outcomes (a fuller discussion of this issue follows in section 4).

Support for that proposition can also be found in the amending regulation the following year,<sup>50</sup> which amended the obligation imposed by regulation 33 to provide that a person could not refuse to answer a question or produce documentary evidence on the ground that such an answer or evidence would tend to incriminate the person.<sup>51</sup> Some protection was provided by a new regulation 33A, which provided that such incriminating answers or evidence could not be used in a criminal proceeding against the person. The explanatory memorandum to the amending regulation states that:

The amendments to the Regulations ensure that where the Regulations require a person to provide information or answer questions, then the person cannot refuse to do so solely on the grounds that it might incriminate him or herself or make him or herself subject to a penalty.<sup>52</sup>

It seems that getting the answer or evidence became more important than assigning culpability for the incident, and the coercive powers conferred on the Court of Marine Inquiry, combined with the protection against criminal action, were a significant step towards ensuring that the inquiry had all the evidence it needed to determine the cause of the incident.

However, even more change was in the air, with the establishment of the *Australian Transport Safety Bureau* in 1999.

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<sup>45</sup> *Ibid*, regulation 19.

<sup>46</sup> Statutory rules 1990, number 257, made on 2 August 1990 under the *Navigation Act 1912* (Cth), regulation 33.

<sup>47</sup> M White *Marine Inquiries* (1993) 9 *Queensland University Of Technology Law Journal* 61 at 64.

<sup>48</sup> There was no express provision requiring hearings to be held in public (c.f. s 138 TOMSA), and the Board had the power to give directions as to the admission of a person to or exclusion of a person from a sitting of the Board in regulation 22 (e), Statutory rules 1990, number 257

<sup>49</sup> Regulation 31, Statutory rules 1990, number 257.

<sup>50</sup> *Navigation (Marine Casualty) Regulations (Amendment)* 1991 No. 462.

<sup>51</sup> *Navigation (Marine Casualty) Regulations* 1990, Regulation 33 (1A).

<sup>52</sup> Explanatory Statement Statutory Rules 1991 No. 462.

## 4. Australian Transport Safety Bureau

The Australian Transport Safety Bureau (ATSB) is an operationally independent body within the Commonwealth Government. According to its literature,<sup>53</sup> the ATSB is Australia's prime agency for transport safety investigations. The ATSB is separate from transport regulators and service providers and its objective is safe transport. Its mission is to maintain and improve transport safety principally by independent investigation of transport accidents.

The ATSB has four divisions: aviation, road, rail and maritime. The ATSB presently administers the *Transport Safety Investigation Act 2003* (Cth), which covers all four transport modes, and the ATSB derives its various powers and responsibilities from that Act (more of which later).

It is useful to consider the origins of the ATSB and the transition from marine inquiries under the *Navigation Act 1912* (Cth) to safety investigations conducted under the *Transport Safety Investigation Act 2003* (Cth), whilst briefly touching on the academic literature relating to human error and 'no-blame' safety investigations.

### 4.1. Origins of the safety investigation agency

The ATSB model is not unique; the United Kingdom's Marine Accident Investigation Bureau ('MAIB')<sup>54</sup> was established in July 1989 under section 33 of the *Merchant Shipping Act 1988* (UK), and operates under the *Merchant Shipping (Accident Investigation) Regulations 1989* (UK). These include the powers to investigate accidents involving or occurring on board any United Kingdom ship worldwide, and any other ship within UK territorial waters. Its creation made possible the investigation of marine accidents independently of the Marine Directorate which is the regulatory authority for ship safety and where this work was formerly undertaken.<sup>55</sup> In other words, the separation of the formal work of the marine inquiry was now made not only independent of the disciplinary jurisdiction (where previously it had been fused), but was also now completely separated from the relevant government regulatory body.

Even further though, recent developments have seen the complete quarantine of the investigation from any other legal purpose, whether criminal, disciplinary or civil. So the United Kingdom *Merchant Shipping (Accident Reporting and Investigation) Regulations 2005* provides at Regulation 5:

The sole objective of the investigation of an accident under the Merchant Shipping (Accident Reporting and Investigation) Regulations 2005 shall be the prevention of future accidents through the ascertainment of its causes and circumstances. It shall not be the purpose of an investigation to determine liability nor, except so far as is necessary to achieve its objective, to apportion blame.

Consequently, all investigation reports published by the MAIB<sup>56</sup> contain the following preface:

This report is not written with litigation in mind and, pursuant to Regulation 13(9) of the Merchant Shipping (Accident Reporting and Investigation) Regulations 2005, shall be inadmissible in any judicial proceedings whose purpose, or one of whose purposes is to attribute or apportion liability or blame.

The ATSB now uses a similar formulation in its reports, as follows:<sup>57</sup>

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<sup>53</sup> Brochures are available for free download from <http://www.atsb.gov.au/index.aspx>.

<sup>54</sup> See <http://www.maib.gov.uk/home/index.cfm>, accessed 7 May 2008.

<sup>55</sup> Marine Accident Investigation Branch Review 1989, London, HMSO, 1990, accessed from [http://www.maib.gov.uk/cms\\_resources/annual%20report%201989.pdf](http://www.maib.gov.uk/cms_resources/annual%20report%201989.pdf) 7 May 2008.

<sup>56</sup> [http://www.maib.gov.uk/publications/investigation\\_reports.cfm](http://www.maib.gov.uk/publications/investigation_reports.cfm) accessed 8 May 2008.

<sup>57</sup> [http://www.atsb.gov.au/publications/investigation\\_reports/index.aspx?mode=mar](http://www.atsb.gov.au/publications/investigation_reports/index.aspx?mode=mar) accessed 22 May 2008.

The ATSB performs its functions in accordance with the provisions of the Transport Safety Investigation Act 2003 and, where applicable, relevant international agreements. ATSB investigations are independent of regulatory, operator or other external bodies. It is not the objective of an investigation to determine blame or liability. However, an investigation report must include factual material of sufficient weight to support the analysis and findings. At all times the ATSB endeavours to balance the use of material that could imply adverse comment with the need to properly explain what happened, and why, in a fair and unbiased manner.

Initially, the Commonwealth's *Navigation (Marine Casualty) Regulations 1990*<sup>58</sup> did not go so far as to separate the Inspector of Marine Accidents from the regulatory authority; but there were confidentiality obligations that prevented the Inspector from disclosing evidence 'to any person' other than the persons prescribed, including a Board of Inquiry. Notwithstanding these minor differences, the Australian reforms can be directly linked to these initiatives in the United Kingdom.

## 4.2. Human Error Theory

The change in focus in casualty investigation and the conduct of inquiries into marine incidents can also be linked to the significant academic work on human factor relationships in the causes of accidents, particularly in aviation, such as the influential work of Professor James Reason.<sup>59</sup>

The principal thesis of Professor Reason's work has been described as the 'Swiss cheese model' of accident causation. That is, most accidents can be traced to one or more of four levels of failure: organizational influences, unsafe supervision, preconditions for unsafe acts, and the unsafe acts themselves. In the 'Swiss Cheese' model, an organization's defences against failure are modelled as a series of barriers, represented as slices of Swiss cheese. The holes in the cheese slices represent individual weaknesses in individual parts of the system, and are continually varying in size and position in all slices. The system produces failures when all of the holes in each of the slices momentarily align, so that a hazard passes through all of the holes in all of the defences, leading to a failure. The failures can be both active and latent, in that the direct failure maybe an active human error, but a contributory factor may be a latent error in the system that could have been present for some time.

One of the criticisms made against 'traditional' investigation techniques, including marine inquiries, are that such investigations and inquiries are predicated on a 'blame culture'. Blame culture is concerned with attributing blame to participants, and the supporting legal framework supports this adversarial approach; but the legal framework also provides corresponding protections, such as a requirement for procedural fairness and the privilege against self-incrimination. This focus on blame, it is said, results in a concentration of attention on active failures that caused the incident, usually the negligence or recklessness of participants, and provides insufficient attention to latent or system failures which may, in some circumstances, be of even greater importance. If such system failures are not detected, or if detected are not effectively remedied, then incidents may recur without the underlying causes having been remedied.

The aviation industry in particular were quick to realise the potential of this work, resulting in the development of a 'Human Factors Analysis and Classification System' for investigating aviation accidents.<sup>60</sup>

Parallel to this work on human error, Reason also hypothesised that in order to improve safety, an organisation needed to have a 'safety culture' (as distinct from a blame culture) to ensure reporting of human error and organisational failures.<sup>61</sup> Such a safety culture is evidenced by monitoring and

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<sup>58</sup> Statutory Rules 1990 number 257.

<sup>59</sup> In monographs such as Reason J *'Human Error'* Cambridge University Press; 1 edition (October 26, 1990) and Reason J *'Managing the Risks of Organisational Accidents'* Ashgate Publishing; 1 edition (December 1, 1997).

<sup>60</sup> In the American context, see [http://www.nifc.gov/safety/reports/humanfactors\\_class&anly.pdf](http://www.nifc.gov/safety/reports/humanfactors_class&anly.pdf) accessed 7 May 2008.

<sup>61</sup> Reason J (1998) *Achieving a safe culture: theory and practice Work and Stress*, 12, 293 - 306.

review of organizational safety systems, including awareness of the numerous factors that have an impact on such safety systems, such as human, technical, organizational, and environmental factors.

These academic developments had a profound affect on incident investigation. Where previously investigators were looking for direct proximate causes of marine casualties, usually with an eye on culpability of the participants, investigators were now actively looking for secondary causes, including latent organisational, managerial, systemic and cultural failures.<sup>62</sup>

#### 4.3. Legal reform of Commonwealth marine inquiries

As we have seen, this shift in investigation focus away from the culpability of the human participants towards a more holistic approach to human error, safety culture and causation of accidents resulted in a shift in the legal apparatus in which such investigations and inquiries were conducted. In Australia, this legal reform started with the separation of the inquirial and disciplinary jurisdictions with the *Navigation (Marine Casualty) Regulations 1990*. It should be recalled that these Regulations had important confidentiality obligations; neither the evidence gathering nor any hearings need be conducted in public; and the subsequent report need only be disclosed as a matter of discretion. The relationship between a marine inquiry conducted under the Regulations and the concept of a marine inquiry as defined at the beginning of this paper was becoming increasingly remote.

The 1991 amendment to the Regulations, which abrogated the privilege against self-incrimination whilst preventing the use of any such evidence being used in a prosecution, put further distance between the 2 kinds of inquiry.

Up until the full commencement of the *Transport Safety Investigation Act 2003* (Cth) in July 2003, the ATSB in its maritime jurisdiction continued to rely upon the *Navigation (Marine Casualty) Regulations 1990* made under the *Navigation Act 1912* (Cth) as amended from time to time.

#### 4.4. Confidentiality

It appears that the confidentiality provisions, when combined with the abrogation of the privilege against self-incrimination, were intended to facilitate the holistic human error approach to accident investigation by encouraging participants to engage fully and frankly with investigators without any fear of criminal punishment or other consequences, such as civil liability for admissions of negligence. It is thought that by quarantining such evidence from being disclosed and therefore used for any other purpose, then witnesses and participants will more readily divulge possibly incriminating matters when being interviewed by the then Inspector of Marine Accidents.

However, this intention was not necessarily supported by the courts. In the *Sanko Steamship Company Limited v Sumitomo Australia Limited*,<sup>63</sup> in a case concerning limitation of liability relating to the grounding of the ship 'Sanko Harvest' near Esperance in Western Australia on 14 February 1991, the preliminary issue arose whether the interviews conducted with the officers of the ship obtained by the then Inspector of Marine Accidents under the *Navigation (Marine Casualty) Regulations 1990* could be inspected by the parties.

The evidence before the court was that Captain Filor [the Inspector] explained to the Master of the ship that the inquiry was a confidential one and 'that he [the Master] should feel relaxed about talking to him because of the confidentiality of it.'<sup>64</sup>

It should be recalled that regulation 15 of the Regulations at that time prevented an investigator from divulging a record of evidence obtained to 'any person' other than the person who provided the evidence, a board of inquiry, the secretary to a board of inquiry or the Minister.

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<sup>62</sup> See for example Cullen WD 1990 *The Public Inquiry into the Piper Alpha Disaster*. HMSO, London.

<sup>63</sup> (1992) 37 FCR 353.

<sup>64</sup> (1992) 37 FCR 353 at [14].

In deciding that regulation 15 did not impair the courts' ordinary powers to compel the production of documents in a civil case which is to be heard by it, Sheppard J. concluded that 'it would seem that there is a clear preponderance of authority for the view that the words 'to any person' do not apply to a court'<sup>65</sup> and that further:

Despite the reasons which there are for the presence of regulation 15 in the regulations, the regulations relating to investigations by the Inspector and investigators and the provisions of the regulations relating to marine inquiries show that disclosures made by persons interviewed in the course of an investigation may become public. The very procedure which is set in train may well lead to that occurring. No person interviewed can therefore safely assume that what he or she says will not or may not eventually become public.<sup>66</sup>

This conclusion, and the subsequent disclosure of the evidence obtained by the Inspector to the parties in the civil litigation, led to further amendment of the Regulations, and in particular regulation 15, in 2001.<sup>67</sup> Specifically, regulation 15 was amended to implement the *Code for the Investigation of Marine Casualties and Incidents* adopted by the assembly of the International Maritime Organisation on 27 November 1997 (the 'Code'), which Code was set out in schedule 1 to the then Regulations.

The objective of the Code, expressed in article 2, is to:

...prevent similar casualties in the future. Investigations identify the circumstances of the casualty under investigation and establish the causes and contributing factors, by gathering and analysing information and drawing conclusions. Ideally, it is not the purpose of such investigations to determine liability, or apportion blame.

The influence of the human error and safety systems approach to incident investigation pioneered by Professor Reason, amongst others, is clear. The concept of an investigation for safety purposes as distinct from determining liability or apportioning blame is also made express. It appears that there is an inherent link between an investigation for a safety purpose and ensuring that the investigation is not used for other purposes that carry liability or blame consequences; it is suggested that one element of this link lies in the belief that participants in a casualty or incident will not fully cooperate with investigators unless the evidence they provide is quarantined from legal consequence; that is, made confidential.

In order to give effect to this 'quarantining of evidence', article 10 of the Code relevantly provides:

The State... should not make the following records, obtained during the conduct of the investigation, available for purposes other than casualty investigation, unless... their disclosure outweighs any possible adverse domestic and international impact on that or any future investigation.

This disclosure test was incorporated into the Regulations at subregulation 15(5), which provided that a court may order or authorise the disclosure of information 'to any person' only if the public benefit outweighs the possible effect on the investigation itself or future investigations, and the disclosure is permitted by the parties.<sup>68</sup>

This apparent restriction on the court's power to compel disclosure of documents was considered shortly afterwards by Tamberlin J in *Craig the Pioneer*.<sup>69</sup> A marine safety investigation was conducted by the ATSB into a collision between a prawn trawler 'May Belle II' and the woodchip carrier 'Craig the Pioneer' that occurred near Newcastle New South Wales on 9 October 1999. In the resulting civil claim for damages brought by the owners of the trawler against the various interests in the woodchip carrier, a subpoena was issued to the ATSB to produce documents relating to the investigation. The amended regulation 15 of the Regulations was relied upon by the ATSB to claim privilege for some of the documents; in particular, the records of interview conducted by the

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<sup>65</sup> *Ibid* [22].

<sup>66</sup> *Ibid* [27].

<sup>67</sup> *Navigation (Marine Casualty) Regulations* 2001 (No 1) Statutory Rules 2001 No 16.

<sup>68</sup> Specified in paragraph 15(5)(b) *Navigation (Marine Casualty) Regulations* 1990.

<sup>69</sup> *Christoforidis v Cygnet Bulk Carriers SA* [2002] FCA 690.

investigator with the ship's crew and some other records taken from *Craig the Pioneer* during the investigation.

The court rejected the ATSB's claim for privilege, relying on similar reasoning to that in the *Sanko Harvest*; specifically, that the production of documents on a subpoena to a court is not an 'order' or 'authorisation' of the disclosure of information by any person within the meaning of regulation 15(4).<sup>70</sup> Tamberlin J stated at paragraph 21 that:

again, the use of the expression 'person' in these provisions does not include the court and therefore these provisions do not apply... this language simply does not fit with the way in which courts deal with the production of documents produced on subpoena.

His Honour went on to be critical of the ATSB's submissions relating to the public benefit test encapsulated in regulation 15(5), which requires a balancing of the public benefit in the disclosure of information against any possible effect on the investigation to which the information relates, saying:<sup>71</sup>

I am not persuaded from the generalised and speculative material presented by the ATSB, including the matters referred to in the evidence of Mr Alan Stray, that if the material were made available under a strict confidentiality regime there would be any significant detrimental effect which would restrict the availability of information in the future to the extent that this consideration would outweigh the powerful public interest in the Court having full and sufficient information. The Court should not lightly be constrained from performing its functions in the light of full access to all relevant material. If, however, there were clear and express provisions which precluded the court from adopting such an approach, then effect must be given to such provisions. But that is not the present case. If the Legislature had intended to apply regulation 15 to court proceedings, such as the present, it would have been a simple matter to make that clear. In my opinion, the Legislature has not done so.

This is the central policy issue in the safety investigation model, that is, the contest between the public policy in resolving disputes and ascribing legal responsibility in an efficient and fair way by ensuring the availability of relevant evidence; as against the public policy, as expressed in article 10 of the Code and regulation 15 of the Regulations, about keeping evidence confidential in the belief that granting such confidentiality will encourage full and frank disclosure during the investigation process, and therefore lead to improved safety outcomes. It is clear that the court in *Craig the Pioneer* was not convinced that the latter public policy was adequately supported by the evidence available when describing the material presented by the ATSB supporting that position as 'generalised' and 'speculative'.

Nevertheless, the Legislature considered that ensuring that the evidence provided to ATSB investigators should be confidential was the more important public policy and subsequently amended section 15 of the *Navigation (Marine Casualty) Regulations 1990*.<sup>72</sup> The explanatory memorandum<sup>73</sup> states that the amendment was necessary:

... in view of the inconsistent interpretation of this provision by courts in the past. In particular, Tamberlin J's interpretation of sub regulation 15(1) in *Christoforidis v Cygnet Bulk Carriers SA* [2002] FCA 690 **could have had an adverse impact on the future free-flow of safety information to the ATSB** if the provisions were not going to be applied to information required to be produced to a Court. The amendment clarifies that the confidentiality provisions are applicable to the production of documents to a Court, so as to ensure information collected by the ATSB will not be used for the purposes of **blame apportioning court proceedings** except in accordance with the regime set out under sub regulation 15(3) to 15(8) [which refer to the public benefit test described above] [emphasis added].

The net effect of the amendments was to ensure that the confidentiality obligations contained in regulation 15 expressly applied to the production of evidence to a Court as well as to any person. As stated in the explanatory memorandum, the amendment 'better reflects the ATSB's intent to protect

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<sup>70</sup> 'A person may apply to a Court for an order authorising a person to disclose information that is held by the person and to which sub regulation (1) applies'.

<sup>71</sup> *Christoforidis v Cygnet Bulk Carriers SA* [2002] FCA 690 at paragraph 36.

<sup>72</sup> *Navigation (Marine Casualty) Amendments Regulations 2002* (No 1) Statutory Rules 2002 No 199.

<sup>73</sup> Explanatory Statement Statutory Rules 2002 No. 199.

information that is required to be kept confidential, in order to ensure the future free-flow of safety information to the ATSB for the purposes of no-blame safety investigations.'

The evolution of the Court of Marine Inquiry into the 'no-blame safety investigation agency' was almost complete. The Commonwealth provisions had evolved from the traditional Court of Marine Inquiry; constituted by a judge sitting with and advised by nautical assessors; with hearings conducted in public; and having a fused inquirial and disciplinary jurisdiction; to a 'no-blame' safety investigation conducted entirely by trained nautical investigators; with no hearings; with the privilege against self-incrimination expressly abrogated; and with the evidence obtained effectively quarantined from any other legal purpose, whether disciplinary, criminal, civil or otherwise, subject to a public benefit test.

This evolution would shortly reach its current form in the *Transport Safety Investigation Act 2003* (Cth), which brought together similar no blame safety investigation powers and confidentiality provisions across the four major transport modes: aviation, road, rail and maritime.

However, before considering the *Transport Safety Investigation Act 2003* (Cth) in more detail, it is worth reflecting upon Tamberlin J.'s criticisms of the ATSB's concerns about the release of the documents as 'generalised' and 'speculative'. The explanatory statement to the 2002 amending regulation stated that Tamberlin J.'s decision 'could have had an adverse impact on the free flow of information to the ATSB'. It seems reasonable to infer from the language used that the amendment to the Regulation was made before any such adverse impact was observed or measured. It is submitted that the tenor of both of these statements is that there is no evidence, or at least no convincing evidence, that disclosure of material gathered by an ATSB investigation to a Court, as occurred in *Sanko Harvest* and *Craig the Pioneer*, had any subsequent effect on the 'free flow of information to the ATSB'. Whilst the difficulties associated with quantifying any such impact are recognised, the author is not aware of any attempt to do so.

Further, given the wide powers granted to the ATSB by the then *Navigation (Marine Casualty) Rules 1990* and the current *Transport Safety Investigation Act 2003* (Cth), it is difficult to see how such a 'free-flow' would be restricted by the contingent release of some evidence, subject to appropriate orders concerning confidentiality as envisaged by Tamberlin J, for specific purposes, generally years after the event. For example, in the *Sanko Harvest*, the initial application concerning the use of the evidence was 18 months after the event, and the litigation was not ultimately concluded until 4 years later; it is suggested such time frames are fairly typical of major litigation.

It is also worth remembering that the only evidence where the 'flow' could be 'obstructed' in this sense are admissions of fault by responsible persons; such persons, in a maritime context, are often foreign, for whom English is a second language and who come from varied cultural backgrounds and from differing legal systems. It is arguable that such persons may still not fully cooperate with a 'no-blame' investigation process, even when fully explained, due to a natural reticence to make admissions to government officials investigating an incident in a foreign country. Indeed, part of the problem may be that 'full cooperation' is difficult to measure, and that apparently cooperative witnesses may fail to fully disclose information without the failure ever being discovered.

The ATSB has the power to compel answers; it is an offence provision of strict liability.<sup>74</sup> However, the vast majority of the evidence of any marine casualty, including the majority of the evidence provided by responsible persons, is objective, is obtainable by traditional enforcement powers without relying upon abrogating the privilege against self-incrimination; and could, it is submitted, be used in 'blame-apportioning proceedings' without having any affect on the 'free-flow' of information to the ATSB.

In other words, in the quest for obtaining admissions from participants that may (or may not) inform a safety investigation, the whole of the evidence obtained by the ATSB has been quarantined from any other use. In the author's opinion, this is a disproportionate response to the issue of obtaining full admissions, and can, in some circumstances, lead to the safety investigation actually hindering the

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<sup>74</sup> *Transport Safety Investigation Act 2003* (Cth) section 32.

desired safety outcome [see later discussion on quarantining of VDR in the *Endeavour River* investigation in the next section].

Quarantining the evidence, and the use of the report for any other purpose, is also unnecessary to ensure that the investigation has a no-blame safety focus. In the author's view, such a focus is principally a matter of construction and interpretation of the evidence, rather than any relationship with the confidential status of the evidence itself. An illustration of this point is the *ANL Excellence* grounding, considered in more detail in section 6.

## 5. Transport Safety Investigation Act

The *Navigation (Marine Casualty) Regulations* were repealed<sup>75</sup> on the commencement of the *Transport Safety Investigation Act 2003* (Cth) in July 2003.

The essential characteristics of the Act, insofar as it relates to maritime casualties, are as follows:

- the object of the Act is to improve safety by:
  - requiring the reporting of accidents;
  - providing for independent investigations;
  - allowing for the making of statements and recommendations arising from the independent investigations; and
  - permitting the publication of investigation reports.<sup>76</sup>
- the Act applies to accidents in which death or serious injury to a person, or damage to a ship or property, occurs that is associated with the operation of the ship;<sup>77</sup>
- the constitutional limitations of the Commonwealth Parliament are recognised by limiting the application of the Act to the safety of ships and marine navigation which have an international, interstate or other constitutional nexus, such as the trade and commerce power;<sup>78</sup>
- the position of 'Executive Director of Transport Safety Investigation' is created,<sup>79</sup> and the independence of that position from ministerial direction is provided for;<sup>80</sup>
- investigation reports must be published as soon as practicable and may include submissions made by persons in response to a draft report, thereby permitting a form of procedural fairness;<sup>81</sup>
- if a draft report is provided to a person, then the person may not copy the draft report or disclose the draft report to any other person or to a Court (both the copying and disclosure is an offence, with the disclosure offence carrying a maximum penalty of two years imprisonment);<sup>82</sup>
- neither the draft report nor the final report is admissible in evidence in any civil or criminal proceedings, other than a coronial inquiry;<sup>83</sup>

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<sup>75</sup> *Navigation (Marine Casualty) Repeal Regulations* 2003 Statutory Rules 2003 No 157.

<sup>76</sup> *Transport Safety Investigation Act* 2003 (Cth) section 7.

<sup>77</sup> *Transport Safety Investigation Act* 2003 (Cth) section 3.

<sup>78</sup> *Transport Safety Investigation Act* 2003 (Cth) section 11 (2).

<sup>79</sup> *Transport Safety Investigation Act* 2003 (Cth) section 12.

<sup>80</sup> *Transport Safety Investigation Act* 2003 (Cth) section 15.

<sup>81</sup> *Transport Safety Investigation Act* 2003 (Cth) section 25.

<sup>82</sup> *Transport Safety Investigation Act* 2003 (Cth) section 26.

<sup>83</sup> *Transport Safety Investigation Act* 2003 (Cth) section 27.



- the Executive Director (and delegated investigators) is granted a wide variety of powers, including the power to require a person to attend and answer questions,<sup>84</sup> enter 'special' premises (generally accident sites and ships) without consent or warrant,<sup>85</sup> to search for, record, copy, operate, secure, remove (with consent or warrant) evidential material,<sup>86</sup> and to stop and detain ships;<sup>87</sup>
- self-incrimination is not an excuse for a person to refuse to answer a question or fail to produce evidential material; but for an individual, protection is provided in that the answer or the material is not admissible in evidence in any civil or criminal proceedings against the individual. It may be concluded that admissions may be compelled from a corporation by use of this provision, and such admissions may subsequently be used against the corporation in civil or criminal proceedings, subject to the restrictions on the release of such evidence under Part 6 Division 2;<sup>88</sup>
- it is an offence, carrying a maximum penalty of two years imprisonment, to copy or disclose on-board recordings<sup>89</sup> (known on ships as voyage data recorders or VDR's<sup>90</sup>), unless the Executive Director allows the on-board recordings to be disclosed<sup>91</sup> or released;<sup>92</sup>
- on board recordings cannot be used for disciplinary action against employees,<sup>93</sup> are inadmissible in criminal proceedings against crew members of ships<sup>94</sup> and are not admissible in civil proceedings unless the Executive Director discloses the information and the Court makes a public interest order;<sup>95</sup> and
- restricted information, which principally comprises the evidence gathered during an investigation, cannot be disclosed unless certified by the Executive Director; disclosure to courts is subject to a public interest test, taking into account domestic and international impact on current or future investigations.<sup>96</sup>

The net effect is quite similar to the preceding *Navigation (Marine Casualty) Regulations 1990*, but with consistency across transport modes, and with specific provisions concerning on-board recordings.

### 5.1. On-board recordings

On-board recordings or VDRs are extremely important for fairly obvious reasons. Similar to the 'black box' in aviation, VDRs capture a range of data from various instruments on board the ship, together with recordings of what was said by the ship's crew members at the critical time. Consequently, the VDR information enables an investigator to almost completely reconstruct a sequence of events

<sup>84</sup> *Transport Safety Investigation Act 2003* (Cth) section 32.

<sup>85</sup> *Transport Safety Investigation Act 2003* (Cth) section 33.

<sup>86</sup> *Transport Safety Investigation Act 2003* (Cth) section 36.

<sup>87</sup> *Transport Safety Investigation Act 2003* (Cth) section 39.

<sup>88</sup> *Transport Safety Investigation Act 2003* (Cth) section 47.

<sup>89</sup> *Transport Safety Investigation Act 2003* (Cth) section 53.

<sup>90</sup> VDRs are required on ships by the International Convention for the Safety of Life at Sea 1974 (SOLAS) at chapter V, as follows: Under regulation 20 of SOLAS chapter V on Voyage data recorders (VDR), the following ships are required to carry VDRs:

- passenger ships constructed on or after 1 July 2002;
- ro-ro passenger ships constructed before 1 July 2002 not later than the first survey on or after 1 July 2002;
- passenger ships other than ro-ro passenger ships constructed before 1 July 2002 not later than 1 January 2004; and
- ships, other than passenger ships, of 3,000 gross tonnage and upwards constructed on or after 1 July 2002.

<sup>91</sup> *Transport Safety Investigation Act 2003* (Cth) section 50.

<sup>92</sup> *Transport Safety Investigation Act 2003* (Cth) section 51.

<sup>93</sup> *Transport Safety Investigation Act 2003* (Cth) section 54.

<sup>94</sup> *Transport Safety Investigation Act 2003* (Cth) section 55.

<sup>95</sup> *Transport Safety Investigation Act 2003* (Cth) section 56.

<sup>96</sup> *Transport Safety Investigation Act 2003* (Cth) section 60.

leading up to an incident with information such as position, speed, course, engine and helm movements, as well as what was said and perhaps done by the crew in relation to all of these things.

It is hard to imagine better evidence in relation to an incident involving a ship than the evidence contained in the VDR. Therefore, VDR information assumes a critical importance to the safety investigator, but also to other parties concerned in the incident, such as the relevant regulatory agency, the owner of the ship and other interests such as cargo owners and charterers, as well as the crew members themselves.

The provisions relating to on-board recordings in the *Transport Safety Investigation Act 2003* therefore also assume critical importance. As may be seen from the brief summary above, access to such recordings has been heavily restricted, and the uses to which the recordings can be put has also been effectively confined to safety investigation only.

It is suggested that the underlying basis for these restrictions on the use of onboard recordings lies in the International Maritime Organisation guidelines on VDR recordings, which relevantly state that:

Any disclosure of VDR information should be in accordance with section 10 of the Code for the Investigation of Marine Casualties and Incidents.<sup>97</sup>

It will be recalled that section 10 of the Code required that any records obtained during an investigation, including on-board recordings, should not be available for purposes other than the investigation (such as civil, disciplinary, or criminal purposes) unless the disclosure outweighed any impact on the current or any future investigation. However, the provisions concerning on-board recordings in the *Transport Safety Investigation Act 2003* appear to go further than the Code requires.

As noted above, section 50 of the Act provides that the Executive Director may issue a certificate in relation to on-board recordings stating that the disclosure of the information is not likely to interfere with any investigation. However, such a certificate can only be used for the admissibility of on-board recordings in civil proceedings; it cannot be used in criminal proceedings at all. This clearly exceeds the protection required by the Code.

Even in respect of civil proceedings, the issue of a certificate by the Executive Director is not enough on its own to obtain admissibility of on-board recordings. The court must also make an order in relation to the public interest in relation to the admission of the on-board recordings, having to be satisfied that:

- a material question of fact will not be able to be properly determined from other evidence available; and
- the on-board recording information will assist in the determination of the question of fact; and
- any adverse domestic and international impact that the disclosure of the information might have on any current or future investigations is outweighed by the public interest in the administration of justice.

It is submitted that this two-step process, requiring both the Executive Director and the court to decide that any investigations will not be interfered with by the disclosure of information, together with the additional hurdle involved with requiring that no other cogent evidence is available on the material point, is excessive in all the circumstances and certainly exceeds the requirements of the Code.

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<sup>97</sup> The International Maritime Organisation Circular: *Guidelines on Voyage Data Recorder (VDR) Ownership and Recovery* Ref. T1/2.02 MSC/Circ.1024 29 May 2002; [http://www.imo.org/includes/blastDataOnly.asp/data\\_id%3D5628/1024.pdf](http://www.imo.org/includes/blastDataOnly.asp/data_id%3D5628/1024.pdf) accessed 8 May 2008.

Further, asking the court to decide whether current or future investigations are not going to be affected by the disclosure calls in to play the same ‘generalised’ and ‘speculative’ evidence to be considered by the court that was criticised by Tamberlin J in the *Craig the Pioneer*<sup>98</sup>, especially when the Executive Director, who must be in a much better position to decide whether any future investigations are going to be affected, has already issued a certificate stating that investigations will not be affected. The test is necessarily speculative in the sense that the court is required to predict what effect the disclosure will have, if any, on an investigation into an incident that has yet to occur. It also begs the question whether a court should only take into consideration the issue of the certificate by the Executive Director in deciding whether there is any ‘adverse domestic and international impact...on any current or future investigation’<sup>99</sup> or whether further evidence is required, and what that further evidence might be.

Such restrictions cannot be justified by reference to the previously described ‘could have had an adverse impact on the free flow of information to the ATSB’<sup>100</sup> argument. On board recordings are automatically generated on a continuous basis and cannot be tampered with. It is spurious to suggest that crew members are going to change their behaviour in case they have an accident and in case such recordings might be used for other purposes than a safety investigation. This is a double contingency beyond the realms of probability when considering the ordinary performance of operational tasks on the bridge of a ship. Given the ATSB has ample powers to seize such recordings and secure them, the restriction of the subsequent use of such recordings is not necessary in order to ensure that the recordings are available for a safety investigation or for any other purpose.

Indeed, in the author's experience, the quarantining of such vital evidence can actually be detrimental to the overall safety outcome. For example, during the investigation into the grounding of the *Endeavour River* in Gladstone Harbour in December 2007, there were three concurrent investigations: a safety investigation by the ATSB; a regulatory investigation conducted by Maritime Safety Queensland; and an investigation by the owner of the ship for their own safety purposes. The ATSB, exercising their powers under Part 6 of the *Transport Safety Investigation Act 2003* (Cth), denied access to the on-board recordings to the owners of the ship and to Maritime Safety Queensland until some months after the event.

The owner of the ship was concerned about the causation of the incident, because it has ships berthing at the facility in Gladstone Harbour on a very frequent basis, and denial of the VDR recordings for months effectively delayed the owner from putting in place its own remedies to the incident for some time.

Maritime Safety Queensland is responsible for the safe movement of ships in the port, including interactions between shipping movements, administers a vessel traffic advisory service with the key role of ensuring the safety of shipping movements in the port, and also exempted the master from the requirement to carry a pilot. The denial of the on-board recordings during MSQ's investigation and response period effectively handicapped Maritime Safety Queensland from fulfilling its safety responsibilities. As the safety agency responsible for the regulation of a crucial export port, the investigation and implementation of effective countermeasures needs to be done as soon as practicable. MSQ does not have the luxury of waiting for more than six months to obtain the ATSB's report before taking effective action to improve safety.<sup>101</sup>

[Since this article was submitted for publication, the ATSB Report on the *Endeavour River* has been published (August 2008). Comments in relation to the ATSB Report are made at the end of this paper.]

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<sup>98</sup> *Christoforidis v Cygnet Bulk Carriers SA* [2002] FCA 690.

<sup>99</sup> *Transport Safety Investigation Act 2003* (Cth) section 56 (3)(iii).

<sup>100</sup> Explanatory Statement to the *Navigation (Marine Casualty) Amendment Regulation 2002* (No 1) 2002 Statutory Rules number 199, page 2

<sup>101</sup> At the time of writing, the ATSB report was not available; see [http://www.atsb.gov.au/publications/investigation\\_reports/2007/MAIR/mair248.aspx](http://www.atsb.gov.au/publications/investigation_reports/2007/MAIR/mair248.aspx) accessed 16 May 2008.

Similar restrictions on access to VDR data do not appear to be the norm in other maritime jurisdictions. For example, JohanWong, a maritime law practitioner from Singapore,<sup>102</sup> notes that:

With the evidence from devices such as AIS, VDR and ECDIS now more commonly available on board ships, it is easier to establish what happened more quickly and far more accurately. This means parties will have fewer disputes relating to the facts and are able to focus instead on the issues of liability and quantum. The net result is collision matters are now concluded within a much shorter period of time, which is good news for shipowners and underwriters but not so for lawyers!

It may be inferred that the legislators in Singapore take a more robust view of Article 10 of the Code in determining what kind of use of the VDR information might affect future safety investigations. Perhaps there is also more emphasis on the public interest involved in the efficient resolution of disputes arising out of maritime casualties, permitting the use of VDR information in civil litigation more readily. There is no suggestion that marine safety investigation in Singapore is adversely affected by this use of VDR data.

In sum, it is submitted that the restrictions on the use and availability of VDR exceeds both the international guidelines and what is reasonably necessary to ensure that there is no impact upon current or future safety investigations. Further, given the powerful public interest considerations in ensuring that all other matters arising from the incident, such as criminal and civil proceedings, are resolved as effectively and efficiently as possible, it is unnecessarily obstructive to prevent the best evidence relating to the incident, comprising the VDR data, from being used at all (in relation to criminal proceedings against crew members) or its use being heavily restricted (in relation to civil proceedings).

Finally, it is submitted that preventing VDR data from being used by other responsible persons who have an interest in the incident can, in some circumstances, be detrimental to the overall safety outcome.

## 6. ANL Excellence

In the author's experience, if there is any distinction between the evidence gathered using the 'free-flow of information' to the ATSB based upon the confidentiality incentive, compared with the use of more traditional investigative powers and techniques, then the difference may be indistinguishable in the key findings of the final reports. Of course it is not possible to directly compare the evidence because of the restrictions placed on the release of evidence gathered by the ATSB under the then *Navigation (Marine Casualty) Regulations 1990* (Cth) and the current provisions of the *Transport Safety Investigation 2003* (Cth).

The author has access to only one investigation that is directly comparable; the grounding of the *ANL Excellence* in Moreton Bay on 19 July 2002 at 0318 hours. The incident was investigated by both Maritime Safety Queensland<sup>103</sup> and the ATSB<sup>104</sup>. The essential findings of fact are virtually identical; what changes is the interpretation of those facts by the relevant investigators, which reflect their respective organisational prejudices.

The facts can be shortly stated, as follows:

- the ship had a foreign crew and was under the conduct of a Queensland marine pilot;
- the pilot ordered an alteration of course to starboard during the inbound voyage to the Port of Brisbane;
- the order was acted upon by the ship's crew;

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<sup>102</sup> Wong J *Collision Investigations – The New Technologies And Other Interesting Bits*, Delivered to Maritime Law Association of Australia and New Zealand 34<sup>th</sup> Annual Conference, Canberra, 2007.

<sup>103</sup> Maritime Safety Queensland departmental file.

<sup>104</sup> Independent Investigation into the Grounding of the Liberian Registered Containership *ANL Excellence*, Marine Safety Investigation Report Number 181, available from [http://www.atsb.gov.au/publications/investigation\\_reports/2002/MAIR/mair181.aspx](http://www.atsb.gov.au/publications/investigation_reports/2002/MAIR/mair181.aspx) accessed 13 May 2008.

- the order was given too early, with the result that the ship left the marked channel and grounded in Moreton Bay;
- before giving the order, the pilot did not verify his visual perception of the ship's position by using his navigation computer or by any other means; and
- the ship's crew did not detect or correct the pilot's error in time to prevent the grounding.

Notwithstanding the commonality of key facts, the description of the incident in the ATSB and MSQ reports are quite different, as follows<sup>105</sup>:

**Table 1 – description of the ANL Excellence grounding incident**

ATSB Report	MSQ Report
<p>As the vessel passed starboard lateral beacon E3, the pilot ordered starboard rudder to bring the ship to a heading of 240° and then called Brisbane Port Control to advise that the ship would be at the entrance channel at 0600.</p> <p>The master, sitting in front of one of the two radars, realised that the relative bearings of Beacons E4 and E2 were changing and went to the helmsman to see what was happening. The pilot went to his electronic chart system, which had reverted to a blank screen stand-by mode. He tapped a key and when the chart was restored he suddenly realised that he had ordered the course alteration too soon.</p> <p>The main engines were stopped and put astern, but the ANL Excellence grounded before the ship had begun to slow.</p>	<p>At 0525, [the Pilot] ordered an alteration of course to starboard, believing that Beacon E3 was Buoy E5. Simultaneously, whilst making the alteration, [the Pilot] was communicating his ETA [estimated time of arrival] to the Entrance Beacons with Brisbane Port Control.</p> <p>Shortly after the alteration the ship grounded on Middle Banks, Moreton Bay between E3 and E5 navigation aids (the 'Grounding'). The time of the Grounding was approximately between 0527 and 0530. [The Pilot] reported the Grounding to Brisbane Port Control at 0539 hours.</p>

A difference in focus by each investigator in describing the incident is apparent; yet of even greater interest is the conclusions drawn from these facts. The following table summarises the relevant conclusions of each report:

**Table 2 – ANL Excellence report conclusions**

ATSB Report	MSQ Report
The pilot did not follow his normal procedure of checking the position of the course alteration using his portable electronic chart system	The pilot lost situational awareness because he did not use all the equipment on the bridge. He did not check his position visually.
The temporary buoy marking the original position of the original east cardinal beacon E5 (the turning mark) was obscured by rain.	There did not appear to be any attempt by the pilot to check the navigation aids visually...The wipers on the bridge windows were functional and operating and were only used occasionally.
The green light on the temporary buoy was not as conspicuous as a white light, which would normally be associated with a cardinal navigation mark.	The pilot assumed beacon E3 was beacon E5, and failed to check that assumption. The pilot had rounded the [temporary] E5 at night in at least 12 inward ships and 17 outward ships since E5 was

<sup>105</sup> *Ibid*, p 1.

	changed to a buoy...and a further 34 ships around E5 by day.
Although not suffering from chronic fatigue, the pilot's performance was probably affected by the trough in his circadian rhythm associated with the hours between 0400 and 0600	In my [the investigator's] opinion, the pilot did not have sufficient rest and did not manage his rest period properly.
The pilot's electronic chart system was placed at a significant distance from where he was standing, with its display in power saving mode at a critical moment.	The Pilot spent the majority of his time on the starboard side of the wheelhouse and behind the console. The Pilot seems to have been using his laptop almost exclusively to navigate...The Pilot did not use other equipment available in the wheelhouse.
The bridge team did not detect the erroneous helm order and failed to challenge the pilot.	...there was very little communication or exchange of information between the pilot, the master and the remainder of the bridge team. The role of the bridge team was ill-defined and bridge resource management was poor...the mate who plotted and recorded the times of passing the various nav aids recorded passing E3 at 0525 but did not challenge the early alteration of course and did not alert the master.

An additional factor which does not appear in the ATSB report, but is commented upon in the MSQ report, was that 'the master stated that the pilot was very talkative and perhaps this was a factor for him losing concentration'.

The essential difference in the conclusions presented by the two reports appears to be on the construction that is placed upon the facts. The ATSB concluding that the principal causes were external to the pilot, relating to the placement of a temporary buoy and the pilot's computer powering down at the crucial moment. By contrast, the regulator concluded that the actions and omissions of the pilot were the principal causes of the incident, using the language of blame, for failing to observe basic principles of seamanship, such as verifying the ship's position before altering course, and for possibly being distracted by talking to the master and reporting by radio at critical decision making moments. This difference can be explained by the different objectives of the respective agencies, rather than any difference in the legal powers used to collect and protect the evidence.

At its foundation though, organisational prejudice aside, there is no difference in the essential facts due to the different legal regimes used to investigate the incident. Indeed, it appears that the evidence relied upon by the ATSB may have been slightly less complete (see for instance the 'obscured by rain' point in table 1 above) than the evidence available to MSQ. This conclusion cannot be fully supported however, because of the disclosure limitations imposed on the evidence obtained by the ATSB.

In respect of the *ANL Excellence* investigation, the legal framework of an ATSB investigation, that is, superior evidence gathering powers; the quarantine of the evidence; and the inability of the report to be used from any other purpose; had very little bearing upon the essential findings of fact. The MSQ report, using traditional investigation powers that afford participants the privilege against self-incrimination, as well as the ability to use the report for any purpose, including disciplinary purposes, was essentially the same in relation to the key facts.

The only real difference appears to lie in the approach of each investigative agency to the construction of those facts in drawing conclusions and making recommendations, with the ATSB focussing on systemic causes, and MSQ focussing on the pilot's personal performance. It is recognised that much depends upon the facts of each case. In the *ANL Excellence* there were a number of witnesses who would not be found culpable on any construction of the facts and who owed no loyalty to the pilot, and

so could therefore be relied upon to give full and frank evidence. The result may be different if the only witnesses may have committed an offence or are loyal to persons who may have committed an offence. But the important point is that the TSIA regime is not correspondingly flexible.

It may be concluded that there is no apparent difference in key findings due to the different legal frameworks under which the evidence was gathered; rather, the differences between the conclusions of the 2 reports may be entirely attributed to the construction of the evidence by the respective agencies in meeting their differing objectives.

For the sake of completeness, it should be noted that the ATSB's recommendations were:

Where port authorities use a buoy or other temporary aid to replace an established navigation aid, the shape and the light characteristics of the temporary aid should be consistent with those of the aid it replaces. [*comment – the temporary aid was consistent with IALA*<sup>106</sup>]

Brisbane Marine Pilots should review the power management settings and placement of a pilot's portable electronic chart system to ensure that the information displayed remains easily visible from the pilot's conning position at all times during a pilotage. [*comment - the evidence was that the pilot did not check the laptop until after giving the order to alter course, and so the 'power-down' was not strictly a cause of the incident*]

By contrast, MSQ commenced disciplinary action against the pilot, and as a consequence suspended the pilot's licence for six months<sup>107</sup>.

In the author's view, the similar fact findings in the reports do nothing to justify the public policy associated with the restrictions on the use of the ATSB report or the confidentiality of the evidence gathered by the ATSB. It is submitted that the common safety purpose of both MSQ and ATSB could have been achieved by each respective agency drawing on the same evidence in order to draw their respective conclusions. In this case at least, the different legal regimes did not produce any difference in the material facts and it may be inferred that the evidence available to each agency, from which those facts were drawn, although collected separately and using different powers, was substantially the same. All the differences in the conclusions can be explained by the differences in organisational objectives and prejudices. It begs the question of whether a traditional marine inquiry into the incident, with a fused inquirial and disciplinary function, would have formed similar conclusions to that of both the ATSB and MSQ; in the author's opinion, that is likely.

A final issue is timeliness: the MSQ report is dated 12 August 2002, a matter of only weeks after the incident; the ATSB Report was not released until May 2003, 9 months later.

## 7. The Pasha Bulker

The Pasha Bulker came to national and international attention when it ran aground on Newcastle's famous Nobby's Beach at the height of a winter storm in June 2007.

Both the ATSB and the relevant New South Wales marine safety regulator, NSW Maritime<sup>108</sup>, conducted an investigation into the grounding of the ship. The relevant facts and circumstances of the incident, succinctly described in the New South Wales Maritime report, were as follows:

On Friday 8 June 2007 a strong gale passed through the Newcastle region, producing winds from the south-east of up to nearly 50 knots (93km/h) and waves of about 7 metres. The gale created dangerous and untenable conditions in the anchorage off Newcastle, particularly for lightly ballasted large bulk ships with limited manoeuvrability.

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<sup>106</sup> International Association of Marine Aids to Navigation and Lighthouse Authorities; see <http://www.iala-aism.org/> accessed 14 May 2008.

<sup>107</sup> The pilot had previous history for similar errors resulting in incidents that was taken into consideration in the disciplinary process.

<sup>108</sup> See <http://www.maritime.nsw.gov.au/> accessed 4 July 2008.



On 7 June 2007, there were 56 ships at anchor waiting to enter the Port of Newcastle. In response to the forecast south-easterly gale two ships departed the anchorage late on 7 June. From about 0200 on 8 June, ships began to put to sea and at 0400 there were 41 ships remaining at anchor...

...By 0700 only nine ships (including the Pasha Bulker) remained in the anchorage. All vessels, except the Pasha Bulker, eventually put to sea during Friday 8 June. At least three ships experienced difficulties in manoeuvring or dragging anchors during the morning.

One ship, the Pasha Bulker, was driven ashore by the weather and grounded on Nobbys Beach. Another, the Sea Confidence, had difficulty manoeuvring and closed the coast to 0.7nM (1.3km) off Stockton Beach and nearly ran aground. A third ship, the Betis, was unable to weigh anchor and dragged towards the coast.

The grounding of the Pasha Bulker created a very public spectacle with much interest. Fortunately there was no loss of life and no lasting damage to the environment. All costs associated with the ship's salvage, its repairs and the contingency preparations which were put in place in the event of an oil spill are the subject of a claim on the ship's insurers.

Both organisations published a report: the NSW Maritime report was released on 5 December 2007, within 6 months of the incident; the ATSB report was released on 23 May 2008, almost 12 months after the incident.

The principal findings of each report are contained in the table below.

**Table 3 – Pasha Bulker Report Conclusions**

ATSB Report <sup>109</sup>	NSW Maritime Report <sup>110</sup>
<p>The ATSB investigation found that <i>Pasha Bulker</i>'s master did not appropriately ballast the ship and did not weigh anchor until it dragged in severe weather.</p> <p>The unwise decision to not ballast the ship for heavy weather and remain at anchor were the result of his inadequate knowledge of issues related to ballast, anchor holding power and local weather.</p>	<p>The Investigation assessed that the grounding of the <i>Pasha Bulker</i> resulted from a series of judgements and decisions made by the Master. The most significant being:</p> <ul style="list-style-type: none"> <li>• his failure to realise the potential impact of the weather forecast for the anchorage on 7/8 June;</li> <li>• an initial decision to ride out the gale at anchor; and a decision not to ballast the ship for heavy weather.</li> </ul>
<p>After the ship got underway, the master became increasingly overloaded and affected by fatigue and anxiety and his inappropriate control of the ship at critical times inevitably led to its grounding.</p>	<p>In addition, the handling of the ship while weighing anchor and when trying to depart the anchorage contributed to the <i>Pasha Bulker</i>'s dire situation and the eventual outcome.</p>
<p>Furthermore, the master incorrectly assumed that Newcastle VTIC would, if necessary, instruct</p>	<p>In general the standard of seamanship and decision making displayed by the Master of the</p>

<sup>109</sup> Australian Transport Safety Bureau, 2008, *Independent investigation into the grounding of the Panamanian registered bulk carrier Pasha Bulker on Nobbys Beach, Newcastle, New South Wales on 8 June 2007* [http://www.atsb.gov.au/publications/investigation\\_reports/2007/MAIR/mair243.aspx](http://www.atsb.gov.au/publications/investigation_reports/2007/MAIR/mair243.aspx) accessed 3 July 2008

<sup>110</sup> NSW Maritime, 2008, *Investigation Report Into The Grounding Of Mv Pasha Bulker And Near Grounding Of Mv Sea Confidence And Mv Betis Off Newcastle On 8 June 2007*, [http://www.maritime.nsw.gov.au/docs/pasha\\_bulker\\_final\\_report.pdf](http://www.maritime.nsw.gov.au/docs/pasha_bulker_final_report.pdf) accessed 3 July 2008.



ships to put to sea and the fact that most other ships also remained at anchor reinforced, in his mind, the initial unwise decision to remain at anchor. Consequently, he ignored signs of the dangerous situation developing.	<i>Pasha Bulker</i> is assessed as being poor.
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The NSW investigation went on to find that:

- there was evidence that the Master of the *Pasha Bulker* may have committed the offence of Negligent Navigation under the *Water Traffic Regulations – NSW*.
- On examining the evidence and the elements of the offence that must be proved to the criminal standard, that is ‘beyond reasonable doubt’, the likelihood of a successful prosecution is low.
- Following this conclusion and in applying the *Prosecution Guidelines of the Office of the Director of Public Prosecutions for New South Wales*, NSW Maritime will not proceed to a prosecution.

Similar to the *Endeavour River* discussed above, the ATSB seized the highly relevant VDR recordings and neither the recordings nor the data derived from them were made available to NSW Maritime for the purpose of preparing their report.<sup>111</sup>

Very similar conclusions to the *ANL Excellence* report can be drawn from the summary of the key findings outlined above. Despite the superior powers of the ATSB for evidence gathering, and the isolation of key evidence such as the VDR recordings from further use, even by key stakeholders like NSW Maritime, the key findings of each report are essentially the same. Such differences as there are can be readily explained by organisational prejudice and NSW Maritime's responsibility, as the regulator, to consider whether any offences have been committed.

It is submitted that none of the exclusive investigative powers granted by the *Transport Safety Investigation Act 2003*, nor the restrictions on use of the evidence gathered, nor the restrictions on the use of the final report, can be justified on the basis that the key findings would have been different without these powers and restrictions. Manifestly they are not. Further, the issue of timeliness is relevant, with NSW Maritime delivering a substantially similar report, within the context of its own legislative responsibilities, almost 6 months before the ATSB report.

For balance, it should be noted that the most important material difference between the two reports is the role of the Vessel Traffic Information Centre in the incident, with the ATSB report making strong recommendations about that role. Nonetheless, it is suggested both the safety and regulatory outcomes could have been achieved by using traditional methods, such as a marine inquiry, without the unnecessary duplication of effort and positive interference that occurs when regulators and safety investigators compete for evidence.

<sup>111</sup> At page 21 of the report, NSW Maritime state: ‘NSW Maritime does not have the equipment to decipher the VDR data. The Australian Transport Safety Bureau (ATSB) has the necessary equipment but would not release their interpreted data. NSW Maritime tested its analysis with the ATSB within the extent permitted by the *Transport Safety Investigation Act 2003* to verify the broad conclusions reached by this investigation.’

## 8. The ATSB – concluding remarks

The ATSB was created to ensure that accident investigation had a systemic and human error focus in order to ensure that the causes of incidents were properly determined so that such incidents were not repeated. That this is a worthy objective is beyond argument, and the academic literature overwhelmingly supports the concept of safety investigation. The investigative function of the ATSB has effectively replaced the marine inquiry at Commonwealth level, even though the marine inquiry had a different legislative framework and delivered a report that could be relied upon for a variety of purposes. The loss of that functionality is of concern.

It is acknowledged that the ATSB has been very successful in its investigation function; more than 200 investigations have been conducted and published,<sup>112</sup> and the ATSB is well-regarded for its expertise and professionally presented findings and recommendations.

It is not intended to re-visit the *Transport Safety Investigation Act 2003* in this section. A summary of the Act's powers and legal issues in comparison with the powers of a board of inquiry under part 12 of the *Transport Operations (Marine Safety) Act 1994* are contained in Table 3 below.

Rather, it is useful to consider some of the principal characteristics of the ATSB's powers, and the legal consequences attendant to those powers, when considering the utility of the ATSB's functions in the overall context of maritime incident investigation and the other legal consequences flowing from a shipping casualty.

In summary, the *Transport Safety Investigation Act 2003* (Cth):

- has the principal objective of investigating maritime accidents, and the making of safety statements and recommendations, which are then published;
- provides for powers of compulsion to require information and answers to questions, which powers are strict liability offence provisions;
- abrogates the privilege against self-incrimination;
- there is no right of procedural fairness to participants in marine casualties, although draft reports may be provided on a confidential basis for comment within the discretion of the ATSB;
- reports, and the vast majority of the supporting evidence,<sup>113</sup> cannot be used in evidence in any civil or criminal proceedings, other than a coronial inquiry;
- arguably the most crucial evidence, the on-board recordings, also cannot be used in criminal matters against the participants, in civil matters unless the onerous two-step process is followed, and even for coronial inquiries, the use of such vital evidence is conditional upon satisfying a public interest test.<sup>114</sup>

A number of criticisms can be made about the ATSB's jurisdiction. Whilst the importance of the safety objective cannot be doubted, the legal mechanisms used are, in the author's opinion, excessive for the benefit conferred. In particular, the prohibition against using evidence for any other purpose, particularly on board recordings, is a significant price to pay for the only apparent benefit; that is, to obtain admissions from participants in the accident.

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<sup>112</sup> [http://www.atsb.gov.au/publications/investigation\\_reports/index.aspx?mode=mar](http://www.atsb.gov.au/publications/investigation_reports/index.aspx?mode=mar) accessed 12 May 2008.

<sup>113</sup> Restricted information – *Transport Safety Investigation Act 2003* (Cth), part 6 division 2 and section 3.

<sup>114</sup> *Transport Safety Investigation Act 2003* (Cth), section 59.

Further, the evidence gathered by the ATSB is effectively quarantined from further use. Even the coroner, with a similar inquirial jurisdiction to the ATSB, might be refused access to evidence by the Executive Director if future investigations might be affected. It is submitted that the appropriate use of selected evidence, subject to relevant court directions on matters such as confidentiality, could lay a proper foundation for the expeditious conduct of a matter, whether the matter is coronial, disciplinary, civil or criminal.

Such restrictions on the use of evidence, and the reports derived from that evidence, are not justified by reference to the supporting IMO Code for the investigation of marine casualties. The provisions in the *Transport Safety Investigation 2003* (Cth) clearly exceed the protections envisaged by the Code.

It is also worthwhile considering the ATSB jurisdiction in contrast to the traditional marine inquiry. There seems little doubt that the ATSB jurisdiction has rendered the Court of Marine Inquiry obsolete by apparently fulfilling the same function; that is, conducting an investigation into the causes of an incident in order to make recommendations. Putting to one side the disciplinary aspect (which the ATSB definitely does not fulfil), the inquirial jurisdictions exercised by the ATSB and the former marine inquiry are very similar.

However the key difference is that the report of the inquiry would have been given to the relevant marine regulator to take appropriate action, potentially both in a safety and a disciplinary aspect. The report, and the evidence given to the inquiry, could have been relied upon in other forums and for other purposes. To balance this, the participants in the inquiry could be legally represented, and procedural fairness to all parties was a key element in the conduct of an inquiry.

Now however, the ATSB is not required to afford procedural fairness to any party (although its practice is to make draft copies of reports available for comment to affected persons). The report cannot be used for any other purpose (save for the coronial jurisdiction). Nor can much of the evidence and the report itself have any legal standing. The ATSB has no responsibility for the implementation of its recommendations nor for the findings in its reports. The ATSB also does not have to consider the cost/benefit relationship when making recommendations, unlike its counterpart in New Zealand.<sup>115</sup>

Such a report leaves the maritime regulator, whether at Commonwealth or State level, in something of a quandary. The regulator does not have access to the evidence used to prepare the report, is not required to be consulted in relation to the draft report (although typically is), has no recourse regarding adverse findings or impracticable recommendations, and yet recommendations are routinely made to the relevant regulator to take actions concerning the findings of the Report. This separation of the recommendation making power from regulatory responsibility is not of itself the problem; the same issue arises with marine inquiries. The essential difference is that the regulator now has to obtain the evidence afresh in order to justify the implementation of the recommendations, and also in order to fulfil its regulatory and safety responsibilities.

In other words, the safety and regulatory purpose have been so effectively separated that it could be argued that the safety purpose may actually be frustrated by the provisions intended to promote safety. At the very least it leads to wasteful duplication. Before a safety regulator can take effective action to ensure safety in its area of responsibility, evidence of the kind obtained by the ATSB and protected from disclosure is required. Yet such evidence cannot be used because of unquantified concerns about the future 'free-flow' of information to the ATSB. This justification is in any case flawed, because it necessarily involves speculation about future consequences. It also has no bearing to on-board recordings, and yet such recordings are specifically protected from disclosure.

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<sup>115</sup> New Zealand Transport Accident Investigation Commission; see <http://www.taic.org.nz/Home/tabid/36/Default.aspx> accessed 4 July 2007.

It is also worth reflecting upon the role of the ATSB investigator as the descendant of the marine inquiry assessor. Like assessors, ATSB investigators are usually technically skilled mariners and engineers, but with the benefit of additional investigation training to assist them in obtaining evidence relevant to human error and safety investigation findings. The key difference is that the ATSB investigator is now using the evidence to draw conclusions about the causation of incidents without reference to a legally trained or judicial officer. The other key difference is the absence of procedural fairness as a requirement of the procedure; rather it is now a matter of discretion.

Let us now consider the development of BOI provisions in Queensland, and the current provisions under TOMSA for a comparison with the ATSB jurisdiction.

## 9. Marine boards of inquiry in Queensland

### 9.1. History

The development of marine inquiries in Queensland has a common starting point with the Commonwealth provisions. The first Queensland legislation providing for marine inquiries was the *Navigation Act of 1876* (Qld),<sup>116</sup> which, like the Commonwealth's *Navigation Act 1912*, was modelled on the equivalent Imperial legislation in force at the time, that is, the *Merchant Shipping Act 1854*.

These early provisions provided for a preliminary inquiry and also for an investigation by the Marine Board of Queensland or two justices, who could be assisted by one assessor if the cancellation of a certificate or licence was an issue.<sup>117</sup>

The *Queensland Navigation Act of 1876* was repealed and replaced by the *Queensland Marine Act 1958*. Part IX of that Act dealt with '*Inquiries and Investigations into Shipping Casualties, Incompetency, and Misconduct*'.

Part IX of the *Queensland Marine Act 1958* provided for a system of investigation and inquiry consequent to a shipping casualty that is typical of the characteristics of the marine inquiry summarised at the beginning of this paper. That is, the Act provided for:

- a preliminary inquiry, usually conducted by an experienced mariner employed by the then Department of Transport;
- consideration of that report by the Marine Board (that was constituted by the Act), which had power to caution or reprimand the holder of a licence;
- if appropriate, a formal investigation by the Marine Board itself or, with ministerial approval, before a stipendiary magistrate;
- if the investigation was conducted by a stipendiary magistrate, the Governor-in-Council had the power to appoint one or more assessors of appropriate skill, with two assessors mandatory if suspension or cancellation of licenses was involved;
- all persons with an interest in the proceedings to be notified so that they could seek leave to appear; and
- the investigation's powers are statutory, not those of a court.<sup>118</sup>

These characteristics of a formal investigation are unsurprising and, with the exception of the role of the Marine Board, are quite similar to the equivalent Commonwealth provisions at the time.

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<sup>116</sup> Reproduced in the Public Acts of Queensland 1828-1936, volume 8 (the White series of reprints) at 435, cited in M White *Marine Inquiries* (1993) 9 *Queensland University Of Technology Law Journal* 61 at 64.

<sup>117</sup> M White *Marine Inquiries* (1993) 9 *Queensland University Of Technology Law Journal* 61 at 64.

<sup>118</sup> See generally Part IX *Queensland Marine Act 1958* and White M *Marine Inquiries* (1993) 9 *Queensland University Of Technology Law Journal* 61 at 64-66.

## 9.2. Marine inquiries under TOMSA

The *Transport Operations (Marine Safety) Act 1994* (Qld) ('TOMSA') commenced on 3 June 1994, but did not replace the *Queensland Marine Act 1958* until the 'changeover day', which was 31 December 1995.<sup>119</sup>

Part 12 of TOMSA provides for Boards of Inquiry into marine incidents<sup>120</sup> to be established by the Minister by gazette notice.<sup>121</sup> Such Boards must inquire into the circumstances and probable causes of the relevant marine incident and give the Minister a written report of the findings. The report may contain recommendations and, when provided, must be tabled by the Minister and the Legislative assembly within 14 days of receipt.<sup>122</sup>

The essential characteristics of a TOMSA Marine inquiry are as follows:

- the board must observe natural justice; and act as quickly and with as little formality and technicality as is consistent with a fair and proper consideration of the issues;<sup>123</sup>
- the board is not bound by the rules of evidence; may inform itself in any way it considers appropriate, including by holding hearings; and may decide the procedures to be followed;<sup>124</sup>
- the inquiry is to be held in public unless there are special circumstances;<sup>125</sup>
- the members, legal representatives and witnesses of the Board have the same protections and immunities conferred on judges, barristers and witnesses in a Supreme Court;<sup>126</sup>
- by a notice, require witnesses to attend at the inquiry;<sup>127</sup> failing to attend is an offence; as is failing to answer a question without reasonable excuse;<sup>128</sup>
- self-incrimination is expressly abrogated. However the answer is not admissible in evidence against the person in any criminal proceeding provided that the person claims the privilege prior to answering;<sup>129</sup> and
- if the board considers the evidence before it discloses an offence, it may make a report accordingly to the relevant authority to take further action as appropriate.<sup>130</sup>

Thus a marine inquiry under TOMSA retains many of the essential elements normally associated with marine inquiries, but it has evolved from the combined disciplinary and inquirial functions to only fulfilling the inquirial; the Board has no disciplinary powers to suspend or cancel a licence.<sup>131</sup>

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<sup>119</sup> Section 219 *Transport Operations (Marine Safety) Act 1994*; see Endnotes at 6.

<sup>120</sup> Defined in section 123 *Transport Operations (Marine Safety) Act 1994*.

<sup>121</sup> *Transport Operations (Marine Safety) Act 1994*, s 131.

<sup>122</sup> *Transport Operations (Marine Safety) Act 1994*, s 132.

<sup>123</sup> *Transport Operations (Marine Safety) Act 1994*, s 136(1).

<sup>124</sup> *Transport Operations (Marine Safety) Act 1994*, s 136(2).

<sup>125</sup> *Transport Operations (Marine Safety) Act 1994*, s 138.

<sup>126</sup> *Transport Operations (Marine Safety) Act 1994*, s 139.

<sup>127</sup> *Transport Operations (Marine Safety) Act 1994*, s 143.

<sup>128</sup> *Transport Operations (Marine Safety) Act 1994*, s 146.

<sup>129</sup> *Transport Operations (Marine Safety) Act 1994*, s 147.

<sup>130</sup> *Transport Operations (Marine Safety) Act 1994*, s 151.

<sup>131</sup> A licence is an 'authority' under the *Transport Operations (Marine Safety) Regulation 2004* and the procedure for suspension and cancellation is in part 6. The power to cancel or suspend licences resides with the general manager of Maritime Safety Queensland or the chief executive of Queensland Transport – see s 63 *Transport Operations (Marine Safety) Act 1994*.

The abrogation of the privilege against self-incrimination, balanced with the inadmissibility of such evidence in criminal proceedings, allows a Board to fulfil its inquirial function and get to the cause of incidents by compelling incriminating admissions. However, the material before the Board, and also the Board's report, can be used for any other purpose, that is, civil, disciplinary or criminal, with the sole exception of material that may be incriminating and for which privilege is claimed, in which case it is inadmissible in a criminal proceeding.

Indeed, it might be said that the discretion conferred on the Board to report offences to the relevant authority<sup>132</sup> requires the Board to at least consider whether the material before it discloses an offence, in addition to performing its principal function of establishing the causes of the marine incident.

In the disciplinary context, the chief executive and the general manager of Maritime Safety Queensland have the discretion to suspend authorities, including licences, after a marine incident.<sup>133</sup> Whilst Boards of Inquiry do not have any direct input into that decision, or any other subsequent disciplinary action, the holding of a Board of Inquiry may have a direct impact upon a person whose licence has been suspended, because the term of suspension may be extended until seven days after the Board has given the Minister's report.<sup>134</sup> Depending upon the efficiency of the Board in gathering evidence and holding its hearings, and the speed with which it delivers its report, such a suspension could be extended well beyond the six months provided for in section 164 of the *Transport Operations (Marine Safety) Regulation* 2004.

It is notable that there is no express role for assessors in the legislation, although it has been the practice for Boards of Inquiry established under TOMSA (more of which below) to have persons with technical expertise appointed to the Board.

A fuller discussion of the board of inquiry provisions under TOMSA, together with the comparison with the ATSB jurisdiction, follows at Table 3 below. For present purposes, White's remarks, written before TOMSA came into effect, seem remarkably prescient:

But reform is in the air in the Queensland Department of Transport with the newly passed [Transport Operations] Marine Safety Act 1994 (Qld) which repeals some or all of the Queensland Marine Act 1958 (Qld). The Marine Safety Act has quite modest pretensions in the area of marine inquiries, as its terms merely empower the Minister to set up a marine inquiry at his discretion. The Act has no constraints as to the circumstances in which the Minister must set up an inquiry, nor as to who should conduct it, nor as to the procedure which it should follow. Such a wide provision gives great flexibility which, provided it is exercised by knowledgeable and temperate persons, has many advantages. However, if such powers come to be exercised by persons who lacked those qualities, they may well become a source of abuse, as the act contains no constraints on how they are to be used. It is to be hoped that some restraint on such powers may be contained in the Regulations, which will follow the Act. The Marine Safety Act 1994 (Queensland) does, however, address the deficiencies that investigations for purposes of safety and the preferring of charges of incompetency or misconduct are to be kept quite separate.<sup>135</sup>

At present, there are no Regulations under TOMSA that refer to Boards of Inquiry.

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<sup>132</sup> *Transport Operations (Marine Safety) Act* 1994, s 151 provides that the board may make the material before it available to the commissioner of the police service, the crime and misconduct commission, the director of public prosecutions and the chief executive.

<sup>133</sup> *Transport Operations (Marine Safety) Regulation* 2004, s165.

<sup>134</sup> *Transport Operations (Marine Safety) Regulation* 2004, s166(3).

<sup>135</sup> M White *Marine Inquiries* (1993) 9 *Queensland University Of Technology Law Journal* 61 at 78.

## 10. The Wunma Board of Inquiry

Since the commencement of TOMSA, there have been two boards of inquiry established under part 12. The first was held in August 2002, and inquired into the circumstances of a collision between the *Sun Paradise* and the *Pride of Airlie* in the Whitsunday Passage on 18 November 2001. The subsequent report of the Board was delivered on 9 October 2003 and was published after being tabled in the legislative assembly.<sup>136</sup>

Interestingly, the Board made no recommendations for prosecution or disciplinary action;<sup>137</sup> with the recommendations focused upon developing a safety culture, appointing an officer to manage the implementation of the Board's recommendation, continuous education, marine safety standards and training programs. In short, the Board focused upon systemic issues in considering the causes of the marine incident, quoting from Professor Reason in the preface to the report, and referred extensively to the literature on human error and generating a safety culture.

Whilst this report will not be considered in detail in this paper, it is a useful illustration of the value of the marine inquiry process, with:

- procedural fairness being observed;
- extensive evidence being heard;
- cross-examination of witnesses allowing the board to consider all aspects of the evidence;
- the use of assessors being continued, with members of the board having nautical expertise (one member was a master mariner, the other members, including the chairperson, were experienced maritime lawyers with the Royal Australian Navy). The use of such persons removed the necessity for expert evidence;
- the conduct of separate criminal prosecutions arising out of the incident did not inhibit or deter the evidence that was given before the inquiry, because of the protection granted by section 147 TOMSA.

Whilst the timeliness of the Board's report should be criticised, taking almost 2 years to deliver from time of the incident to the delivery of the report, it is submitted that the inquiry was otherwise successful. The inquirial jurisdiction was exercised effectively, the causes of the marine incident were established and effective recommendations were made about the prevention of a similar kind of incidents, principally by the promotion of a safety culture in the maritime industry in Queensland and in the Whitsundays region in particular. Further, the conduct of a regulatory response, including the prosecution of one of the masters involved in the incident for offences under TOMSA, was also allowed to proceed independently of the Inquiry and did not interfere with the safety aspect of the Board's work.

It is interesting to note that, similar to the consideration of the *ANL Excellence* above, the organisational prejudices of the inquiry may have a greater impact upon the construction of the findings and the ultimate recommendations than the legal regime used to collect the relevant evidence. In this inquiry, the terms of reference required a consideration of the safety culture of the maritime industry, and that focus was realised in the ultimate report. However, it is suggested that the marine inquiry model, permitting representation, procedural fairness and cross-examination of witnesses, when combined with criminal prosecution immunity to witnesses, permitted the inquiry to obtain a superior marine safety outcome than mere investigation alone.

The establishment and conduct of the second board of inquiry under TOMSA into the marine incident concerning the ship 'Wunma' is considered in more detail below.

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<sup>136</sup> [http://www.msq.qld.gov.au/Home/Publications/Reports\\_of\\_boards\\_of\\_inquiry/](http://www.msq.qld.gov.au/Home/Publications/Reports_of_boards_of_inquiry/) accessed 12 May 2008.

<sup>137</sup> Although the master of the *Sun Paradise* was independently prosecuted for offences under TOMSA arising out of the incident.

## 10.1. The Wunma Marine Incident

The Wunma (the ship) is a 5140 DWT barge engaged in transporting zinc ore between Karumba and anchored bulk carriers in the Gulf of Carpentaria. The ship is registered as a commercial ship in Queensland, as it is engaged in primarily intrastate voyages.<sup>138</sup>

In early February 2007, the ship had partially loaded a bulk carrier anchored in the Gulf of Carpentaria, the MV *Ernest Oldendorff*, when the forecast for a tropical depression was given by the Bureau of Meteorology.<sup>139</sup> The ship proceeded to sea fully laden, but was unable to discharge into the MV *Ernest Oldendorff* because of the weather conditions.

The ship's 'dirty water tanks' filled with rain water, and the ship returned to Karumba and emptied the dirty water tanks. The tropical depression forecast was upgraded to a tropical cyclone, and so the ship proceeded to sea to ride out the cyclone in the Gulf of Carpentaria, still laden from its previous journey.

The ship took on water, both rainwater and seawater, beyond the capacity of the ship to remove it - the 'dirty water tanks' filled again. Water ingress into the ship eventually led to a loss of propulsion and electrical power.

The ship anchored and was relatively secure, but worsening weather conditions and concern of continued water ingress caused the master to send a distress call. On 7 February, the crew were rescued by helicopter and returned to Karumba.

The owners of the ship entered into a salvage agreement with professional salvors; the salvors boarded the ship and, with the chief engineer, and the assistance of a tug operated by the Commonwealth's Australian Maritime Safety Authority ('AMSA'), proceeded to take the ship safely to Weipa, where it was subsequently repaired.

In these circumstances, a marine incident occurred within the meaning of s123 TOMSA, in that the ship was abandoned and material damage was done to the ship. Consequently, shipping inspectors from Maritime Safety Queensland commenced investigating the marine incident in accordance with s126 TOMSA.

## 10.2. Establishment on the board of inquiry

During the preliminary stages of that investigation, it became apparent that the causation of the marine incident was complex and multi-faceted, and that therefore, the marine incident could properly be the subject of a board of inquiry.

The then Minister for Transport and Main Roads, the Hon Paul Lucas MP, established a board of inquiry into the marine incident ('the Board') on 15 March 2007 pursuant to part 12 of the *Transport Operations (Marine Safety) Act 1994*.

In his media press release<sup>140</sup> the then Minister stated:

'While this incident ended with the safe rescue of the crew and salvage of the ship, it highlighted a number of concerns about the safe operation of vessels in cyclonic conditions,' Mr Lucas said.

'This is one of those incidents that could easily have ended in tragedy and I think it is beholden on all parties concerned to consider the circumstances leading up to and during this incident, to identify ways to reduce the risks of similar incidents in the future.'

**'Boards of Inquiry aren't about playing a blame game, and the aim is not to point fingers at individuals,'** Mr Lucas said.

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<sup>138</sup> As to the application of TOMSA, see sections 11-16. As to the requirement for registration, see part 5, Division 2 TOMSA.

<sup>139</sup> <http://www.bom.gov.au/> accessed 14 May 2008.

<sup>140</sup> <http://www.cabinet.qld.gov.au/MMS/StatementDisplaySingle.aspx?id=50939> accessed 23 April 2008.



‘However, while you can't stop cyclones from occurring, it is important that there are stringent procedures and practices for ships that operate in these environments. The board will look at all of the facts and make recommendations that will hopefully have safety benefits for the whole of the marine industry operating in far north Queensland.’ *[emphasis added]*

Underlying the decision to establish the board of inquiry were the following considerations:

- a the operation of the ship from Karumba is a vital one from a mining and shipping perspective, and a proper and independent examination of the issues was important to guarantee its future;
- b the incident raised technical issues of significance relating to the design and operation of the ship, upon which independent expert assessment was required;
- c the incident raised the possibility of a conflict between marine safety and operational and commercial decision-making. Given that one of the objectives of TOMSA is to balance safety and cost,<sup>141</sup> it was prudent to obtain an independent assessment of that issue;
- d there were no deaths or serious injuries, meaning that the coronial<sup>142</sup> and criminal<sup>143</sup> jurisdictions were not enlivened. The exclusive jurisdiction of a board of inquiry under TOMSA into this incident was clear and unambiguous.

On 16 March 2007 the Board of Inquiry and terms of reference were established by Gazette Notice.<sup>144</sup>

### 10.3. Conduct of the inquiry

After a Directions Hearing that took place on 22 May 2007, the public hearings of the Board commenced on 13 August 2007 and were completed on 6 September 2007; the Board conducted public hearings for a total of eleven days.

Given the Board has complete flexibility in relation to its procedures,<sup>145</sup> the Board made a number of directions about the manner on which the Board would be conducted, including:<sup>146</sup>

- leave being required to appear as a party;
- evidence-in-chief to consist of written statements, with cross-examination by leave of the Board;
- expert evidence admissible by statement;
- claims of confidentiality permitted in relation to evidence, including identity;
- the scope of oral evidence within the discretion of the chairperson, with cross-examination also within the discretion of the chairperson;
- order of witnesses selected by the Board within availability constraints; and
- permitting oral address and written submissions to the Board by a party with leave to appear.

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<sup>141</sup> Section 3 of TOMSA provides that the overall primary objective of the act is to achieve an appropriate balance between regulating the Queensland maritime industry to ensure marine safety and to enable the effectiveness and efficiency of the Queensland maritime industry to be further developed. Specifically, section 3 (2) (iii) provides that account must be taken of the need to provide adequate levels of safety with an appropriate balance between safety and cost.

<sup>142</sup> See *Coroners Act 2003 (Qld)* available from <http://www.legislation.qld.gov.au/OQPChome.htm>

<sup>143</sup> See *Criminal Code Act 1899 (Qld)* available from <http://www.legislation.qld.gov.au/OQPChome.htm>, and in particular, s328A regarding dangerous operation of a vehicle, which includes a vessel.

<sup>144</sup> Electronic copies of the Queensland Gazette are available for free download from <https://www.publications.qld.gov.au/productbrowse.aspx> accessed 23 April 2008.

<sup>145</sup> As no regulations have been made as envisaged under Section 136(3) TOMSA.

<sup>146</sup> Practice Direction, 16 May 2007, Exhibit 3 to the Inquiry.

Evidence in the form of witness statements was presented to the Board from 57 witnesses, many of whom were called to supplement their written testimony with oral evidence. A total of 141 exhibits - comprising several hundred pages - were tendered in evidence.

The Board considered all of the submissions made by the parties, along with the evidence given during the course of the Inquiry, and delivered the final report of the Board on Monday, 19 November 2007 to Maritime Safety Queensland on the Minister's behalf.

Pursuant to s132(3) *Transport Operations (Marine Safety) Act* 1994, the Board's report was tabled on Monday 3 December 2007. Although Parliament was not then sitting, the report was tabled under s59 of the *Parliament of Queensland Act* 2001.

The Board's report is publicly available and is available on Maritime Safety Queensland's website at <http://www.msq.qld.gov.au/>.

#### 10.4. Wunma Inquiry Findings and Recommendations

It is not proposed to fully review the conduct of the inquiry and the findings and recommendations made by the Board. For present purposes, it is sufficient to note that the Board concluded that one cause (listed first in a list of 29 causes) was the absence of appropriate infrastructure to which the ship could be moored during cyclonic conditions.<sup>147</sup> The absence of that infrastructure meant that the ship went to sea when the tropical cyclone was imminent, exposing it to hazards for which it was not designed, and allowing inherent defects to come into play. These defects included:

- the presence and location of a ventilation grill that allowed water to enter the emergency generator room and the engine room, blacking out the ship at the time of greatest storm activity; and
- the 'dirty-water system', which was designed and operated to retain water on board the ship for environmental protection reasons, rather than the usual marine safety purpose of spilling water from the ship as quickly as possible.

The conduct of the Wunma Board of Inquiry is considered in the context of the principal themes discussed in this paper; that is, the role of the assessor and the relationship with expert evidence, the relationship between the inquirial function of the marine inquiry, and the legal powers used to collect the evidence; and the uses of the report and the confidentiality of evidence.

#### 10.5. The Inquirial function

The terms of reference for the inquiry<sup>148</sup> required it to consider the direct and proximate causes of the incident. This is unsurprising, and is simply a restatement of the statutory function of a board of inquiry under part 12 TOMSA.<sup>149</sup> The scope of the inquiry was described in the Board's own words:

The Board is not concerned simply with what occurred on 6 and 7 February 2007, after the ship went to sea. The Board must inquire into the probable causes of the marine incident and is asked to consider whether there were any systemic or regulatory arrangements that contributed to the incident.

The consideration of such systemic and regulatory issues included the adequacy of the managerial systems and processes in place, and whether persons involved in the ship's operation followed those systems and processes.

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<sup>147</sup> See generally chapter 17 of the *Report of the Board of Inquiry into the Marine Incident Involving the Ship Wunma in the Waters of the Gulf of Carpentaria on 6 and 7 February 2007*, at [http://www.msq.qld.gov.au/Home/Publications/Reports\\_of\\_boards\\_of\\_inquiry/](http://www.msq.qld.gov.au/Home/Publications/Reports_of_boards_of_inquiry/) accessed 14 May 2008.

<sup>148</sup> Reproduced at chapter 2 of the Report.

<sup>149</sup> Section 132 (1).

It may be concluded that such terms of reference were included to ensure that there was express consideration by the Board of the systemic factors and human errors that are now an ordinary element of modern safety investigation practice and which is integral to the ATSB's jurisdiction. But it also begs the question of whether the Board saw itself as having a disciplinary jurisdiction, given that it would be considering whether persons had failed to follow procedures, and if so, in what way.

Interestingly, the Board said that:<sup>150</sup>

The Board's function is not to apportion responsibility for the incident, or make findings in terms of culpability. It is required to report on the causes of the marine incident.

But perhaps against that statement, the Board drew conclusions that have clear culpability implications, such as the use of the word '*failure*' in the following findings:<sup>151</sup>

(10) The failure to take adequate steps on 5 February 2007, or beforehand, to prepare the ship and her crew for a prolonged voyage in open waters during cyclonic conditions, including:

- bunkering sufficient fuel to enable the ship to remain at sea for an extended period whilst operating all three of her engines;
- unblocking deck drains to permit, so far as possible, rainwater to be directed overboard through deck drains;
- familiarisation by navigation officers of procedures in the ship's Safety & Quality System to avoid cyclones at sea.

(11) The failure during the voyage that commenced on 5 February 2007, and particularly during the period prior to the decision at around 1140 hours on 6 February to turn South, to obtain current weather information by email or satellite phone. The consequential lack of plotting of the cyclone's position and path, and the ship's position in relation to the cyclone. The making and recording of only infrequent observations of wind direction and barometric pressure.

(12) In general the failure to apply the procedure to avoid cyclones at sea contained in the ship's Safety & Quality System (SQS 06; D 220) or similar procedures to avoid cyclones at sea.

(13) The decision of the Master at approximately 1140 hours on 6 February 2007 to turn South without:

- adequate current information about the cyclone's position and path;
- adequate analysis of the limited information that was on hand at 1140 hours;
- adequate consideration of the consequences of turning South;
- consultation with the Chief Mate, the Second Mate, the Designated Person Ashore or other persons ashore about the proposed course of action.

It takes little imagination to conclude that these findings, which principally relate to the master's management of the ship, could found disciplinary, civil and possibly criminal liability.

On the other hand, the Board itself has no power to take disciplinary or regulatory action against any person. The highest the Board may go is to refer any incriminating material to a relevant authority pursuant to s151 TOMSA. As previously noted, this may mean that the Board must consider whether any criminality is involved in a particular incident in deciding whether are not to make such a report.

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<sup>150</sup> Report of the Board of Inquiry into the Marine Incident Involving the Ship *Wunma* in the Waters of the Gulf of Carpentaria on 6 and 7 February 2007, at [http://www.msq.qld.gov.au/Home/Publications/Reports\\_of\\_boards\\_of\\_inquiry/](http://www.msq.qld.gov.au/Home/Publications/Reports_of_boards_of_inquiry/) accessed 14 May 2008 chapter 17, [5].

<sup>151</sup> Ibid at chapter 17.

In any event, aside from making findings that could possibly be used in subsequent ‘blame attributing proceedings’ and considering whether material should be referred for criminal prosecution, the Board has no other disciplinary role; as noted above, the board confined itself to determining the causes of a marine incident.

Given the great disparity in the legal mechanisms for gathering evidence under the ATSB and the marine inquiry jurisdiction, it is worth considering briefly how that mechanism worked in the Wunma board of inquiry. Overall, the protections provided to witnesses by part 12 TOMSA include:

- a person summoned to attend or appearing before the board as a witness has the same protection as a witness in a proceeding in the Supreme Court;<sup>152</sup>
- whilst the privilege against self-incrimination is abrogated, the incriminating evidence cannot be used in a criminal proceeding against the witness (other than for a proceeding about the false or misleading nature of the evidence), provided that the witness first claims privilege before giving the incriminating evidence;<sup>153</sup>
- whilst not strictly a protection of a witness, to the extent that the owner and the master usually do testify, then legal representation is important. Consequently, the board must give the owner and master the opportunity of making a defence to all claims made either in person or by counsel, solicitor or agent.<sup>154</sup>

In the event, the only witness to claim privilege against self-incrimination under s147 TOMSA was the master. The master had willingly provided a statement to a shipping inspector employed by Maritime Safety Queensland immediately after the incident. No privilege was claimed at that point, and the statement was tendered in evidence as an exhibit to the Board. All subsequent statements by the master, including his oral evidence, were prefaced by the privilege against self-incrimination. After having done so, the master willingly answered all questions put, both in his evidence in chief and under cross-examination by various parties, at the inquiry. Given that the master's evidence occupied the better part of two days of the hearings, it might be concluded that the protection conferred by s147 TOMSA was more than sufficient to ensure that the inquiry had the benefit of the master's full cooperation in obtaining the evidence required to make findings about the causation of the incident in a safety context.

All other witnesses called, in particular the ship's crew, gave evidence in a frank manner, and many made suggestions about how to improve the safety of the ship. Notably, the master and the chief mate made suggestions concerning the arrangements on board the ship to prevent a recurrence of the incident, which suggestions were adopted by the board as recommendations.<sup>155</sup>

In the author's view, the protections granted by part 12 TOMSA to witnesses were sufficient to ensure the ‘free flow of information’ to the board. This is so even in the absence of the kinds of protection is provided by the *Transport Safety Investigation Act 2003* (Cth), meaning that the potential for criminal, disciplinary and civil action arising out of the evidence being provided was present. It is notable that the master was independently legally advised.

For the sake of completeness, the author is not aware of any criminal action that has been commenced in relation to any party arising out of the Wunma inquiry. Further, because the master was licensed by the Commonwealth authority (the Australian Maritime Safety Authority) and not in Queensland, MSQ has no jurisdiction in relation to any disciplinary decision. The author is also not aware of any civil litigation arising out of the Wunma inquiry. The Board did not make a report of material disclosing a criminal offence pursuant to s 151 TOMSA.

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<sup>152</sup> Section 139 (3) TOMSA. The protections of witnesses include the protection from suit for defamation, breach of confidence and professional confidentiality.

<sup>153</sup> Section 147 TOMSA.

<sup>154</sup> Section 141 TOMSA.

<sup>155</sup> *Report of the Board of Inquiry into the Marine Incident Involving the Ship Wunma in the Waters of the Gulf of Carpentaria on 6 and 7 February 2007* at 18.2.6 and 18.2.7.

## 10.6. Confidential evidence

The board also considered submissions from parties concerning the confidentiality of certain kinds of evidence, and made an appropriate direction accordingly.

The Board stated:<sup>156</sup>

Under section 138 of the TOMS Act, an Inquiry must be held in public unless a direction is given to the contrary, and such a direction may only be given if the Board is satisfied that it is proper to make the order in 'the special circumstances of the Inquiry'.

The Board's Practice Direction made provision for parties to apply for the preservation of certain confidential information contained in exhibits and the like, such as commercially confidential information. In some instances proper claims to confidentiality in respect of certain financial matters justified portions of a small number of exhibits being redacted. However, those few exceptions apart, the evidence before the Inquiry was accessible to the public. Public access was facilitated by the uploading of transcripts and exhibits on the Board's website.

It is submitted that the Board's flexibility in setting its own directions in the context of allowing some evidence to be provided on a confidential basis, within the context of a public inquiry, was sensible and appropriate. It is certainly preferable to the blanket confidentiality provisions contained in the *Transport Safety Investigation 2003* (Cth).

Having said that, it would be desirable for future boards to have the benefit of some criteria by which the granting of confidentiality could be assessed. Such criteria might include, as referred to by the board, matters of a significant commercial nature, but other issues might also be the proper basis for confidential evidence being provided, such as a reasonable fear of recrimination.

## 10.7. Expert evidence and assessors

As has been previously discussed, there is a trade-off in the use of assessors informing a judicial officer in a marine inquiry. The presence of assessors, when combined with the general rule that expert evidence within the assessor's field of expertise was not admitted, meant that the assessor was giving expert opinion to the judicial officer throughout the hearings, was able to interpret the evidence and advise right up to the moment that the report was delivered. This facility has obvious efficiency and cost benefits, obviating the need for lengthy and possibly conflicting expert evidence.

However it also has disadvantages in a procedural fairness sense, as the parties to the inquiry do not know what advice is being given by the assessor, have no opportunity to test or challenge that advice, and they cannot call their own expert evidence to support that party's position. In the past, the advantages associated with the use of assessors were seen to outweigh the disadvantages. However, in more modern times, the use of assessors has fallen out of favour in the Admiralty jurisdiction altogether in Australia, and lingers on only in the marine inquiry jurisdiction.

Both boards of inquiry established under TOMSA have had persons with professional qualifications and expertise appointed, presumably to function in the assessor's role. However, part 12 TOMSA is silent on the use of assessors and also silent on the issue of expert evidence.

In the *Wunma* inquiry, the chair of the board was a respected member of the Queensland Bar.<sup>157</sup> The other two members appeared to be assessors (although were not expressly appointed as such), with qualifications as a master mariner and as a naval architect.

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<sup>156</sup> Ibid, Chapter 2.

<sup>157</sup> His Honour, Justice Applegarth SC, was appointed to the Queensland Supreme Court on 3 September 2008.

The directions of the Board<sup>158</sup> permitted the admission of expert evidence and the Board called for expert evidence in relation to the design of the ship. The Board also permitted the admission of expert evidence in relation to matters of nautical expertise, naval architecture, marine engineering and meteorology.

It is submitted that the combination of using both assessors and permitting the admission of expert evidence is a poor option. The use of expert evidence inevitably increases the costs and length of the inquiry, even if oral testimony is not taken. Further, the nature of the opinions of the board, in their professional and expert capacities, is not known to the parties and has not been tested. Consequently, it is suggested that the appointment of assessors to the board, and the use of expert evidence, be the subject of legislative amendment to make clear whether the use of assessors is required, and if so, also provide for corresponding reasonable limitation on the admission of expert evidence.

## 10.8. Frequency

A final minor point can also be made about the frequency of Boards of Inquiry under TOMSA. In the almost 14 years the Act has been in force, 2 inquiries have been held under Part 12. By contrast, between the years 1863 and 1945, almost 2000 marine inquiries were held under the applicable marine legislation in force in Queensland; an average of approximately 20 per annum.<sup>159</sup>

Given the overall increase in the maritime industry and marine incidents generally,<sup>160</sup> the relative infrequency of Boards of Inquiry under TOMSA should be considered, and if necessary, regulations under Part 12 TOMSA should be introduced to facilitate the efficient and cost effective conduct of Boards of Marine Inquiry, so as to give full effect to the benefits of the jurisdiction and to enhance marine safety.

## 11. The role of the marine inquiry against the safety investigation agency

The principal aim of this paper has been to trace the development of the marine inquiry jurisdiction, and to consider and contrast the present expression of that jurisdiction at Commonwealth level in the ATSB and at state level with boards of inquiry established under part 12 TOMSA.

To facilitate the discussion, some of the key characteristics of each jurisdiction are summarised in table 4 below.

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<sup>158</sup> Dated 16 May 2007, Exhibit 3 to the inquiry, at paragraph 15.

<sup>159</sup> Harbours and Marine Department *List of vessels involved in accidents on Qld Coast, 11 Sept. 1863-7 Dec. 1945* Har/83 Queensland State Archives, File Issue 20150 Item 17749.

<sup>160</sup> Refer to the marine incident annual reports published by Maritime Safety Queensland, available from [http://www.msq.qld.gov.au/Home/Publications/Marine\\_incident\\_annual\\_reports/](http://www.msq.qld.gov.au/Home/Publications/Marine_incident_annual_reports/) accessed 22 May 2008.

**Table 4 – Summary of key characteristics of ATSB investigations and Boards of Inquiry under TOMSA**

	<b>Australian Transport Safety Bureau</b> <i>Transport Safety Investigation Act 2003 (Cth)</i>	<b>Maritime Safety Queensland Board of Inquiry</b> <i>Transport Operations (Marine Safety) Act 1994 (Qld)</i>
<b>Establishment and jurisdiction</b>	<ul style="list-style-type: none"> <li>• Executive Director of Transport Safety Investigation (ATSB) permanently established: s12</li> <li>• inquire into transport safety matters: s23</li> <li>• within Commonwealth jurisdiction: s11</li> <li>• discretion to investigate unless directed by Minister: s21</li> <li>• publish report: s25</li> </ul>	<ul style="list-style-type: none"> <li>• ad hoc; established by the Minister at Minister's discretion: s131</li> <li>• inquire into the causes of marine incidents (s123) to which TOMSA applies (ss 11-16): s132(1)(a)</li> <li>• must provide a report to the Minister: s132(1)(b)</li> <li>• Report must be tabled in Legislative Assembly: s132(3)</li> </ul>
<b>Evidence powers</b>	<ul style="list-style-type: none"> <li>• powers of entry and seizure: Part 5 Division 3</li> <li>• require persons to attend and answer questions: s32</li> <li>• inspect and take possession of evidence: s36</li> <li>• protection orders on evidence: s43</li> </ul>	<ul style="list-style-type: none"> <li>• shipping inspectors may exercise powers to board ships and seize evidence: s135</li> <li>• compel witnesses to attend: s143</li> <li>• inspect and take possession of evidence: s144</li> </ul>
<b>Self-incrimination</b>	<ul style="list-style-type: none"> <li>• privilege is abrogated: s47</li> <li>• if individual, evidence cannot be used in civil or criminal proceeding against the person: s47(2)</li> </ul>	<ul style="list-style-type: none"> <li>• privilege is abrogated: s147(1)</li> <li>• evidence cannot be used in a criminal proceeding: s147(2)</li> </ul>
<b>Confidentiality of evidence</b>	<ul style="list-style-type: none"> <li>• disclosure of restricted information (evidence) is an offence: s60</li> <li>• disclosure to a court not permitted unless public interest test is satisfied: s60(6)</li> <li>• if disclosure not permitted, then restricted information is not admissible: s60(8)</li> </ul>	<ul style="list-style-type: none"> <li>• not expressly provided for</li> <li>• parts of inquiry can be held in private in special circumstances: s138</li> </ul>

<b>Confidentiality and use of on-board recordings (OBR)</b>	<ul style="list-style-type: none"> <li>• copying or disclosing OBR is an offence: s53</li> <li>• not basis for disciplinary action: s54</li> <li>• not admissible in criminal proceedings against crew: s55</li> <li>• not admissible in civil proceedings unless certificate from ATSB and public interest test: s56</li> <li>• can be made available to coronial inquiry unless ATSB believes that investigation would be interfered with: s59</li> </ul>	<ul style="list-style-type: none"> <li>• not expressly provided for</li> <li>• parts of inquiry can be held in private in special circumstances: s138</li> </ul>
<b>Procedural Fairness and Representation</b>	<ul style="list-style-type: none"> <li>• procedural fairness and representation are not expressly provided for.</li> <li>• draft reports may be provided on a confidential basis for comment: s26</li> </ul>	<ul style="list-style-type: none"> <li>• Must observe natural justice: s136</li> <li>• master and owner of ships(s) must have opportunity to make a defence against claims: s141</li> <li>• master and owner have right to be represented: s141</li> <li>• may permit or refuse person to be represented: s142(1)(c)</li> </ul>
<b>Hearings and public access</b>	<ul style="list-style-type: none"> <li>• not expressly provided for.</li> </ul>	<ul style="list-style-type: none"> <li>• must act quickly, with minimal formality (s136)</li> <li>• may hold hearings (s136)</li> <li>• must be held in public unless there are special circumstances (s138)</li> </ul>
<b>Role of assessor – use of expert evidence</b>	<ul style="list-style-type: none"> <li>• The role of assessor is not expressly provided for.</li> <li>• No restriction on the use of expert evidence</li> </ul>	<ul style="list-style-type: none"> <li>• The role of assessor is not expressly provided for.</li> <li>• No restriction on the use of expert evidence.</li> </ul>
<b>Use of Report</b>	<ul style="list-style-type: none"> <li>• reports not admissible in evidence in any civil or criminal proceeding: s27</li> <li>• it is an offence to disclose or copy draft report: s26</li> </ul>	<ul style="list-style-type: none"> <li>• unrestricted.</li> </ul>
<b>Disciplinary Role</b>	<ul style="list-style-type: none"> <li>• None.</li> <li>• Apportioning blame, determining liability, assisting court proceedings and even allowing adverse inferences to be drawn are expressly excluded as objectives of the Act: s7(3)</li> </ul>	<ul style="list-style-type: none"> <li>• may report offence and provide evidence to police or other persons: s151</li> </ul>



<b>Witness offences</b>	<ul style="list-style-type: none"> <li>• failing to report an accident: s18</li> <li>• hindering an investigation: s24</li> <li>• fail to attend: s32(5)</li> <li>• fail to take oath or affirmation: s32(5)</li> <li>• fail to answer a question: s32(5)</li> <li>• fail to produce evidence: s32(5)</li> </ul>	<ul style="list-style-type: none"> <li>• fail to attend: s146(1)</li> <li>• fail to take oath or affirmation: s146(2)</li> <li>• fail to answer a question: s146(2)</li> <li>• fail to produce evidence: s146(2)</li> <li>• false or misleading statements: s148</li> <li>• false or misleading documents: s149</li> <li>• contempt of board: s150</li> </ul>
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Many of these characteristics have been discussed previously, but for present purposes, the comparison table is a useful aid in comparing certain key features, in particular:

- self-incrimination is abrogated under both pieces of legislation, but the corresponding protection under the ATSB jurisdiction is broader, extending to civil liability;
- there is little evidence protection granted under TOMSA, compared to the extensive and far-reaching prevention of disclosure under the TSIA provisions;
- there is no prohibition against using a report created by a TOMSA Board of Inquiry, as against the almost complete quarantine of the ATSB report. Only the coronial jurisdiction is exempted;
- procedural fairness is enshrined in TOMSA, but is not required under the TSIA;
- assessors and the use of expert evidence are not provided for in either Act. In the ATSB jurisdiction, this is perhaps unsurprising given the very prominent role of nautical expertise provided by the investigators themselves; although there is no requirement for the investigators to have such skills.<sup>161</sup> By contrast, TOMSA envisages the appointment of a board to inquire into the causes of an incident, and yet provides no guidance on the skills, qualification or experience considered desirable for board members. Further, if it is desirable to have board members with expertise in the areas relevant to the incident, then consideration should also be given to the question of whether expert evidence in the board member's area of expertise ought to be prohibited or restricted for the reasons set out earlier in this paper. It is submitted that these omissions should be rectified by appropriate subordinate legislation.

### 11.1. A short note on jurisdiction

A detailed examination of the respective jurisdictions of the ATSB and Boards of Inquiry under TOMSA is outside the scope of this paper. For present purposes, it should be noted that there is considerable overlap between the 2 jurisdictions, as highlighted by the *ANL Excellence* and *Endeavour River* examples used in this paper.

Shortly stated, the TSIA empowers the ATSB to investigate 'Transport Safety Matters' that occur in Australia; such matters generally involve death or injury, or damage, destruction or abandonment of transport vehicles, including ships. TOMSA permits Boards of Inquiry to investigate 'Marine Incidents' that fall within the jurisdiction of the Act, principally involving ships in Queensland Waters and ships connected with Queensland wherever they may be.

<sup>161</sup> c.f. the requirement for shipping inspectors appointed under TOMSA, who investigate marine incidents, to have the necessary expertise or experience to be a shipping inspector or to have completed approved training at s 157 TOMSA.

Consequently, a shipping casualty that occurs in Queensland waters will most likely enliven both jurisdictions. Given also that TOMSA prescribes the use of pilots in Queensland Pilotage Areas<sup>162</sup> for all ships greater than 50m in length, the safety and regulatory aspects of a major shipping incident regularly arise.

## 12. Conclusion

It is argued that the powers and limitations created by the *Transport Safety Investigation Act 2003*, whilst laudable in intention:

- exceed what is necessary in order to achieve the safety purpose. Indeed, there is no evidence from the findings of the reports considered in this paper that there has been any material increase in the 'free-flow of information to the ATSB' that is often used to justify the powers and limitations conferred on the ATSB;
- exceed what is required under international treaty, particularly the use of VDR recordings;
- unnecessarily interfere with regulatory agencies performance of their respective duties by isolating key evidence from their use; and
- results in a report that has limited utility, and which contains largely untested evidence.

By contrast, the marine inquiry process contained in part 12 TOMSA is a robust and sound method of achieving marine safety outcomes whilst retaining the flexibility of using the report, and the evidence given to the inquiry, for other purposes that would best serve the public interest, such as use in civil, disciplinary and criminal proceedings.

Where the use of evidence before a board of inquiry under TOMSA is circumscribed, such as by claims of privilege against self-incrimination or confidentiality, such limitations are sensible and proportionate to the goal of promoting candour from witnesses, and so facilitate the board of inquiry's function.

It is submitted that the marine inquiry procedure in part 12 TOMSA, if appropriately amended and constrained to address the issues highlighted above (such as the use of assessors and limiting hearings to the minimum necessary for procedural fairness), is a superior method of obtaining safety outcomes in some incidents, as compared to the safety investigation regime established under the *Transport Safety Investigation Act 2003*, because it permits a robust examination of the issues, fully engages the parties, allows legal representation and provides procedural fairness, and also serves the public interest in ensuring that all consequential matters arising out of the incident, including 'blame-apportioning proceedings', are dealt with in an efficient manner.

However, Boards of Inquiry are established ad hoc and only for some incidents. To date, Boards of Inquiry under TOMSA have been infrequent, especially compared to previous eras. The permanent establishment of the ATSB and its safety investigation remit have certain advantages for responding to incidents and obtaining evidence quickly. However, there does not appear to be a corresponding efficiency gain, with reports from the ATSB generally taking 6 months or longer to be published; a time-frame similar to that for the Wunma board of inquiry.<sup>163</sup>

Neither Boards of Inquiry under TOMSA nor investigations under the TSIA expressly utilise the concept of the nautical assessor, although both jurisdictions retain the function; under TOMSA as a board member, and under TSIA as an investigator with technical expertise. It is submitted that both jurisdictions would benefit from a proper consideration of the role of the assessor, and the corresponding use of expert evidence.

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<sup>162</sup> See generally Part 8 TOMSA.

<sup>163</sup> See [http://www.atsb.gov.au/publications/investigation\\_reports/index.aspx?mode=mar](http://www.atsb.gov.au/publications/investigation_reports/index.aspx?mode=mar) accessed 15 May 2008.

*End note: The ATSB report into the grounding of the Australian registered bulk carrier Endeavour River at Gladstone on 2 December 2007 was publicly released on 3 September 2008.<sup>164</sup> As discussed in section 5.1 above in relation to VDR data, the ATSB investigators exercised their powers under Part 6 of the Transport Safety Investigation Act 2003 (Cth) to take control of, and deny 3<sup>rd</sup> party access to, the VDR data. Consequently, both the owners of the ship and the state regulator responsible for the safe movement of ships in the port of Gladstone independently investigated the facts and circumstances of the grounding without the benefit of the VDR data.*

*Further, both the owners of the ship and the state regulator then took prompt action to rectify what were perceived to be the causes of the incident on the basis of their own investigations. These separate investigations and actions were taken and implemented within a matter of weeks of the incident. The MSQ investigation in particular was finalised and delivered to the General Manager of MSQ before the end of January 2008. Such urgency is necessary in the context of a busy world-class export port, where a grounding and subsequent blockage of a channel could have far-reaching and very large safety and financial implications.*

*The conclusions of the ATSB Report, released 9 months after the incident, are sound and certainly reflect the findings of the MSQ and ship owner's investigations. Ironically, the ATSB ultimately made no recommendations, saying that:<sup>165</sup>*

*The ATSB acknowledges the safety actions that ASP Ship Management and Maritime safety Queensland have taken to address all the safety issues identified during this investigation. Because of these actions, the ATSB has not issued any recommendations or safety advisory notices.*

*In short, despite not having access to the VDR data, the ship's owner and MSQ implemented appropriate countermeasures.*

*The importance and relevance of an independent safety investigation agency is not challenged. However, it is submitted that the legal framework under which the ATSB operates, particularly the extreme restrictions on the release and use of VDR data, is excessive for the benefit conferred. The ATSB's use of its powers to seize and restrict access to evidence can and does interfere with agencies and organisations that are actually responsible for ensuring safety outcomes. The legal framework of the ATSB should be reviewed to align it with international obligations, international practice and the obligations of regulators and industry to better achieve a timely overall safety outcome.*

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<sup>164</sup> [http://www.atsb.gov.au/publications/investigation\\_reports/2007/MAIR/pdf/mair248\\_001.pdf](http://www.atsb.gov.au/publications/investigation_reports/2007/MAIR/pdf/mair248_001.pdf) accessed on 10 October 2008.

<sup>165</sup> Ibid, p 44.