Australian Government
Australian Maritime Safety Authority

Submission to the Senate Standing Committee on Rural and Regional Affairs and Transport inquiry into the performance of the Australian Maritime Safety Authority

March 2019

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Introduction

The Australian Maritime Safety Authority (AMSA) makes the following submission to the:

> *Senate Standing Committee on Rural and Regional Affairs and Transport* inquiry into the performance of the Australian Maritime Safety Authority.

We have heard the concerns of the Committee, and in particular the statements made by the family of Mr Mills at the hearing in Perth on 21 March 2019. AMSA has implemented new procedures for investigations including briefing the Chief Executive Officer of all serious incidents. We have a new Enforcement and Inspector Support team and we are looking at new measures of accounting for passengers, minimising the chances of them going overboard in the first place and maximising their chances of rescue if they do. We will pursue actions aimed at improving safety for high risk vessels that are currently operating under 'grandfathered' arrangements.

We understand that when a tragedy like this occurs, the family, the public and their representatives want to know how it happened, what actions were taken by regulators, and what measures are or should be in place to prevent a similar incident from happening again.

AMSA will now ensure that where appropriate there is a nominated contact person assigned to family members of people affected by serious marine incidents.

A number of the key decision-makers who were involved in this matter are no longer employed at AMSA. However, we have reviewed their actions and the relevant documentation in the time available. We have done so with a view to understanding what occurred, where there are shortcomings, and what we need to address to continue to improve as a regulator. It is in this light that we make the following submission.

Shared responsibility for investigation and enforcement

At the time of the tragedy, responsibility and authority for investigations, compliance and enforcement was shared between AMSA, the Western Australian Department of Transport (WADOT) and Western Australian Police (WA Police). We were working together in accordance with an Intergovernmental Agreement (IGA), agreed by the Council of Australian Governments (COAG), which set out specific roles for AMSA and state and territory marine safety agencies in administering the National System for Domestic Commercial Vessel Safety (the National System).

Under the IGA, WADOT had primary responsibility for the physical conduct of compliance and enforcement activities including investigations, and AMSA had primary responsibility for ensuring WA officers had the necessary powers and guidance to conduct compliance and enforcement activities under the *Marine Safety (Domestic Commercial Vessel) National Law Act 2012* (the National Law). In cases of compliance and enforcement actions involving prosecutions or infringement notices, AMSA relied on state and territory officers to obtain sufficient admissible evidence to support those actions **(refer Attachment A)**. The WA Police also played a vital role as marine safety inspectors (MSI) in compliance and enforcement activities, and still do.

Given these arrangements, this submission includes references to or quotes from evidence, reports and recommendations from WA authorities.

Immediate actions taken

When an incident occurs, AMSA's regulatory focus is on dealing with immediate safety issues. We will then work with the operator to identify any additional or different compliance measures that may be required. Identifying whether enforcement action is warranted for non-compliance, and amending the regulatory framework, comes later.

In the immediate aftermath of the tragedy, AMSA assisted WADOT by providing it with draft notices for use by WADOT delegates and MSIs if they decided such action was needed. The effect of these notices would have been to:

- prohibit the operator, Dolphin Dive Centre Fremantle Pty Ltd (DDCF) from operating its vessels *Ten Sixty-Six, Pia Rebecca, C998* and *Takashi*;
- suspend DDCF's certificate of operation;
- suspend the master of the *Ten Sixty-Six's* certificates of competency; and
- require that DDCF 'show cause' as to why its certificate of operation should not be revoked.

The effect of these notices, if issued, would have been to prevent vessels operated by the operator and master posing any immediate further risks to passenger safety. Generally, issuing these kinds of notices would have significant financial and reputational implications for the operator and master.

Prohibition notices issued in relation to *Pia Rebecca*

Following the incident, WADOT looked at the DDCF vessels including the Pia Rebecca. As a consequence of safety deficiencies found during an inspection of the vessel Pia Rebecca by WADOT MSIs after a voyage on 2 November 2014, two prohibition notices were issued to DDCF. The effect of the notices was to:

- prohibit operation of the vessel until specified actions in relation to specified equipment had been carried out; and
- prohibit passenger access to the bow of the vessel and require minimisation of crew access and movement around the bow area of the vessel.

Direction notice issued requiring an additional crew member

On 7 November 2014, a WADOT MSI issued a direction notice requiring DDCF to engage an additional crew member on all its charter operations with their sole duty being the supervision of passengers. The direction was valid for 90 days. AMSA has no evidence as to whether this direction was complied with or whether the vessels continued to operate in accordance with this notice after the 90 day period.

The recipient of this direction did not seek an internal review or court stay in relation to this action.

DDCF's certificate of operation suspended

As a consequence of further information gathered by WA MSIs, a recommendation was made to a WADOT sub-delegate to suspend DDCF's certificate of operation. The suspension of the certificate of operation effectively prohibited the operation of all four vessels operated by DDCF. The WADOT sub-delegate made that decision and issued a notice of suspension on 13 November 2014.

DDCF asked to show cause why its certificate of operation should not be revoked

WADOT decided, on or around 2 December 2014, to issue a notice to DDCF asking DDCF to show cause why its (then suspended) certificate of operation should not be revoked. That show cause notice was given to a representative of DDCF on 3 December 2014.

Direction notices issued requiring out of water survey for all vessels

As a consequence of concerns raised during an inspection of DDCF vessels Ten Sixty-Six, Pia Rebecca and Takashi on 20 November 2014 by WADOT MSIs and a WADOT marine surveyor, a WA MSI issued a direction notice on 3 December 2014 requiring that all vessels whose operation was authorised by DDCF's certificate of operation undergo 'out of water surveys'.

Application made for internal review of decisions to suspend DDCF's certificate of operation and to issue direction notices requiring out of water survey – direction notices 'overturned'

The National Law provides a right to internal review by AMSA of specified decisions made under the National Law. Those decisions include the suspension of the certificate of operation and the issue of the direction notice requiring 'out of water surveys'. DDCF applied for internal review of those decisions on 12 December 2014.

Under section 140 of the National Law, internal review of specified decisions involves a person not involved in making the original decision and who is senior to the original decision-maker stepping into their shoes and deciding whether the original decision is the correct and preferable one, having regard to all available information. It is open to the internal review decision-maker to affirm, vary or revoke the original decision; and if they do revoke the original decision, to make any other decision they think appropriate.

On 24 December 2014, a person acting in the position of AMSA's General Manager Domestic Vessel Division (GM DVD), as a delegate exercising the internal review power, revoked the decision of the MSIs as the original decision-maker to issue direction notices for out of water survey. The suspension of the certificate of operation remained in effect.

The internal review was informed by an independent technical assessment conducted by a then AMSA employee, suitably qualified in the area of vessel survey. That report concluded there was insufficient evidence to indicate the vessels Ten Sixty-Six, Pia Rebecca and Takashi were unsafe, or to justify these vessels needing to be removed from the water for inspection. It is understood that the vessels were well known to WADOT, which had certified that the vessels were fit for purpose prior to the incident in a recent periodic survey. The report stated that it would be most unusual that a vessel which had recently passed a periodic survey (performed by WADOT) to deteriorate in a manner which required an out of water survey, unless there had been some major trauma to the hull.

On application from DDCF, the Federal Court orders a stay of the decision to suspend DDCF's certificate of operation and the decision to issue the show cause notice

On 24 December 2014 the Federal Court made orders staying the WA delegate's decision to suspend DDCF's certificate of operation and to issue the show cause notice as to why that certificate should not be revoked. Although DDCF's application to the Federal Court also requested a stay of the direction requiring the out of water surveys, that direction had effectively been 'overturned' by the acting GM DVD and did not therefore have to be considered by the Court. The effect of the Court's orders and the 'overturning' of the direction requiring the out of water surveys was that DDCF was lawfully able to return to operations.

The Federal Court's decision was an interim one. It was not a finding that the decisions under review were unlawful. The Court's judgment stated, among other things, that:

> *It is the peak usage time of the year for Dolphin Dive. Inability to operate poses a serious financial risk to the viability of the business and its employees. … A primary concern to me is the extent to which safety is at risk.… I form no final view… I do not propose to rehearse all of the arguments of the parties...*
>
> *I do not propose descending, at this point into an analysis of the strength of the argument [that Dolphin Dive was not afforded an opportunity to be heard in relation to the Suspension Decision], other than to observe that there are clearly challenges in the arguments that are advanced by Dolphin Dive. …*
>
> *From a more practical perspective, the nature of the communications to date between the parties and their representatives, the nature and extent of the arguments today and what is at risk from the point of view of Dolphin Dive, together mean that there is a very clear understanding from Dolphin Dive's perspective, that its activities will potentially be under the microscope by AMSA and its representatives, particularly if a brief interlocutory stay is granted.*
>
> *I am satisfied that if Dolphin Dive is granted a brief stay of the Decisions that have been made by AMSA, the public interest will be protected, particularly bearing in mind the matters I have just mentioned. …*

As a consequence of the Court's orders, officers of the WA Government and AMSA worked on the preparation of reasons for the decision to suspend the certificate of operation. These were due by 9 January 2015. The Court said, in effect, that the internal review of the decision to suspend the certificate of operation could continue.

Suspension of certificate of operation 'lifted'

On or around 14 January 2015, WA MSIs inspected the vessels *Takashi* and *Ten Sixty-Six* and formed the view that all issues of concern had been addressed. WADOT officers sought advice from AMSA on how to end the suspension of DDCF's certificate of operation. AMSA drafted a letter for WADOT's consideration which, if issued by WADOT, would bring that about, for consideration by the WADOT delegate. AMSA also asked whether the show cause process potentially leading to revocation of the certificate of operation should continue. WADOT decided that the show cause process should continue, given their ongoing concerns about DDCF at that time.

On or around 23 January 2015, WA MSIs inspected the vessel *Pia Rebecca*, and formed the view that all issues of concern in relation to that vessel had been addressed and recommended to AMSA that the suspension of DDCF's certificate of operation be 'lifted'. The letter lifting the suspension was sent by the WADOT delegate on the same day.

Withdrawal of the notice to show cause as to why the certificate of operation should not be revoked

During the period 30 January 2015 to 3 February 2015, discussions occurred between WADOT and AMSA officers. The position of WADOT officers was that the show cause process and Federal Court proceedings should continue. AMSA's representative recommended they be discontinued.

The WADOT officers indicated that if AMSA recommended that the show cause notice be withdrawn, and provided a draft notice of withdrawal, WADOT would act on that recommendation.

AMSA sent a draft notice of withdrawal to the WADOT on 2 February 2015.

Records indicate that AMSA recommended that the show cause be withdrawn because, among other things:

> *The requirement to 'show cause' aims to oblige the operator to provide evidence in response to material that may suggest to a decision maker that a certificate of operation be revoked. However evidencing compliance may be able to be accomplished more effectively by direct National Regulator involvement with the operator.*

If this approach were taken, there would be nothing remaining for substantive argument in the Federal Court.

Records show that AMSA offered to arrange for a safety management system (SMS) audit which would require the operator to demonstrate competence to operate vessels. This audit would have involved a review of the appropriateness of the SMS, the risk assessments undertaken to identify required responses and a verification that processes and procedures were being practically implemented according to the SMS.

WADOT officers declined the assistance of an SMS auditor.

The WADOT delegate withdrew the show cause notice on 3 February 2015, which effectively ended the show cause process.

Outcome of internal review of decision to suspend DDCF's certificate of operation

On 17 February 2015 AMSA's GM DVD completed the internal review of the WA delegate's decision to suspend DDCF's certificate of operation on 13 December 2014. GM DVD decided that the certificate should not have been suspended on 13 November 2014. However, at the point AMSA's GM DVD made the decision (17 February 2015) the WA delegate had already 'lifted' the suspension (23 January 2015).

Assessment of WA reports

AMSA considered the reports of both the WA Police and WADOT in relation to the operation of the *Ten Sixty-Six* on the day of the incident, and the wider operations of DDCF.

WADOT summary report

On or about 21 December 2014, WADOT provided AMSA with a summary report. The report outlined the sequence of events that followed from initial enquiries into the death of Mr Mills. It also included their inquiries and the copies of evidence gathered.

When the summary report was submitted to AMSA, it stated that evidence gathered up until that date indicated that the master/owner may have failed to comply with his general safety duty as provided for by sections 12, 16 and 17 of the National Law; and may have breached a condition on a certificate of survey under sections 45 and 46 of the National Law.

WA Police report

On 12 February 2015, the WA Police provided a copy of their investigation report to AMSA. It recommended that two charges be brought against the master for general safety duty breaches as provided for by section 16(1) of the National Law. The proposed charges were based on the following:

1) The master failed to implement and comply with the SMS for the vessel and the operations of the vessel: by not complying with the master's responsibilities and induction requirements as outlined in the safety management system'.

2) The master failed to implement and comply with the safety management system for the vessel and the operations of the vessel: by not conducting a count of the passengers at the conclusion of the charter while disembarking'.

Final WADOT report

The final WADOT report was submitted to AMSA on 22 May 2015, recommending that a number of offences be considered, specifically offences general safety duties and breaches of a condition on certificates of survey.

AMSA assessment of the WADOT and WA Police reports

During the period February to August 2015, AMSA reviewed the reports from the WA Police and WADOT together.

Both WA Police and WADOT recommended charges be considered against the master for breaching his general safety duties. In addition, the WADOT report concluded that the owner breached his general safety duties and caused vessels owned by DDCF to be operated in breach of their respective certificates of survey.

WA Police recommendations - failure to conduct a headcount

AMSA identified several issues with the recommended offence relating to headcounts. Primarily, the evidence supplied in relation to head counts to AMSA by the WA Police, then to the coroner for the inquest into the death of Mr Mills, did not support, beyond a reasonable doubt, the conclusion that a head count wasn't conducted as required in the SMS. The master maintained that he did conduct the required headcounts, while the statements of other persons on the *Ten Sixty-Six* provided by WA Police are inconclusive in this regard.

Five of the 34 other people that spoke to police definitively say that a head count wasn't conducted at the conclusion of the charter. Of the remaining 29 people, 23 indicate that they either don't know, don't believe or don't remember if a headcount was conducted, and the remaining six were not asked about headcounts conducted at the conclusion of the voyage.

The primary difficulty faced by AMSA in assessing the evidence in relation to the allegation that a headcount was not conducted was that there was no identified procedure for conducting a headcount listed in the SMS for the operation. As a result, it was not possible to prove the master had not done a head count as that process could be undertaken without being obvious to an observer. In addition, there is no specific offence for undertaking an incorrect head count.

If investigators can prove the required act or omission, then the degree of fault of the master becomes relevant. The WA Police report did not make any recommendation as to the level of fault they had found or the evidence specific to the fault element they sought to prove.

WA Police recommendations - failure to induct a crew member

In terms of the induction of the crew member the report provided evidence that indicated that the crew member hadn't been appropriately inducted onto the vessel. The SMS for the operation contained a procedure for the induction of crew.

There was also evidence contained in the report that the deckhand spent some time incapacitated (possibly sea sick) because of the nature of the voyage.

AMSA Compliance and Enforcement Policy and the associated National Law Protocol that applied at the time did not support prosecution for such an alleged breach. The Protocol stated that '*prosecution would be undertaken for the most serious breaches of the National Law*'.

AMSA's assessment of possible penalties

No evidence was provided by WA Police that the master intended to, by failing to conduct a headcount and failing to induct a crew member, put the safety of a person or the domestic commercial vessel concerned at risk. Further, no evidence was provided by the police to support the conclusion that in failing to conduct a headcount and failing to induct a crew member that the master was reckless or negligent.

Had these charges been prosecuted without proof of fault, the maximum penalty possible on conviction would have been a fine of $10,200.

AMSA accepts that we could have issued the master with an infringement notice relating to the allegation that he failed to induct the crew member with an associated fine of $2040.

In accordance with the *Crimes Act 1995* (Cth) there is a 12 month period allowed to prosecute an individual for an offence for which the penalty is less than six months imprisonment. Only the general safety duty offence requiring proof of intent carries a penalty greater than six months imprisonment.

In relation to the WA Police report, AMSA has again reviewed the recommendations made by the police and maintains that the facts and matters raised by WA Police did not support and/or warrant prosecution of the master.

Assessment of WADOT report

The primary focus of WADOT's report to AMSA was on the apparent falsification of fire suppression system and life raft documents that were presented to WADOT and which were required for issue of formal statutory certification by WADOT.

WADOT also suggested that on multiple occasions the master of vessels associated with the certificate of operation held by DDCF operated with too many passengers for certain prescribed waters.

In relation to the general safety duty, WADOT recommended that:

(1) the owner intentionally, by falsifying the records, put at risk the safety of a person or the domestic commercial vessel concerned; and
(2) the owner breached a condition on the certificates of survey held by DDCF, by operating, or causing or permitting the vessels to be operated with too many passengers for certain prescribed waters; and
(3) the master intentionally, by operating with safety equipment that was unserviceable , put at risk the safety of a person or the domestic commercial vessel concerned; or
(4) in the alternative, that AMSA consider multiple counts of the strict liability offences associated with the breach of duties as an owner and master.

No evidence was provided with the WADOT report that the operator or master intended, by allegedly falsifying records or operating with 'unserviceable' safety equipment, to put the safety of a person or the domestic commercial vessel concerned at risk. In addition, there was no evidence provided that falsified certification directly led to a risk to safety (for example, the firefighting systems and life raft may still have worked perfectly at the time the documents were shown to the surveyors on the date they were last surveyed by WADOT).

As stated previously in relation to the proposed WA Police charges, the lack of evidence suggesting intent to do harm or being reckless or negligent in relation to general safety duty breaches left AMSA with the option of pursuing multiple counts of the strict liability offences, which carry a maximum penalty of $10,200 per offence and no jail time.

For the reasons outlined above, issuing an infringement notice was considered inappropriate in the circumstances.

Carrying too many passengers

There was evidence provided to suggest that the master of the three vessels operated by DDCF may have operated with too many passengers for certain prescribed waters. WADOT suggested this would be an 'owner' offence; however, the 'conduct element' of the offence would be more appropriately attributed to the master.

Commission of the offences would depend on exactly where the vessel was operating. WADOT and later AMSA made attempts to clarify what the logbook entries meant in this regard; however the entries remained uncertain. AMSA could have issued the master an infringement notice with a fine of $2040 for each offence with less evidence than would have been required to prosecute. However, it should be noted that if an infringement notice is not paid, the remaining option is to prosecute for the original offence. Given this, AMSA decided that pursuing the matter via infringement was also inappropriate.

Fraudulent certificates

Following receipt of WADOT's report, AMSA, in conjunction with WADOT, sought and obtained additional evidence from WA Fire Protection in relation to work that they had done on vessels associated with DDCF. These inquiries were conducted between 4 and 9 June 2015. On 15 July 2015, following on from earlier discussions, AMSA sent an email to the acting Manager of Compliance and Investigations at WADOT asking for additional evidence for the *Dolphin Dive* brief of evidence.

AMSA again sought the information from WADOT on 3 August 2015 stating that the evidence was pivotal to the offence elements and it was critical that AMSA received that information as soon as possible.

On 24 August 2015 AMSA had a teleconference with WADOT where AMSA raised concerns about recent evidence and draft statements from the marine surveyors.

WADOT agreed with these concerns and undertook to obtain statements from all the surveyors across the three vessels that addressed the elements of the alleged offences.

The quality of these statements and evidence were critical decision points for this matter and AMSA briefed WADOT accordingly. It is important to note that at this stage the discussions still related to the charges under the National Law.

On 26 August 2015, WADOT and AMSA had a teleconference where WADOT informed AMSA of further apparent fraudulent behaviour. Following the teleconference, WADOT sent an email to AMSA outlining this new information. Specifically, this new information related to an apparent false declaration made to clear a prohibition notice.

As AMSA was already considering possible offences under the *Criminal Code Act 1995* (Cth) (Criminal Code Act) relating to the facts and matters raised by WADOT, AMSA chose to use this new information provided by WADOT to supplement existing evidence of the fraudulent behaviour.

On 27 August 2015, AMSA and the Commonwealth Department of Public Prosecutions (CDPP) met in Townsville to discuss the DDCF matter. This was the first meeting AMSA had with the CDPP to formally discuss this matter. On 2 September 2015, AMSA had a teleconference with the CDPP to further discuss the matter.

Production of a brief of evidence relating to the allegation of fraudulent behaviour

On 2 September 2015, AMSA began the production of a brief of evidence for alleged offences set out in the following sections of the Criminal Code Act:

- 145.1 (using a forged document related to certification for fire suppression and life rafts) and
- 137.1 for providing false and misleading information in relation to the clearance of the prohibition notice).

Conversations following the production of this brief of evidence indicate that the CDPP and AMSA also considered an additional alleged offence of general dishonesty (section 135.1(1)).

On 8 September, David Marsh, Manager of Domestic Vessel Compliance and Enforcement at AMSA, emailed Chris Mather from WADOT stating that AMSA would be in Fremantle on 14 September 2015 to obtain, among other things, additional statements from four WADOT staff members:

- Jeremy House – one of the WADOT investigators who produced their report
- Brett Hurley – one of the WADOT investigators who produced their report
- Luke De Gracie – WA MSI who issued the prohibition notice in question, and
- Kurt Lund – the marine surveyor who accompanied Brett Hurley and Jeremy House on their inspection of DDCF vessels on 20 November 2015.

The additional statements were required to provide further clarity in relation to the issue and clearance of the prohibition notice and apparent fraudulent documents discovered from 2 November 2014 onwards. The email from David Marsh to Chris Mather made it clear that a limitation period applied. This limitation period only applied to any National Law charges recommended by WADOT that were still under consideration. The Criminal Code Act offences being considered had no limitation of time due to the quantum of the possible penalty.

On 14 September 2015, AMSA travelled to WA to attend WADOT's offices to get the additional statements and evidence from WADOT staff. Meetings were also arranged with the service agents for the life rafts and the firefighting systems along with WA Water Police. AMSA was unable to obtain a statement from Kurt Lund at this time.

On 23 September 2015, AMSA received a draft statement from another WADOT inspector, Brad Wilson, who was with Luke De Gracie for the inspection of the *Pia Rebecca* on 2 November 2015. It was this inspection that led to the prohibition notice being issued. Brad Wilson was on leave and stated that he was unable to obtain a signed version of the statement until he returned from leave in October 2015.

On 2 October 2015, AMSA offered the master an opportunity to participate in a formal record of interview. AMSA was also considering on or about this date seeking advice from handwriting experts to analyse documents received to date.

On 9 October 2015, AMSA and the CDPP met in Townsville to discuss the DDCF matter. A brief of evidence had been prepared prior to this meeting. As a result of this meeting AMSA focused on supporting the Criminal Code Act offences.

AMSA continued work until 15 October 2015 to produce the brief of evidence, including drafting evidence matrices.

On 19 October 2015, AMSA received Brad Wilson's signed statement and supporting exhibits.

On 22 October 2015, David Marsh emailed WADOT asking that Kurt Lund provide his statement. On 26 October 2015, WADOT replied stating:

> 'I had a chat with Kurt Lund and he is not willing to give a statement of any kind in relation to his attendance with Brett and Jeremy in November 2014 on the Dolphin Dive

> vessels. The most we now have in relation to his observations is encapsulated within the email attached'.

Further on 29 October 2015 WADOT emailed AMSA and stated:

> 'We are looking at alternative means to obtain a statement from Kurt. Unfortunately this is not possible in the immediate short term. However, we hope that we may have an outcome, one way or the other, within the next couple of weeks. While we will do our best to ensure it is sooner rather than later, given the current and potential sensitivities we are dealing with we are not able to guarantee an outcome in the next week.'

The email asked that AMSA advise the CDPP that they were still gathering evidence and it was not yet over.

WADOT investigators continued to attempt to obtain a statement from Kurt Lund. However, he informed AMSA on 3 November 2015 that he would not provide a statement to AMSA and at most would only provide an email outlining his involvement with the inspection on 20 November 2014. On 4 November 2015, AMSA expressed its concern to WADOT about the fact that Kurt Lund was not willing to provide a statement.

On 5 November 2015, WA DoT provided a signed statement from Kurt Lund to AMSA. Of important note is paragraph 6 of his statement which reads 'Following my Manager's advice I did NOT make notes and I did NOT take any photos.'

On 30 November 2015, AMSA, after gathering all evidence available, met with the CDPP via teleconference to discuss the DDCF matter. The attendees from AMSA were David Marsh and Mandy Nixon, Senior Officer Prosecutions; and from the CDPP, Gary Davey, Assistant Director and Madonna Hayes. AMSA updated the CDPP on the current situation and evidence gathered to date. The CDPP representative expressed concerns about the matter in general including concerns that quality control across both WADOT and AMSA was poor.

The CDPP further expressed concern to AMSA that Kurt Lund's actions and statement were problematic due to Kurt Lund stating that the accused was keen to correct the situation, and was cooperative; and questioned the motives of Kurt Lund's own actions and the way in which he was directed to act by his manager. David Marsh has produced his notes from this meeting and has confirmed that the notes reflect the CDPP representative's final comment to the effect that there remained significant obstacles to completing a brief of evidence with a reasonable likelihood of successful prosecution.

The CDPP undertook to provide AMSA with written 'pre-brief' advice. On 4 and 17 December 2015, AMSA provided the CDPP with additional information to assist the CDPP in providing this.

The CDPP sent AMSA written 'pre-brief' advice on 8 January 2016. This was specifically in relation to information provided to the CDPP in relation to the *Pia Rebecca* and identified a number of significant issues with the evidence provided to date, which could be applied across the evidence gathered in relation to the two other vessels.

AMSA met with WADOT on 22 February 2016 to brief them on both the meeting with the CDPP on 30 November 2015 and the 'pre-brief' advice received from them on 8 January 2016. The focus of the discussion was on the concerns raised by the CDPP on 30 November 2015; however, the entire DDCF matter was discussed, including the WA Police report and its shortcomings in evidence.

AMSA stated at the meeting that it decided not to complete the brief of evidence based upon discussions with and written 'pre-brief' advice from the CDPP because pursuing charges was unlikely to be successful.

AMSA has since reviewed the recommendations contained in the WADOT report and maintains that the facts and matters raised by WADOT were difficult to pursue under the National Law, but were appropriate to be considered as relevant information to support the Criminal Code Act charges that AMSA 'built' its draft brief of evidence around. AMSA still considers that lack of

direct evidence of the owner's involvement in creation of the false documents means the likelihood of securing a conviction remains low.

Relevant regulations

Regulatory requirement at the time of the incident

The Statement of Intent in Schedule C of the IGA obliged AMSA to 'grandfather' survey, construction, equipment and operational requirements for domestic commercial vessels. This meant that at the time of the incident, the *Ten Sixty-Six* was complying with requirements imposed by WA law in relation to, among other things, head counts, crewing, rail heights and equipment carriage. A vessel built today would be built, operated, equipped and inspected to a higher standard.

As a safety regulator, the obligation to allow vessels to continue to comply with older requirements has never sat comfortably with AMSA. It limits our capacity to make changes focussed on enhancing safety, because there is no obligation for operators with older vessels to comply with the newer, safer standard.

In terms of the National Law, the operational standards that apply to a domestic commercial vessel are imposed through conditions on a certificate of operation. In addition to passenger monitoring and head counts, operational standards include requirements in relation to undertaking risk assessments, crewing arrangements, emergency preparedness and maintenance.

Marine Order 504 (Certificates of operation – national law) 2013 (Marine Order 504 – 2013), which was in force on 31 October 2014 imposed specific conditions on certificates of operation. These conditions gave effect to 'grandfathering' arrangements allowing existing vessels such as the *Ten Sixty-Six* to comply with certain state and territory requirements that applied before 1 July 2013.

As an existing class 1 passenger vessel, the owner of the *Ten Sixty-Six* was required to comply with the operational requirements and practices applied by Western Australia on 30 June 2013.

Accordingly, the practices and requirements imposed by WA prior to 1 July 2013 include those in the *W.A. Marine (Emergency Procedures and Safety of Navigation) Regulations 1983* which gave effect to the NSCV Part E (Operational Practices), Edition 2 dated 2008.Clause 2.11.2.2:

> 'For all other passenger-carrying vessels *(vessels on voyages less than 12 hours in duration)* a head count of the passengers on board at any time shall be maintained.' (Italics inserted.)

As well as the conditions imposed on the certificate of operation for the vessel, the owner and master have general safety duties imposed by the National Law. The general safety duties are a separate and additional obligation from the requirement to comply with the conditions imposed by a certificate of operation. However, these two requirements are complementary.

Since 1 July 2013, the National Law has provided, among other things, that the owner of a domestic commercial vessel must implement and maintain a SMS that ensures that the vessel and the operations of the vessel are, so far as reasonably practicable, safe. A corresponding duty is placed on the master of a vessel to implement and comply with the vessel's SMS.

It is noted that, irrespective of the requirements imposed through the certificate of operation and the *W.A. Marine (Emergency Procedures and Safety of Navigation) Regulations 1983*, the SMS for the *Ten Sixty-Six* did have a requirement for two head counts to be conducted and recorded in the logbook.

WA Police only investigated potential breaches of the general safety duties, including failure to comply with the requirement in the SMS to conduct two head counts. WA Police did not investigate breaches of conditions on the operator's certificate of operation.

The current regulatory requirement

The general safety duties, including the requirement for a master to implement and comply with a SMS, continues to apply.

Marine Order 504 (Certificates of operation and operation requirements – national law) 2018 (Marine Order 504 – 2018), which came into effect on 1 July 2018, incorporated the operational requirements contained in the latest version of Part E into a new schedule of this Order. This was intended to simplify the regulatory structure so that all operational requirements were in the one place. In incorporating these operational requirements, AMSA took the opportunity to clarify and strengthen the wording of the head count requirements to reinforce that there was a positive obligation on the master of a vessel to ensure that a head count is undertaken. The head count requirement now provides that:

> **'For a voyage that is less than 12 hours long, the master must:**
>
> - **ensure that at least 1 head count is conducted of all passengers on board the vessel; and**
> - **know the number of passengers on the vessel at any time.'**

The new Order also places an enhanced focus on the owner's responsibility to ensure that a vessel has appropriate crewing levels to supervise passengers and keep them safe.

Marine Order 504 – 2018 requires that the owner must conduct and document in their SMS an appropriate crewing evaluation in order to determine the number and qualifications of the master and crew required for their particular operation. The factors that they must take into account are set out in the Order. Previously, one of the factors the owner needed to consider was 'the number of persons to be carried on the vessel'. AMSA extended this to provide that the owner's evaluation take into account, among other things

> **'the number of persons to be carried on the vessel and the effectiveness and timeliness arrangements for passenger monitoring by the crew.'**

This requirement was intended to complement the existing head count requirement to ensure that headcounts be undertaken by crew as frequently as is necessary for the type of operation and reported to the master. This highlights how effective passenger monitoring is dependent on a range of different factors.

At the time that the WA Coroner published her report on the coronial inquiry into the death of Mr Mills in 2017, the review of Marine Order 504 was still ongoing. In her report, the Coroner noted AMSA's evidence in relation to the diverse nature of commercial passenger vessels, and the appropriateness of taking a flexible approach requiring the owner and master to address the issue of head counts through the safety management system. The Coroner did not make any recommendations in her report in relation to head count requirements on the basis that she was, on balance, convinced that AMSA's regulatory approach, combined with compliance and education, was the most suitable way of managing the issue.

Education and awareness

From a safety education perspective, SMS workshops have been conducted by AMSA in WA targeting all domestic commercial vessel sectors. These workshops are focussed on ensuring that operators understand their SMS obligations as they apply to their particular vessel and operation.

AMSA has developed new guidance on SMS, including information on head counts. Our dedicated industry liaison officers in each state use the guidance in their work with operators. AMSA has also published guidance material on meeting SMS obligations and the operational safety requirements, including practical guidance on developing, implementing and maintaining a SMS.

More specifically to this sector, AMSA has participated in the past and more recently facilitates annual pre-season briefings of the Charter Boat Industry and the Whale Watching Industry Groups. These briefings are conducted between AMSA, WA Police, WADOT, WA Parks and Fisheries and industry groups such as the Swan River Trust and Rottnest Island Group along with individual operators. These briefings are conducted at the start of holiday / charter seasons and have had specific focus on passenger safety.

AMSA's current governance and structure

If we were to face a similar situation today, things would be vastly different. AMSA has now assumed responsibility for the physical conduct of compliance and enforcement activities in relation to domestic commercial vessel although there remain 225 state and Northern Territory agency officers appointed as National Law MSIs. In addition, all police officers remain National Law MSIs. These are supported by memoranda of understanding (MoUs) and service level agreements (SLAs).

An enforcement and inspector support team has been established in AMSA to investigate and, if necessary, take enforcement action in relation to the most serious breaches of AMSA's regulatory framework and other serious incidents. The team investigates all fatalities reported to AMSA. We also have better internal processes for decision-making, documentation and reporting. This includes providing formal fortnightly reports at AMSA's Executive meetings about the number of investigations, details of those for which AMSA is developing a brief of evidence and those which have been forwarded to the CDPP for assessment.

From an organisational perspective, we are confident in our current structure, delegation and decision-making processes. Resources allocated to our Enforcement and Inspector Support team will be monitored to ensure it is provided with additional investigators to manage caseloads, as required.

AMSA's reflections on the case

Operational interactions

It is evident that the National System transitional arrangements that were in place at the time of the events outlined above were not working as they should. There were differences of opinion between AMSA and WADOT about the appropriate regulatory and administrative actions in response to technical and operational matters.

There was a disconnect between WA Police, WADOT (who were leading the investigations and gathering evidence) and AMSA who was pursuing the prosecution.

AMSA accepts responsibility for its part in this process. We should have communicated better with WA Police and with WADOT, and we should have made clearer where decisions, directions and responsibilities lay.

The November 2014 decision of the COAG Council to end this arrangement by passing full responsibility for all matters related to the National System to AMSA is evidence of the seriousness of these failings.

AMSA assumed responsibility for National System service delivery from states and territories on 1 July 2018 and we are working hard to make sure that these new arrangements result in demonstrable improvements in the safety of the domestic commercial vessel industry.

AMSA's engagement with families

AMSA has reflected on this matter in terms of what we could have done better. Returning to the statements made by Ms Mills at the Perth hearing on 21 March 2019, we deeply regret our lack

of engagement with Mr Mills' family throughout this extended case. While Mr Marsh spoke with Ms Mills on a few occasions, this is an AMSA responsibility, and Ms Mills is right to point out that AMSA should appoint an official who will stay in contact with families and keep them informed until regulatory actions are completed.

AMSA will now ensure that where appropriate there is a nominated contact person assigned to family members of people affected by serious marine incidents.

Head counts

There has been much focus on the issues of head counts, investigation and prosecutions. All of these are clearly relevant but AMSA believes a more comprehensive approach is needed to deliver better safety outcomes. This incident has demonstrated the flaws in relying solely on head counts. The traditional concept of a head count is subject to human error and can be replaced by technology and other innovative solutions. AMSA will pursue a more holistic approach into the future as detailed below.

AMSA believe this approach has a greater likelihood of delivering the outcomes being pursued than focussing on any one particular measure, and propose to work with stakeholders to develop the following proposals.

Potential new AMSA measures aimed at prevention

The *Ten Sixty-Six* was a former cray-fishing vessel, allowed to operate under 'grandfathering' arrangements provided for in the IGA. AMSA is not convinced that these arrangements, which allow higher risk operations such as passenger charters to operate in accordance with an older and often lower standard, are consistent with contemporary safety expectations. For example, some vessels that were constructed in accordance with grandfathered state and territory requirements are known to be 'in survey' with railings at no more than 850 mm when the centre of gravity of an adult male is closer to 1000mm - meaning the likelihood of overbalancing is increased. The contemporary rail height requirement for a vessel of this kind is 1000mm.

Irrespective of 'grandfathering' arrangements, AMSA is investigating further requirements for these types of vessels and their operations aimed at minimising the chance of passengers going overboard, maximising survival if they do, and better ways to monitor and account for passengers throughout the voyage. This is further outlined below.

1. **Accounting for and monitoring of passengers on board**
   Being able to account for the number of passengers on the vessel and in particular those getting on and off, along with monitoring whilst on board, could include:
   a. more explicit requirements in terms of accounting for passengers while embarking, disembarking and during a voyage
   b. as has been highlighted by Mrs Mills, an enhanced role for technology in terms of electronically accounting for those embarking and disembarking, for example swiping, monitoring arrangements and buddy systems, and
   c. the use of CCTV or crew on board with dedicated responsibilities for on board monitoring.

It should be noted that items a. and b. do little to eliminate the risk of a person falling overboard. Item c. would do more to proactively eliminate this risk, which is important given that on the *Ten Sixty-Six,* no one witnessed Mr Mills falling overboard despite it being a relatively small vessel.

2. **Mitigate the risk of passengers falling overboard**
   As noted above, some vessels that were constructed in accordance with grandfathered

state and territory requirements are known to have rail heights that do not align with contemporary standards. Measures that will be considered include mandating:

a. physically raising the rail height in passenger accessible areas
b. barriers on open decks, such as meshing
c. non-slip decking
d. clear decks – removal of trip hazards in the area of exposed deck sides, and
e. stronger requirements for a vessel's safety management system to identify and mitigate the risks.

3. **Maximise the chance of recovery if a passenger falls overboard**
Measures that will be considered include:
    a. the wearing of a personal flotation device while on board if the risk of a person falling overboard cannot be eliminated
    b. incorporation of personal locator beacons on worn lifejackets
    c. employing technology which can monitor the proximity of passengers and raises an alarm should someone fall overboard (man overboard alarm), and
    d. stronger requirements for reviews of on-board emergency procedures and crew training on these procedures.

Ms Mills has proposed that AMSA implement 'Damien's Law', which would mandate two head counts and a system of lanyards or wristbands. We welcome this proposal which highlights that there is an enhanced role for technology in terms of electronically accounting for those getting on and off a vessel. It should also be noted that structured arrangements for crew to monitor passengers would also assist to proactively eliminate this risk.

AMSA will investigate these further requirements for these types of vessels and their operations and if it is considered necessary, we will work to make appropriate regulatory amendments.

Legislative change

In addition, the Committee may also consider making recommendations that legislative change occur, including that:

- the limitation period for bringing non-custodial charges under the National Law be extended from 12 months to two years, and
- the current general safety duties offences should be augmented by a more serious offence in the case of breach of general safety duty that leads to a death.

Conclusion

We welcome the opportunity to discuss this submission with the Committee. We thank the Committee for shining a light on maritime safety and allowing us the opportunity to make this submission and explain our actions, past and present.

Mr Mills' death was a tragedy, and we are disappointed with the outcome of the case. While we cannot change these events, we will work to help deliver a meaningful outcome which will ultimately improve the safety of those who live, work and spend their leisure time at sea.

Attachment A: 2014 Authority and arrangements for investigations and prosecutions

In the case of potential compliance and enforcement actions involving prosecutions or infringement notices, AMSA necessarily relied on state and Northern Territory officers to obtain sufficient admissible evidence to the requisite standard, in a timely way, to support that action. The arrangements and allocations of responsibilities, and their consequent practical constraints, remained in place until 1 July 2018, spanning the period in which the Mills tragedy occurred.

In relation to compliance and enforcement, the IGA said the following about the role of the states and Northern Territory:

> *On commencement of the national system in 2013, operational functions of the National Regulator will be primarily delivered by existing States and Territory maritime safety administrations, although particular functions, for example survey and on water compliance services, may also (or only) need to be delivered by other accredited service providers. This will be achieved by the National Regulator through delegation or accreditation powers, which are expected to be used, especially in the areas of decision making, compliance and on-water enforcement. Delegation and accreditation will be available for individuals and/or organisations including jurisdictional maritime agencies or, where agreed by the relevant State or Territory, other appropriate entities' (i.e. Water Police), or private sector service providers. This will allow jurisdictions to control staffing and administration.*
>
> *…*
>
> *Jurisdictions will continue to carry out (under delegation or accreditation from the National Regulator where it involves the execution of the national law) all activities they previously undertook, other than those which will now be undertaken by the National Regulator. Activities to be undertaken by jurisdictions include:*
>
> *…*
>
> *Operating national compliance arrangements under the national law within the jurisdictions, including undertaking, or working with State agencies to undertake survey activity and commercial vessel safety inspections, as well as determining and approving operating requirements for vessels.*
>
> *…*
>
> *Undertaking investigations and compliance and enforcement activities, including negotiating enforceable undertakings with individual industry operators. These activities will be conducted in accordance with national guidelines developed through cooperative Commonwealth/State/Territory processes.*
>
> *State and Territory maritime safety agencies will be delegated all necessary powers, including the ability to engage third party enforcement agencies to conduct incident investigations and exercise a range of operational policy, compliance and enforcement powers, such as the power to vary, suspend or cancel certificates, as well issue infringement notices and prepare briefs for prosecutions on behalf of the National Regulator. These arrangements will enable the most appropriate regulatory response to be used to secure compliance with and enforce the National Law. These activities will be conducted to agreed guidelines and codes of conduct and jurisdictions will be involved in the setting of such protocols through consultative functions described above.*

To facilitate the above, the National Law included provisions for:

- delegation of AMSA's powers and functions to officers of state and Northern Territory governments, and the further sub-delegation by those officers to other officers of state and Northern Territory governments
- the appointment of officers of state and Northern Territory governments as MSIs, and
- the automatic recognition of all police officers, including those of state or Northern Territory governments, as MSIs.

In the lead up to the commencement of the National Law, AMSA's focus was on:

- delegating powers to senior state and Northern Territory government officers;
- facilitating the sub-delegation by those delegates of their powers to other state and Northern Territory government officers;
- facilitating the appointment by state and Northern Territory government delegates of MSIs; and
- the training and coordination of the delegates, sub-delegates, appointed marine safety inspectors and police MSIs.

In relation to compliance and enforcement, the IGA said the following about the role of AMSA:

Developing and maintaining national binding guidelines and codes of practice for compliance, breach investigation, enforcement and prosecution

The National Regulator will develop guidance material to assist in the consistent application of the national law and national standards. These will be developed for each of the discrete areas of the national law – these being vessel construction, vessel identification, vessel survey, vessel operation, crewing, crew qualifications and vessel safety equipment. The National Regulator will complement these specific guidelines with guidance material and codes of conduct in the execution of compliance activities, the investigation of potential breaches of the national law, the enforcement of the national law, and prosecution procedures. By developing national guidance material, the National Regulator will aim to facilitate consistency in the application of the national law under the national system.