The Senate

# Rural and Regional Affairs and Transport Legislation Committee

## Performance of the Australian Maritime Safety Authority

June 2020

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# Contents

**Members** ..... **iii**

**Abbreviations** ..... **vii**

**List of Recommendations** ..... **ix**

**Executive Summary** ..... **xi**

**Chapter 1—Introduction and Background** ..... **1**

Referral of inquiry ..... 1

Conduct of inquiry ..... 1

Structure of Report ..... 2

Background ..... 3

Acknowledgements ..... 6

Notes to references ..... 7

**Chapter 2—The maritime legislative framework** ..... **9**

Background ..... 9

The role of AMSA ..... 10

Application of the National Law ..... 11

Purpose of the National Law ..... 11

Compliance and enforcement under the National Law ..... 12

Changes to service delivery ..... 14

National System Statement of Regulatory Approach ..... 15

Marine Orders ..... 16

Marine Safety (Domestic Commercial Vessel) National Law (Consequential Amendments) Act 2012 ..... 17

**Chapter 3—Passenger headcounts as a safety measure** ..... **21**

Coronial findings ..... 21

Coroner's comments on public safety ..... 23

AMSA's evidence on headcounts ..... 24

Suggested changes to headcount requirements ..... 25

Headcount method and prescription ..... 27

AMSA's response to the coronial inquiry ..... 28

AMSA's actions since 2014 ..... 29

Marine Order 504 and headcounts ..... 30

**Chapter 4—Investigations and scope for prosecution under the National Law ..... 39**

Western Australia Police investigation into the death of Mr Mills ..... 39

AMSA response to WA Police regarding headcount requirements ..... 41

AMSA response to WA Police recommendation regarding crew induction ..... 43

Regular inspection and issue of direction notice – 2 November 2014 ..... 46

Suspension of the certificate of operation – 13 November 2014 ..... 47

DoT report to AMSA – 21 December 2014 – 29 May 2015 ..... 54

Investigation into alleged fraudulent certificates ..... 55

Committee view ..... 57

Findings and fallout between AMSA and DoT ..... 58

**Chapter 5—Coronial inquiries and the performance of AMSA ..... 63**

Inquest into the death of Ryan Harry Donoghue – Northern Territory Coroner's Court ..... 63

Inquest into the death of Murray Allan Turner, Mason Laurence Carter and Chad Alan Fairley – Coroner's Court of Western Australia ..... 65

Inquest into the death of Mr Daniel Thomas Bradshaw ..... 69

Committee view ..... 73

**Chapter 6—Grandfathering arrangements and other areas for reform ..... 75**

Grandfathering arrangements ..... 75

Committee view ..... 79

Increased red tape, centralisation and complexity ..... 80

AMSA's regulatory approach ..... 84

Committee view ..... 87

**Labor Senators' Additional Comments ..... 91**

**Appendix 1—Submissions and additional information ..... 95**

**Appendix 2—Public hearing and witnesses ..... 97**

# Abbreviations

| | |
|---|---|
| Act | *Australian Maritime Safety Authority Act 1990* |
| AMSA | Australian Maritime Safety Authority |
| CDPP | Commonwealth Director of Public Prosecutions |
| COAG | Council of Australian Governments |
| Committee | Senate Rural and Regional Affairs and Transport Legislation Committee |
| Criminal Code Act | *Criminal Code Act 1995* |
| DCV | Domestic Commercial Vessel |
| DDCF | Dolphin Dive Centre Fremantle |
| DoT | WA Department of Transport |
| EIS | Enforcement and Inspector Support |
| IGA | Intergovernmental Agreement on Commercial Vessel Safety Reform |
| IIMS | International Institute of Marine Surveying |
| MIAL | Maritime Industry Australia Limited |
| MSI | Marine Safety Inspector |
| MUA | Maritime Union of Australia |
| National Law | *Marine Safety (Domestic Commercial Vessel) National Law Act 2012* |
| NSCV | National Standard for Commercial Vessels |
| PML | Pacific Maritime Lawyers and Consultants |
| SCOTI | Standing Council on Transport and Infrastructure |
| TISOC | Transport and Infrastructure Senior Officials Committee |
| RCD | Residual current device |
| SMS | Safety Management System |
| TSIC | Tasmania Seafood Industry Council |
| USL | Uniform Shipping Laws |
| WHS Act | *Work Health and Safety Act 2011* |

# List of Recommendations

**Recommendation 1**

**4.34 The committee recommends that amendments be made to the *Marine Safety (Domestic Commercial Vessel) National Law Act 2012* (the National Law) in regards to the penalties imposed on an operator of a vessel for acting in a reckless or negligent manner, regardless of intent. In particular, the committee recommends that consideration should be given to situations where the operator of a vessel has been found to be acting in a negligent or reckless manner which has the potential to result in the loss of life.**

**Recommendation 2**

**4.94 The committee recommends that general safety duties offences relating to domestic commercial vessels, contained with the *Marine Safety (Domestic Commercial Vessel) National Law Act 2012*, be augmented by a more serious offence and subsequent penalty in cases where a breach of the general safety duties leads to a loss of life.**

**Recommendation 3**

**4.97 The committee recommends that the limitation period for bringing non-custodial charges under the *Marine Safety (Domestic Commercial Vessel) National Law Act 2012* (the National Law) be extended from 12 months to two years.**

**Recommendation 4**

**6.69 The committee recommends that the Australian Government commission an independent review of the *Marine Safety (Domestic Commercial Vessel) National Law Act 2012* and any associated legislative instruments (such as Marine Orders). The review should consider whether the laws remain fit for purpose and whether they improve marine safety on domestic commercial vessels without being overly burdensome or complex.**

# Executive Summary

This inquiry was established as a means of reviewing the performance and operations of the Australian Maritime Safety Authority (AMSA), with a particular emphasis on the death of Mr Damien Mills whilst he attended a function aboard the charter vessel *Ten-Sixty-Six*, operated by the Dolphin Dive Centre Fremantle (DDCF).

Initially, the committee was largely concerned with the decision-making processes within AMSA around whether to launch prosecutorial action in relation to the death of Mr Mills, as well as marine safety measures such as headcounts. However, as the inquiry progressed the committee pursued numerous other avenues of inquiry including legislative grandfathering arrangements; AMSA's regulatory functions and performance; and issues around centralisation and complexity under the national system.

Overall the committee has found the progress on improving marine safety frustrating. Evidence received throughout the inquiry from various parties has led to the perception that AMSA have been slow, or even at times reluctant, to instigate the necessary legislative and enforcement action required. While the committee welcomes the changes that have been made so far, particularly around headcounts, it is five years since the death of Mr Mills, and the committee is strongly of the view that this has been unnecessarily long. Improvements to safety should have been enacted much sooner.

## Headcounts in relation to the death of Mr Mills

The central focus of the inquiry has always been the tragic death of Mr Damien Mills, the circumstances of his death, and how something similar could be prevented from happening in the future.

The revelations of the coronial inquest exposed the gaps and limitations in the current requirements around headcounts and monitoring of passengers on DCVs. The committee heard harrowing evidence that if more stringent requirements were in place, and acted upon, it would be highly likely Mr Mills would have been found alive.

To this end the committee commends AMSA's amendments to Marine Order 504. The committee accepts that it is difficult to prescribe operational matters across a diverse range of vessels with diverse purposes. That said, the length of time the committee has pressed for improvements, even to the point of Senator Sterle's efforts to expedite the process through his Private Senator's Bill, is concerning.

## The investigation and scope for prosecution in relation to the death of Mr Mills

The report traces, in some detail, the processes undertaken by respective state agencies and AMSA to investigate the matters pertaining to the DDCF and the challenges in taking disciplinary action against the owner and operator of the DDCF. At the time, responsibilities and authority for investigation, compliance and enforcement were shared between three agencies under an intergovernmental agreement.

The committee notes that the reports by both the Western Australia Department of Transport and the WA Police recommended that charges should be considered against the master of the *Ten-Sixty-Six* vessel, for breaches of general safety duties under section 16(1) of the National Law.

The committee recognises that AMSA has recently undertaken further investigations in the case against DDCF and the master of the *Ten-Sixty-Six* and have sought a prosecution assessment from the Commonwealth Director of Public Prosecutions, to which they are awaiting a response. However, the long and drawn out process to get this far has been highly concerning to the committee and has added to the ongoing distress endured by the Mills family.

The committee hopes that this inquiry will lead AMSA to improve its processes, and therefore make it better placed to implement necessary regulatory improvements in a more timely and effective manner moving forward.

## Areas for review and reform

The committee suggests that the time is right for a holistic, independent review of marine safety legislation, especially in light of the evidence considered during this inquiry, and several coronial inquiries.

The complexity and diversity of the types of vessels that AMSA is responsible for, as well as the resourcing and administration required to centralise the marine safety regulatory system, is, and was always likely to be, a huge challenge. Many submitters, while sympathetic to the challenges, were critical of AMSA's performance to date.

The committee are cognisant of the challenges AMSA has faced around data collection from state and territory jurisdictions, as well resourcing and time constraints. However, the committee is of the view that AMSA should continually assess whether the legislation it administers is fit for purpose; that resourcing is

adequate to carry out its functions; and whether timelines for required action are reasonable and achievable. If there are issues which cannot be overcome, it is for AMSA to communicate its requirements to government and not place the burden on the sector to work in a regulatory environment unfit for purpose, or where safety is compromised due to inadequate oversight.

*Grandfathering*

The committee is cognisant of the scale of applying modern safety standards across the 27 000 or so DCVs. While the committee expects over time the regulatory inconsistencies will dissipate as older vessels go off line, there are still some in place that need to be addressed, particularly around a vessel's physical safety standards, and the adequacy of crewing arrangements. The committee is also mindful that the legislative and regulatory framework must keep pace with the changing industry, and to this end will be maintaining a watching brief on how he regulatory regime moves forward in ensuring the industry meets contemporary operational safety standards into the future.

# Chapter 1
# Introduction and Background

## Referral of inquiry

1.1 On 18 February 2019, the Senate Rural and Regional Affairs and Transport Legislation Committee (the committee) self-referred an inquiry into the Performance of the Australian Maritime Safety Authority (AMSA) under Standing Order 25(2)(a).

1.2 On 11 April 2019, the 45th Parliament was prorogued and the House of Representatives was dissolved. A general election for the House of Representatives and half of the Senate was held on 18 May 2019. The inquiry subsequently lapsed at the end of the 45th Parliament on 30 June 2019.

1.3 On 23 July 2019, following the formation of the new committee, the Senate agreed to the committee's recommendation to re-adopt the inquiry for the 46th Parliament.[1]

## Conduct of inquiry

1.4 In undertaking its general oversight responsibilities with regard to AMSA, the committee held a public hearing in Canberra on 4 December 2018. Thereafter, on 18 February 2019 during a Senate Additional Estimates hearing, the committee heard further evidence from AMSA regarding maritime safety and, in particular, the role of AMSA in investigating the death of Mr Damien Mills in October 2014. On the same day, the committee self-referred an inquiry into the performance of AMSA.[2]

1.5 The committee advertised the inquiry on its website, calling for submissions to be lodged by 29 March 2019. Details regarding the inquiry and associated documents are available on the committee's webpage.[3]

1.6 The committee received 14 public submissions which are listed at Appendix 1. Public submissions to the inquiry are also published on the committee webpage.

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1 *Journals of the Senate*, No. 5, 23 July 2019, p. 186.

2 *Committee Hansard*, 18 February 2019, p. 181.

3 As the inquiry took place over two parliaments, the relevant documents are located in two locations; see: https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Rural_and_Regional_Affairs_and_Transport/AMSA45 and https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Rural_and_Regional_Affairs_and_Transport/AMSA

1.7 In addition to the initial public hearing in Canberra on 4 December 2018, prior to the self-referral of the inquiry, the committee held four further public hearings:

- Ascot, Western Australia on 21 March 2019;
- Canberra, Australian Capital Territory on 1 April 2019;
- Brisbane, Queensland on 25 September 2019; and
- Canberra, Australian Capital Territory on 11 November 2019.

1.8 A list of the witnesses who provided evidence at the public hearings is available at Appendix 2.

## Structure of Report

1.9 The report is broken down into six chapters. The first chapter provides an overview of the committee's conduct as well as a brief background to the pertinent issues raised during the inquiry.

1.10 Chapter 2 provides an overview of the legislative framework which underpins maritime safety and regulation in Australia.

1.11 Chapter 3 explores the issue of headcounts as a safety measure on domestic commercial vessels (DCVs). It focuses specifically on the events surrounding the incident on the *Ten-Sixty-Six* and the steps taken by AMSA following the findings of the coronial inquiry to address legislative concerns regarding headcounts.

1.12 Chapter 4 considers the investigations and administrative action taken under the *Marine Safety (Domestic Commercial Vessel) National Law Act 2012* (the National Law) against the owner of the *Ten-Sixty-Six* and Dolphin Dive Centre Fremantle (DDCF).[4] The Chapter also considers the work undertaken by AMSA in response to recommendations from the Western Australian Police to launch prosecutorial action in relation to the DDCF. Further, it discusses the decision making process by AMSA to not proceed with a brief of evidence for the purposes of possible prosecutorial action.

1.13 Chapter 5 considers a number of coronial inquiries where concerns were raised about the role and actions of AMSA and the National Law.

1.14 Chapter 6 focuses on the evidence received by the committee regarding the functions of AMSA, as well as its legislative framework, that potentially require review and reform. The chapter considers the regulatory approach of AMSA as well as focussing on specific issues for review, including Safety Management Systems, grandfathering arrangements and Marine Orders.

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[4] Australian Government, Federal Register of Legislation, Marine Safety (Domestic Commercial Vessel) National Law Act 2012, 10 December 2012, https://www.legislation.gov.au/Details/C2018C00484 (accessed 15 July 2019).

## Background

1.15 The initial focus of the committee during the inquiry was on matters relating to the performance of AMSA in response to a maritime accident that took place on a passenger charter boat in October 2014. This incident became a focal point from which the committee considered the role of AMSA, its performance as the regulator of maritime safety, and the legislative framework underpinning maritime safety in Australia.

1.16 On 31 October 2014, thirty-five-year-old mortgage broker, Mr Damien Mills, attended a networking function aboard a passenger charter boat, the *Ten-Sixty-Six*, operated by the DDCF and supplied to Swan River Boat Charters for the function. Mr Mills was last seen alive off Rottnest Island, Western Australia.

1.17 Mr Mills' disappearance from the boat was not observed by anyone on board. On 1 November 2014, Mr Mills was reported missing by his family. At approximately the same time his body was found floating in the Indian Ocean about three nautical miles off Leighton Beach, at approximately midday on 1 November 2014.

1.18 There were two key matters of particular concern to the committee with regard to the vessel—the *Ten-Sixty-Six*—and the role of AMSA, being:

- the safety measures introduced by AMSA, with particular focus on headcounts, following the coronial inquest into the death of Mr Mills; and
- the decision-making process within AMSA not to proceed with a brief of evidence for possible prosecutorial action in relation to the death of Mr Mills.

1.19 As the inquiry progressed, the committee identified a number of other matters of concern with regard to AMSA. These issues included AMSA's regulatory approach, the application and administration of health and safety provisions under the National Law, grandfathering arrangements, increased red tape and safety management systems.

1.20 Each of these matters has a direct bearing on the safety of maritime operations and is considered in this report.

### *Timeline*

1.21 While the report goes into greater detail regarding the investigation into Mr Mills' death, and concerns about the actions of AMSA, the committee is of the strong view that far too much time elapsed between Mr Mills' death, and AMSA taking definitive action to address serious marine safety concerns.

1.22 Table 1.1 below highlights the events of the past six years, alongside relevant legislative developments. This timeline highlights the fact that these issues have been ongoing for a considerable period of time.

**Table 1.1 Timeline of action by AMSA**

| Date | Event |
|---|---|
| 1 November 2014 | The death of Mr Damien Mills off the *Ten-Sixty-Six* vessel, operated by Dolphin Dive Centre Fremantle (DDCF) |
| 7 November 2014 | WA Department of Transport (DoT) issued a temporary direction notice to DDCF to operate with additional crew members |
| 13 November 2014 | DoT issued the DDCF with a Notice of Suspension of its Certificate of Operation |
| 20 November 2014 | DoT conducted a full investigation of three DDCF vessels, due to systemic failings in the safe operation of the vessels |
| 3 December 2014 | DoT issued a show cause notice to DDCF and the operator of DDCF was directed to undertake a full out-of-water survey of its three vessels |
| 12 December 2014 | DDCF requests that the show cause notice be revoked and AMSA review its suspension decision |
| December 2014 | DoT provided all information it collected to AMSA for an internal review process |
| 21 December 2014 | DoT provided AMSA with a summary report, suggesting a failure by the owner to comply with general safety duties |
| 22 December 2014 | DDCF sought an emergency injunction to have the show cause notice and direction notice lifted |
| 24 December 2014 | Federal Court hearing, where a stay was put on the show cause and direction decisions, with a full hearing scheduled for February 2015 |
| 24 December 2014 | AMSA advised DoT that after internal review, it had determined to overturn the direction to DDCF to perform out-of-water surveys (the show cause notice remained in place) |
| 14 and 23 January 2015 | WA marine safety inspectors determined that all of DDCF's vessels were compliant and on advice from AMSA, DoT lifted the suspension on the DDCF certificate of operation |
| 30 January to 3 February 2015 | DoT expressed to AMSA its concerns about the ability of DDCF to operate safely and legally; DoT would not |

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| | withdraw the show cause notice unless advised by AMSA |
| 3 February 2015 | AMSA advised DoT to discontinue the matter; DoT formally withdrew the show cause notice |
| 12 February 2015 | WA Police submitted its report to AMSA, recommending two charges against the master of the *Ten-Sixty-Six* |
| 17 February 2015 | AMSA completed its internal review of DoT decision to suspend the DDCF certificate of operation, and overturned that decision |
| February to August 2015 | AMSA reviewed the reports from WA Police and DoT |
| 22 May 2015 | DoT provided its completed investigation report to AMSA, recommending a number of offences be considered for possible prosecution |
| 29 May 2015 | AMSA completed an internal review into its handling of the DDCF investigation, making four recommendations |
| August 2015 | AMSA consulted with Commonwealth Director of Public Prosecutions (CDPP) |
| 26 August 2015 | DoT informed AMSA of further apparent fraudulent behaviour, relating to false declarations |
| 27 August and 2 September 2015 | AMSA and the CDPP discussed the DDCF matter |
| 2 September 2015 | AMSA commenced the production of a brief of evidence for alleged offences against the Criminal Code Act |
| 14 September 2015 | AMSA investigators conducted additional work and received further statements |
| 31 October 2015 | Due date for bringing prosecutorial action, due to one-year statute of limitations |
| 30 November 2015 | CDPP indicated to AMSA that there were significant obstacles to completing a brief of evidence with a reasonable likelihood of successful prosecution |
| 22 February 2016 | AMSA told DoT that it had decided not to complete a brief of evidence, as pursuing charges was unlikely to be successful |
| December 2016 | The owner of the DDCF was fined for illegally selling |

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|---|---|
| | beer during the cruise from which Mr Mills went missing |
| 30 October 2017 | Findings of the coronial inquest into the death of Mr Mills delivered |
| 1 July 2018 | AMSA assumed responsibility for all service functions under the National Law |
| 1 July 2018 | *Marine Order 504 (Certificates of operation and operation requirements – national law) 2018* commenced, with provisions about headcounts |
| 18 February 2019 | Committee commenced its inquiry into the performance of AMSA |
| 1 April 2019 | AMSA confirmed to the committee it would seek legislative amendments to allow two years to commence prosecutorial proceedings |
| September 2019 | AMSA confirmed to the committee that it had provided a brief of evidence to the CDPP |
| 27 October to 1 November 2019 | An AMSA investigator was in Perth, investigating allegations against DDCF and Mr Lippiatt |
| 8 November 2019 | Additional material provided by AMSA to the CDPP for prosecution assessment |
| 5 December 2019 | Senator Glenn Sterle introduced a Private Senator's Bill to improve legislative requirements around headcounts |
| 16 December 2019 | AMSA published proposed amendment to Marine Order 504, inviting public comment |
| 28 February 2020 | Following consultation, *Marine Order 504 (Certificates of operation and operation requirements – national law) Amendment Order 2020* was made, strengthening the legislative requirements for headcounts on certain domestic vessels, and for situations where a passenger is unaccounted for |
| 31 May 2020 | Amended Marine Order 504 commences (see above) |

*Source: collated by the Rural and Regional Affairs and Transport Legislation Committee, based on evidence received*

## Acknowledgements

1.23 The committee thanks those individuals and organisations who contributed to the inquiry by preparing written submissions and giving verbal evidence at hearings.

1.24 In particular the committee acknowledges the substantial contribution to the inquiry of Ms Nicole Mills, wife of Mr Damien Mills, and Mr Richard Mills, father of Mr Damien Mills. The committee acknowledges the anguish and grief suffered by the Mills family and applauds their determination in advocating for greater safety on DCVs.

1.25 The committee also recognises the pain suffered by other families who have lost loved ones on DCVs, including passengers and crew.

## Notes to references

1.26 References in this report to the Hansard for the public hearings may be to the proof Hansard. Page numbers may vary between the proof and official Hansard transcripts.

# Chapter 2
# The maritime legislative framework

2.1 This chapter provides an overview of the regulatory framework with regard to domestic commercial vessels (DCVs) in Australia.[1] It explores the establishment of the *Marine Safety (Domestic Commercial Vessel) National Law Act 2012* (the National Law) as well as the role of AMSA, and considers a number of legislative and administrative amendments made since the National Law's commencement.

## Background

2.2 National reform of commercial vessel safety was first initiated in July 2009 when the Council of Australian Governments (COAG) agreed to take a national approach to regulating the safety of all DCVs in Australian waters by 2013.[2]

2.3 In August 2011, COAG signed an Intergovernmental Agreement on Commercial Vessel Safety Reform (IGA).[3] The parties agreed to develop a national approach to the safe regulation of DCVs and to establish AMSA as the single national regulator for DCV safety in Australia.

2.4 The role of state and territory maritime agencies in service delivery was central to the agreement, as expressed in Clause 5 of the IGA Recitals:

> In entering this Agreement, the Commonwealth and the States and Territories recognise that they have a mutual interest in a national system for commercial vessel safety regulation, and affirm their commitment to work cooperatively to achieve this outcome. The ongoing role of State and Territory maritime agencies in service delivery is integral to the national system.[4]

2.5 The aim of the IGA was to 'deliver a national safety system for commercial vessels that is effective, consistent and efficient; minimises legal and

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1 Under Part 1, Section 5(1) of the National Law, a domestic commercial vessel is defined as a vessel 'that is for use in connection with a commercial, governmental or research activity'. This includes passenger vessels, research and emergency response vessels, fishing vessels and vessels that are commercially hired out for recreational use, such as houseboats, sailboats, jet skis and kayaks.

2 *Marine Safety (Domestic Commercial Vessel) National Law Bill 2012*, Replacement Explanatory Memorandum, p. 6.

3 Council of Australian Governments, *Intergovernmental Agreement on Commercial Vessel Safety Reform*, August 2011, https://www.coag.gov.au/sites/default/files/agreements/Maritime_IGA-19August2011.pdf (accessed 17 April 2019).

4 Council of Australian Governments, *Intergovernmental Agreement on Commercial Vessel Safety Reform*, August 2011, p. 3.

administrative costs; and does not result in an overall increase in regulatory burden'.[5]

2.6 The IGA further stipulated that the outcomes of the agreement would include a national law for all commercial vessels operating in Australian waters and a national regulator that develops, maintains and monitors national standards for those vessels.[6]

2.7 COAG's Standing Council on Transport and Infrastructure (SCOTI) noted that the purpose of the national system for DVCs was to provide the industry with 'simpler safety rules, applied consistently around Australia'.[7]

## The role of AMSA

2.8 AMSA is a statutory authority established under the *Australian Maritime Safety Authority Act 1990* (the Act). As stipulated in the Act, AMSA's roles are to:

- combat pollution in the marine environment;
- provide a search and rescue service;
- provide, on request, services to the maritime industry on a commercial basis;
- cooperate with the Australian Transport Safety Bureau in relation to investigations under the *Transport Safety Investigation Act 2003* that relate to aircraft and ships; and
- perform such other functions as are conferred on it by or under any other Act.[8]

2.9 The National Law also specifies AMSA's functions as the national regulator. Amongst its responsibilities, AMSA is required to:

- make and maintain Marine Orders;
- develop and maintain national standards, guidelines and codes of practice relating to marine safety;
- undertake investigation, monitoring and enforcement activities; and
- consult appropriate authorities of the states and territories, and other persons, associations and organisations, on matters related to the activities of the national regulator.[9]

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[5] Council of Australian Governments, *Intergovernmental Agreement on Commercial Vessel Safety Reform*, August 2011, p. 3.

[6] Council of Australian Governments, *Intergovernmental Agreement on Commercial Vessel Safety Reform*, August 2011, p. 5.

[7] Standing Council on Transport and Infrastructure, *Communique*, 15 November 2013, p. 2, https://www.transportinfrastructurecouncil.gov.au/communique/files/SCOTI_5th_Communique_15_November_2013.pdf (accessed 3 May 2019).

[8] *Australian Maritime Safety Authority Act 1990*, s. 16.

[9] *Marine Safety (Domestic Commercial Vessel) National Law Act 2012*, s. 10.

## Application of the National Law

2.10 Prior to the introduction of the National Law, there were eight different marine safety regulatory systems including the Commonwealth, six states and the Northern Territory (NT) that governed the operation of the domestic commercial vessel industry in Australia.[10]

2.11 When the National Law came into force on 1 July 2013, its purpose was to enable 'consistent national regulation of the domestic commercial vessel industry across Australia'. This objective would be achieved through a regulatory framework that promoted continuous improvement in marine safety; promoted public confidence in the safety of marine operations; ensured effective identification and management of safety risks; and sought to reduce the regulatory burden without compromising safety.[11]

2.12 All states and the NT were encouraged to apply the National Law in their respective jurisdictions to the extent necessary to ensure 'national coverage and allow any standards, rules and subordinate legislation (such as regulations and Marine Orders) to have consistent application and effect around the country'.[12]

## Purpose of the National Law

2.13 The National Law applies to all DCVs operating in all Australian states and the NT, Australian Capital Territory and Jervis Bay Territory. In addition, all DCVs that travel beyond 200 nautical miles and are currently regulated by relevant states and territories will remain within the scope of the National System. The National Law regulates approximately 27 000 vessels and 66 000 masters and crew across the country.[13]

2.14 The National Law is also designed to apply the National Standard for Commercial Vessels (NSCV) throughout Australia. The NSCV provides an integrated safety system that combines a vessel's technical characteristics, operator competencies and operational procedures to control risk. It establishes standards for vessel survey, construction, equipment, design, operation and crew competencies for DCVs.[14] The NSCV was developed by all

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[10] Council of Australian Governments, *Intergovernmental Agreement on Commercial Vessel Safety Reform*, August 2011.

[11] Replacement Explanatory Memorandum, Marine Safety (Domestic Commercial Vessel) National Law Bill 2012, p. 1.

[12] Australian Maritime Safety Authority, *National system for domestic commercial vessel* safety, Discussion Paper, p. 1.

[13] *Marine Safety (Domestic Commercial Vessel) Levy Bill 2018; Marine Safety (Domestic Commercial Vessel) Levy Collection 2018* and *Marine Safety (Domestic Commercial Vessel) Levy (Consequential Amendments) Bill 2018,* Explanatory Memorandum, p. 2.

[14] Australian Transport Council, *National Standard for Commercial Vessels Part E: Operational Practices*, 2008, https://www.amsa.gov.au/about/regulations-and-standards/superseded-standards-

state and territory transport agencies and agreed by the relevant transport ministers. It is an evolving document that is amended and updated as required.[15]

## Compliance and enforcement under the National Law

2.15 In recognition of the fact that the Commonwealth, states and territories have a 'mutual interest in the national system for commercial vessel safety regulation', the IGA highlighted that the 'ongoing role of State and Territory maritime agencies in service delivery is integral to the national system'.[16] To this end, the IGA stated:

> The National Regulator will be responsible for the operation and administration of safety regulation of commercial vessels in Australian waters. State and Territory jurisdictions will deliver a range of National Regulator's operational and enforcement functions within their respective jurisdictional territory. This will enable staffing and resourcing to remain at the discretion of each respective maritime agency.[17]

2.16 Thus, the primary agencies for service delivery under the national system are the respective state departments. Under the new arrangements, each jurisdiction was to continue carrying out all activities they previously undertook prior to 2013, other than those that would now be undertaken by the National Regulator. In terms of investigation, compliance and enforcement activities, the IGA stated that:

> 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.[18]

2.17 The IGA noted that these arrangements were established to ensure that the most appropriate regulatory response would be used to secure compliance

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commercial-vessels (accessed 28 February 2019); Australian Maritime Safety Authority, *National Standard for Commercial Vessels (NSCV)*, https://www.amsa.gov.au/about/regulations-and-standards/national-standard-commercial-vessels-nscv (accessed 28 February 2019).

[15] Amended Explanatory Memorandum, Marine Safety (Domestic Commercial Vessel) National Law Bill 2012, p. 11. See: Australian Maritime Safety Authority, Superseded Standards for Commercial Vessels, https://www.amsa.gov.au/about/regulations-and-standards/superseded-standards-commercial-vessels (accessed 26 February 2019).

[16] Council of Australian Governments, *Intergovernmental Agreement on Commercial Vessel Safety Reform*, August 2011, p. 3.

[17] Council of Australian Governments, *Intergovernmental Agreement on Commercial Vessel Safety Reform*, August 2011, p. 10.

[18] Council of Australian Governments, *Intergovernmental Agreement on Commercial Vessel Safety Reform*, August 2011, pp. B3–B4.

with, and enforcement of, the National Law. Furthermore, such activities were to be conducted to agreed guidelines and codes of conduct with jurisdictions involved in the setting of such protocols through consultative functions.[19]

2.18 The National Law further established a national compliance and enforcement framework whereby Marine Safety Inspectors (MSIs) have the power to check and enforce industry compliance. This empowers AMSA, as the regulator, to appoint MSIs and sets out the monitoring and enforcement powers that they can exercise to ensure compliance with the National Law.[20]

2.19 MSIs are provided with entry, inspection and seizure powers, including the power to enter certain premises and board vessels, in some cases without warrant or consent. As agreement had been reached under the COAG IGA that operational functions of the regulator would be primarily delivered by existing state and territory marine safety administrators, most such inspectors were employees of state and territory agencies.[21]

2.20 These service delivery provisions were designed to ensure that AMSA could delegate certain functions to state and territory maritime safety agencies to undertake day-to-day interaction with the DCV industry. As an AMSA delegate, a state department could additionally be authorised to conduct surveys and approvals; issue, suspend, vary and revoke (upon application) a range of certificates; and to appoint MSIs.

2.21 In relation to the *Ten-Sixty-Six* matter, which occurred in October 2014, the respective agencies operated under the IGA as follows:

> [The Western Australian Department of Transport] 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 2013* (the National Law)…The WA Police also played a vital role as marine safety inspectors (MSI) in compliance and enforcement activities, and still do.[22]

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[19] Council of Australian Governments, *Intergovernmental Agreement on Commercial Vessel Safety Reform*, August 2011, p. B-5.

[20] Amended Explanatory Memorandum, Marine Safety (Domestic Commercial Vessel) National Law Bill 2012, p. 52, https://parlinfo.aph.gov.au/parlInfo/download/legislation/ems/r4835_ems_b22b5c08-bec4-45f8-839b-772b0d1e9c6a/upload_pdf/371663repem.pdf;fileType=application%2Fpdf#search=%22legislation/ems/r4835_ems_b22b5c08-bec4-45f8-839b-772b0d1e9c6a%22

[21] Amended Explanatory Memorandum, Marine Safety (Domestic Commercial Vessel) National Law Bill 2012, p. 53.

[22] Australian Maritime Safety Authority, *Submission 1*, p. 3.

## Changes to service delivery

2.22 In 2014, a streamlining review of the National Law was undertaken in line with the government's red tape reduction and deregulation agenda, and in response to industry concerns about the effectiveness of the national system and concerns about the cost of regulation. The review was also to consider changes in international trends such as the increased focus on safety management systems.[23]

2.23 The review found that the service-delivery model limited the potential benefits of the national system due to 'inconsistencies in service delivery, regulatory and cost-recovery arrangements between jurisdictions'.[24] The then-Assistant Minister to the Deputy Prime Minster, Mr Damian Drum MP, later noted that:

> Following an independent review of the national system in 2014, it was evident that there were inefficiencies and inconsistencies in the way it was being delivered. Inconsistent approaches between the state-based service delivery arrangements were identified as the key cause of the full benefits of the national system not being realised.[25]

2.24 AMSA argued that centralised service delivery would 'simplify how the regulatory framework is applied consistently, across Australia'.[26]

2.25 In November 2014, state and territory transport and infrastructure ministers agreed that AMSA should position itself to take up service delivery on a cost recovery basis by 1 July 2017.[27] Over time, it was expected that AMSA would achieve full cost recovery for these services through the introduction of a levy for the national system.

2.26 AMSA reported the changes in its *Working Boats* publication as follows:

> In November 2014, Commonwealth, State and Territory Transport and Infrastructure Ministers unanimously agreed that AMSA be positioned to take up service delivery by July 2017 under the 'one system, one process and one decision maker' principle.

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[23] Australian Maritime Safety Authority, *The National System for Domestic Commercial Vessel Safety: Consultation on Changes to Survey Regime for Domestic Commercial Vessels from 1 July 2018*, https://www.westernrocklobster.org/wp-content/uploads/2018/04/AMSA-Guidance-Document-Propose-Survey-Regime-Amendments-April-2018.pdf (accessed 28 February 2019).

[24] Australian Government, *Cost recovery for services under the National System for Domestic Commercial Vessel Safety, August – October 2016*, Australian Maritime Safety Authority, p. 7, https://www.amsa.gov.au/sites/default/files/dv-levy.pdf (accessed 2 May 2019).

[25] Mr Damian Drum MP, second reading speech: Marine Safety (Domestic Commercial Vessel) Levy Bill 2018, House of Representatives, *Debates*, 28 February 2018, p. 2201.

[26] Australian Government, *Cost recovery for services under the National System for Domestic Commercial Vessel Safety, August – October 2016*, Australian Maritime Safety Authority, p. 10.

[27] Australian Government, *Cost recovery for services under the National System for Domestic Commercial Vessel Safety, August – October 2016*, Australian Maritime Safety Authority, p. 7, https://www.amsa.gov.au/sites/default/files/dv-levy.pdf (accessed 2 May 2019).

> From 1 July 2017, not only will the rules and standards for DCVs be consistent across Australia, but the way you receive services (and the fees for those services) will also be the same across Australia, regardless of where you operate.[28]

2.27 In November 2016, the transport and infrastructure ministers agreed to extend the timeframe to 1 July 2018 to 'allow jurisdictions and industry to better consult and prepare for these significant changes'.[29]

2.28 Thereafter, on 1 July 2018, AMSA finally assumed full responsibility for service delivery under the national system, thereby replacing the seven state and territory service models. At that time, states and territories stopped delivering services and imposing charges.[30]

## National System Statement of Regulatory Approach

2.29 In 2015, in response to the findings of the streamlining review, AMSA released the *National System Statement of Regulatory Approach*. The approach was underpinned by the view that the amount of regulatory oversight should reflect the level of risk posed by a particular operation.

2.30 The statement sets out nine points to guide AMSA when addressing the need for regulation. These include that regulation—and its application—should be flexible enough to address the risks of a highly varied industry in order to support safety, innovation and business and environmental sustainability; that the regulatory scheme is 'performance-based, not prescriptive; and that the operator has the primary responsibility for ensuring the vessel is safe and operates safely'.[31]

2.31 In 2018, a revised *Statement of Regulatory Approach* was produced by AMSA. It states that under the regulatory scheme AMSA would 'take a risk based and proportionate approach in determining where to focus legislative and

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[28] Australian Maritime Safety Authority, *Working Boats*, Autumn 2016, Issue 9, p. 3, https://www.amsa.gov.au/sites/default/files/amsa299-working-boats9.pdf (accessed 3 May 2019).

[29] Transport and Infrastructure Council, *Communique*, TIC Meeting, Perth, 4 November 2016, p. 4.

[30] Policy statement by the Deputy Prime Minister on arrangements from 1 July 2018 for the National System for Domestic Commercial Vessel Safety, Department of Infrastructure and Regional Development, 3 July 2018, https://infrastructure.gov.au/maritime/safety/nsdcvs.aspx (accessed 20 February 2019).

[31] Australian Maritime Safety Authority, *Annual Report 2014–15*, pp. 39–40, https://www.amsa.gov.au/sites/default/files/amsa191-annual-report-2014-15.pdf; Australian Maritime Safety Authority, *Our Regulatory Approach 2014*, https://www.amsa.gov.au/about/regulations-and-standards/our-regulatory-approach-2014 (accessed 28 February 2019).

compliance responses so that those who demonstrate a safety culture, and are compliant, are rewarded by reduced regulatory intervention'.[32]

2.32 The 2018 Statement further noted that AMSA would be 'non-prescriptive where possible, leaving choice to those who bear the responsibility for the outcome'.[33] The statement continues:

> Prescriptive requirements can discourage the regulated community from looking at how they can best manage safety and environment protection, and can stifle innovation. In most cases, the person who is required to manage a risk is best placed to work out how to do that, and we will endeavour to help them do so. In some cases, however, a prescriptive approach is required and appropriate (particularly to give effect to international obligations).[34]

## Marine Orders

2.33 The National Law permits AMSA to introduce regulations by way of Marine Orders, which contain detailed requirements and processes to ensure that legislation keeps up to date with technical and operational advances in maritime safety. The Marine Orders numbered 500 to 507 apply specifically to DCVs.[35]

2.34 In 2015, AMSA undertook a review of the operational safety requirements then made under Marine Order 504, and Part E of the NSCV (Part E related to vessel operation requirements, including headcounts). The intent was to reassess the regulatory approach specifically to operational requirements for DCVs and implement measures identified in the 2014 streamlining review.[36]

2.35 The Marine Order review focused on a number of key proposed changes identified by AMSA with the aim of:

- placing a greater focus on an outcomes-based approach to regulation of operational safety under the National Law;
- incorporating NSCV Part E (that is, the national standards for operations), into a new Marine Order 504; and

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[32] Australian Maritime Safety Authority, *Statement of Regulatory Approach 2018*, p. 2, https://www.amsa.gov.au/about/corporate-publications/statement-regulatory-approach-2018 (accessed 21 April 2020).

[33] Australian Maritime Safety Authority, *Statement of Regulatory Approach 2018*, p. 2.

[34] Australian Maritime Safety Authority, *Statement of Regulatory Approach 2018*, p. 2.

[35] Australian Maritime Safety Authority, *How marine orders are created*, 30 October 2018, https://www.amsa.gov.au/about/regulations-and-standards-vessels/how-marine-orders-are-created (accessed 6 March 2019).

[36] Australian Maritime Safety Authority, *Consultation Feedback Report: Changes to Certificates of Operation and Operational Requirements (New Marine Order 504)*, May 2018, pp. 1–2, https://www.amsa.gov.au/news-community/consultations/closed-consultations (accessed 28 February 2019).

- simplifying operational requirements and clarifying linkages with safety management system requirements.[37]

2.36 Under the proposed change, components for a documented safety management system (SMS) would be set out in detail in the new Marine Order 504. The new Marine Order 504 would require the SMS to address the matters previously dealt with in NSCV Part E.[38]

2.37 As a consequence of its 2015 review, AMSA prepared *Marine Order 504 (Certificates of Operation and Operational Requirements—National Law) 2018*, which took effect on 1 July 2018.[39]

2.38 As discussed in Chapter 3 of this report, Marine Order 504 was further amended on 28 February 2020 to incorporate the *Marine Order 504 (Certificates of Operation and Operational Requirements—National Law) Amendment Order 2020* which specifically strengthens requirements around headcounts and managing situations where a passenger is unaccounted for.[40] The amended Order commenced on 31 May 2020.

## Marine Safety (Domestic Commercial Vessel) National Law (Consequential Amendments) Act 2012

2.39 The bill to enact the *Marine Safety (Domestic Commercial Vessel) National Law (Consequential Amendments) Act 2012* was introduced to Parliament at the same time as the bill for the National Law. While this legislation has been enacted, Schedule 2 to the Consequential Amendments Act has not yet commenced.

2.40 The amendments contained in Schedule 2 relate to breaches of the general safety duties under the National Law. AMSA advises on its website that general safety duties:

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[37] Australian Maritime Safety Authority, *Operational Safety Review: Consultation on Proposed New Marine Order 504 (Certificates of Operation and Operation Requirements—National Law)*, p. 1.

[38] The version of Part E that was copied across to the 2018 Marine Order 504 was the 2016 version. This version of Part E was almost identical to the 2013 version of Part E. The 2013 version of Part E was endorsed by the Standing Council on Transport and Infrastructure on 10 May 2013 and published on 17 May 2013, prior to Mr Mills' death in 2014; Australian Transport Council, *National Standard for Commercial Vessels: Part E—Operations*, 2013; Australian Maritime Safety Authority, *Operational Safety Review: Consultation on Proposed New Marine Order 504 (Certificates of Operation and Operation Requirements—National Law)*, p. 10.

[39] The new Marine Order superseded the *Marine Order 504 (Certificates of Operation—National Law) 2013*; Australian Maritime Safety Authority, *Operational Safety Review: Consultation on Proposed New Marine Order 504 (Certificates of Operation and Operation Requirements—National Law)*, p. 1.

[40] Available at: https://www.legislation.gov.au/Details/F2020L00186, (accessed 6 April 2020); *Marine Order 504 (Certificates of Operation and Operational Requirements—National Law) Amendment Order 2020,* Explanatory Memorandum, p. 1, https://www.legislation.gov.au/Details/F2020L00186/Explanatory%20Statement/Text (accessed 6 April 2020).

> …apply to everyone working on, travelling on, designing, building, or servicing domestic commercial vessels, including those under grandfathering arrangements. They are a legal requirement under the national law. General safety duties are in place to:
>
> eliminate or minimise the risk of incidents involving death, injury or damage
>
> encourage the development, maintenance, and continuous improvement of a safety culture within the domestic commercial vessel industry.[41]

2.41 The Schedule to the Consequential Amendments Act proposed to repeal offence provisions arising from a failure to comply with the general duties of owners of DCVs, and to replace it with the following:

> (1) A person commits an offence if:
>
> (a) the person does an act, or omits to do an act, without reasonable excuse; and
>
> (b) the act or omission contravenes section 12(1); and
>
> (c) the act or omission exposes an individual to a risk of death or serious injury or illness; and
>
> (d) the person is reckless as to the risk to an individual of death or serious injury or illness.

2.42 In addition, Schedule 2 amends the existing offense and penalties for breaches of the general safety duties under the National Law, and replaces them with provisions that mirror Part 2 of the *Work Health and Safety Act 2011* (WHS Act).

2.43 When the bill to enact the Consequential Amendments Act was introduced, it was proposed that the amendments under Schedule 2 would commence when all jurisdictions had enacted Model WHS laws.[42] In other words, despite the bill becoming law, the provisions contained in Schedule 2 remained outstanding, to take effect only when all jurisdictions had enacted the WHS legislation.

2.44 This is explained in the Explanatory Memorandum as follows:

> Schedule 2 will take effect when all States and Territories give effect to, as a State or Territory law, the provisions contained in Part 2 of the WHS Act. The objective of this arrangement is to align the National Law general safety obligations and offences with the WHS duties and offences, once the WHS Act has been enacted nationally.[43]

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[41] Australian Maritime Safety Authority, *General safety duties for domestic commercial vessels*, https://www.amsa.gov.au/vessels-operators/domestic-commercial-vessels/general-safety-duties-domestic-commercial-vessels (accessed 24 April 2020).

[42] In 2011, Safe Work Australia developed a single set of WHS laws to be implemented across Australia. These are known as 'model' laws. For the model WHS laws to become legally binding, the Commonwealth, states and territories must separately implement them as their own laws.

[43] Explanatory Memorandum, Marine Safety (Domestic Commercial Vessel) National Law (Consequential Amendments) Bill 2012.

2.45 As of March 2013, seven jurisdictions with WHS laws had enacted the new, harmonised Work Health and Safety legislation. These jurisdictions included the Commonwealth, New South Wales, South Australia, Queensland, Tasmania, the Australian Capital Territory and the NT. In July 2017, the government of Western Australia announced that it would initiate the development of modernised health and safety laws for WA.[44] However, as Victoria and WA have yet to enact the new legislation, the provisions in Schedule 2 have not taken effect. Therefore, amendments intended to align the National Law with WHS legislation, with similar offences and penalties, have not commenced.[45]

[44] A Ministerial Advisory Panel was formed in mid-2017 for this purpose. The panel's report to the WA Government on harmonisation with the model WHS laws was made public in June 2018. It contained 44 recommendations which are considered technical and administrative changes, but has not sought to substantially alter the national model WHS Act. Ministerial Advisory Panel, Modernising work health and safety laws in Western Australia, WA Department of Mines, Industry Regulation and Safety, 30 June 2018, https://www.commerce.wa.gov.au/sites/default/files/atoms/files/whs_act_consultation.pdf (accessed 29 April 2019).

[45] Mr Mick Kinley, Australian Maritime Safety Authority, *Committee Hansard*, 1 April 2019, p. 2.

# Chapter 3
# Passenger headcounts as a safety measure

3.1 This chapter considers the coronial findings in relation to the accident aboard the *Ten-Sixty-Six*. In particular, it focuses on the issue of headcounts as a key safety measure. It considers the findings of the coronial inquest into the death of Mr Damien Mills, the subsequent actions taken by AMSA following the inquest and ongoing efforts to strengthen headcount requirements.

## Coronial findings

3.2 A coronial inquest into the death of Mr Mills was undertaken in Western Australia with the findings delivered on 30 October 2017.[1] In her report, Coroner Sarah Linton found that Mr Mills had died on or about 31 October 2014 in the Indian Ocean approximately three nautical miles off Leighton Beach, in circumstances 'consistent with immersion'.[2]

3.3 Mr Daniel Lippiatt was the Managing Director of Swan River Boat Charters and the sole Director of the Dolphin Dive Centre Fremantle Pty Ltd (DDCF). DDCF owned and operated the *Ten-Sixty-Six* and three other vessels. As part of a commercial arrangement, DDCF supplied the *Ten-Sixty-Six* to Swan River Boat Charters for the purposes of conducting charter boat cruises. Mr Lippiatt was the master (or skipper) of the *Ten-Sixty-Six* on the day in question and Mr Aaron Crane was hired as a deck hand. The charter boat was booked by Pepper Australia Pty Ltd, to travel from Fremantle to Rottnest Island.

3.4 In her report, Coroner Linton raised a series of concerns about the procedures on board the charter vessel, particularly in relation to headcounts. The inquest found that there was considerable uncertainty regarding the number of individuals aboard the *Ten-Sixty-Six.* Ms Kathryn Mortimer, a staff member with Pepper Australia, recalled that before the boat was boarded, she undertook a headcount on the jetty and told Mr Lippiatt that there were 33 people. It is unclear whether Ms Mortimer included herself in the headcount.[3]

3.5 Other evidence presented to the police by other passengers on the boat suggests there were 34 passengers in total (30 invited guests and four Pepper

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1 Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills*, 30 October 2017, https://www.coronerscourt.wa.gov.au/_files/Mills%20finding.pdf (accessed 20 February 2019).

2 Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills*, 30 October 2017, p. 1.

3 Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills*, 30 October 2017, p. 6.

Australia staff).[4] The captain and the deckhand also, independent of each other, conducted headcounts of 35 passengers when they first embarked.[5] The coroner ultimately concluded that there was sufficient evidence to suggest that there were 34 passengers and two crew members aboard the *Ten-Sixty-Six* for a total of 36 persons on board the boat.[6]

3.6 The inquest also reported on whether Swan River Boat Charters undertook a final headcount upon disembarking at Sardine Jetty in Fremantle. The Coroner noted that Swan River Boat Charters had a safety management plan for its boats including the *Ten-Sixty-Six*, which indicated that 'Passengers will always be counted on and off the vessel and the numbers recorded in the vessel's log'.[7]

3.7 Mr Lippiatt informed the Coroner that he recalled conducting a headcount of passengers as they were disembarking from the boat at Sardine Jetty on Fremantle Harbour at the conclusion of the journey. He indicated that he remembered counting the same amount of passengers that got off the vessel as the amount of passengers who were at Rottnest Island.[8] Mr Lippiatt relied in part, on the fact that he didn't alter his original logbook entry, which he argued was accurate and reliable.

3.8 There was only one entry in the logbook of a headcount which provided the date but not the time at which it was taken. Mr Lippiatt gave evidence that the entry related to the headcount conducted at the start of the day but was made in the logbook while anchored at Rottnest Island.[9] However, the only evidence that headcounts were conducted after the initial count upon embarkation was provided by Mr Lippiatt.

3.9 The accounts of the deck hand, Mr Crane, and passengers differ significantly from that of Mr Lippiatt.[10] Having considered the available evidence obtained during the police investigation, Senior Constable Brandhoff informed the

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4 Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills*, 30 October 2017, p. 6.

5 Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills*, 30 October 2017, p. 6.

6 Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills*, 30 October 2017, p. 6.

7 Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills*, 30 October 2017, p. 21.

8 Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death* of *Damien Mark Mills,* 30 October 2017, p. 21.

9 Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills*, 30 October 2017, p. 25.

10 Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills*, 30 October 2017, pp. 21–25.

Coroner that he had formed the view that a headcount had not been conducted when the vessel returned to Sardine Jetty.[11]

## Coroner's comments on public safety

3.10 The Coroner noted that there was general agreement amongst the passengers on board the *Ten-Sixty-Six* that it would have been possible for the deceased to have fallen overboard during the return trip to Fremantle and not be seen.[12]

3.11 The Coroner made note that, at least in the early stages of the trip, the crew did not supervise the passengers on the return journey and that no additional safety briefing was provided when the boat departed Parakeet Bay on Rottnest Island.[13] This is despite the fact that many passengers had been drinking alcohol through the day and rough conditions were expected on the return journey. The Coroner continued:

> From that safety point of view, the passengers should have been informed of the likely rougher conditions on the return journey and the need to stay seated and then for a crew member to remain on watch outside to ensure that those instructions were followed, that passengers did not require assistance and that all passengers remained safely on board.[14]

3.12 In regards to the requirement to do a headcount, the Coroner made note of Sergeant Michael Wear's opinion that if the police had been informed of a man overboard situation immediately after the deceased had entered the water, there was an 'extremely high probability that the deceased may have been found alive'. Sergeant Wear put the probability of success in finding the deceased alive under these circumstances at 99.9 per cent. Sergeant Wear also noted that the 'Water Police could have had vessels and helicopters in the vicinity of that location within minutes and 15 to 20 vessels there within half an hour'.[15]

3.13 Sergeant Wear further suggested, based upon his own experience, that it was highly likely that the deceased might have been found alive if a prompt search

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[11] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills*, 30 October 2017, p. 28.

[12] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills*, 30 October 2017, p. 38.

[13] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills*, 30 October 2017, p. 38.

[14] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills*, 30 October 2017, p. 39.

[15] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills*, 30 October 2017, p. 41.

had been initiated. He noted that, at the very least, it was almost guaranteed that his body would have been found in a timely manner.[16]

3.14 Though Coroner Linton made no specific recommendations regarding headcounts, in the concluding remarks she noted:

> While [Mr Mills'] death was an accident, there was evidence that it may have been preventable if his disappearance had been identified sooner. The evidence underscored the need for simple processes, such as performing careful and orderly headcounts and supervising passengers properly while on board, to be undertaken by the crew of charter boats to ensure the safety of their passengers. If that had been done in this case, the deceased might still be alive today.[17]

3.15 The concluding remarks of the Coroner further stated:

> With the transition to a new national regulatory body, it is difficult to make any meaningful recommendations. However, I am informed by AMSA, who participated actively in the inquest, that they have understood the safety issues raised by the death of the deceased and it is AMSA's intention that steps will be taken, within the National Law framework, to promote headcounts as a safety measure.[18]

## AMSA's evidence on headcounts

3.16 AMSA informed the inquest that the legal requirements for headcounts on DCVs such as the *Ten-Sixty-Six* arose from the National Law, which commenced on 1 July 2013.

3.17 AMSA noted that the National Law was complex due to distinctions between various classes of vessels, as well as various transitional and grandfathering provisions relating to existing vessels (as compared to new vessels).[19] This complexity may have contributed to the fact that AMSA gave conflicting evidence to the Coroner regarding headcounts, as discussed below.

3.18 In a written response to the Coroner dated 17 November 2016, AMSA indicated that there was no specific statutory requirement to conduct a head count. However, AMSA noted that there was a requirement upon the operator to implement and maintain a safety management system (SMS) for which the 'risks identified and addressed in such a system are a matter for the operator to

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[16] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills*, 30 October 2017, p. 42.

[17] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills*, 30 October 2017, p. 47.

[18] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills*, 30 October 2017, p. 47.

[19] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills*, 30 October 2017, pp. 44–45.

determine'.[20] The SMS for the *Ten-Sixty-Six*, entitled Swan River Boat Charters Safety Management Plan 2014, clearly stated:

> Passengers will always be counted on and off the vessel and the numbers recorded in the vessel's log.[21]

3.19 Months later, however, on 2 June 2017, AMSA confirmed in a statement to the Coroner that there was a requirement under law to complete a head count aboard the *Ten-Sixty-Six*.[22] AMSA noted that this statement 'corrected a response to a question on 17 November 2016 indicating that there was no specific statutory requirement to conduct a head count'. In the 2017 statement, AMSA informed the Coroner that the SMS of the *Ten-Sixty-Six* specified that a head count must be conducted. AMSA continued that:

> Schedule 2 of the 'National Standard for Commercial Vessels (NSCV) Part E Operations' provides a requirement (for passenger vessels on voyages of less than 12 hours long) for at least one head count of all passengers on board the vessel and that the number of passengers on board the vessel must be known by the master at any time. Part 3 of the National Law imposes a separate and additional requirement to implement and maintain a Safety Management System which ensures the safety of the vessel and its operations so far as reasonably practical.[23]

3.20 At the time of the incident, the second edition of the NSCV Part E (Operational Practices), published by the National Marine Safety Council in October 2008, applied and was in effect in Western Australia.[24] AMSA noted that it was this version of NSCV Part E, other than crewing requirements, that applied to the *Ten-Sixty-Six* on the date of the incident.

## Suggested changes to headcount requirements

3.21 At the time of the coronial inquiry, the requirements in relation to headcounts were set out in Part E of the NSCV which specified the minimum requirements for the safe operation of DCVs in Australia. The specific clause states:

> 2.11.2.2 Passenger manifest
>
> A passenger manifest shall be maintained for all passenger-carrying vessels on voyages that are more than 12 hours in duration.

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[20] AMSA, Answer to question on notice from Budget Estimates 2018–2019, Question number 161, https://www.aph.gov.au/Parliamentary_Business/Senate_Estimates/rrat/2018-19_Budget_estimates (accessed 4 March 2019).

[21] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills*, 30 October 2017, p. 21.

[22] AMSA, Answer to question on notice from Budget Estimates 2018–2019, Question number 161.

[23] AMSA, Answer to question on notice from Budget Estimates 2018–2019, Question number 161.

[24] AMSA, Answer to question on notice from Budget Estimates 2018–2019, Question number 161.

> For all other passenger-carrying vessels a head count of passengers on board at any time shall be maintained.[25]

3.22 The Coroner queried the accuracy of the headcount aboard the *Ten-Sixty-Six* noting that 'if I am to accept his [Mr Lippiatt's] evidence of having done three headcounts, the process was flawed as the numbers he reached were incorrect'.[26] The Coroner further stated on the headcounts that:

> If a proper process of headcounts had been done, with correct numbers taken at the start and end of the charter, it would have been noted that a passenger was missing and hopefully an investigation into the identity of the person, and a search for them, could have been started much sooner and perhaps saved a life.[27]

3.23 In addition, the Coroner stated that it was difficult to see the benefit of a single headcount, and expressed the view that the WA Water Police's suggestion of a second headcount at disembarkation was 'obviously to be preferred' if safety is the objective.[28] The Coroner specifically asked AMSA to explain why the National Law does not mandate at least two headcounts, one at the start of the journey and the other at the end of the journey.

3.24 AMSA advised the Coroner that due to the significant diversity in vessel types and operations, it was difficult to be too prescriptive in headcount procedures. The example given was of the difference between Manly ferries operating on Sydney Harbour with hundreds of passengers hourly, and a small charter vessel with relatively few passengers for the day. AMSA indicated that it would not support a change in legislation to require more than one headcount because of the diverse range of operations that would be covered. Ms Clare East, AMSA Marine and Regulations Manager, was reported to have indicated that AMSA's preference was to 'use our various communication channels…to illustrate what would be sufficient for a head count'.[29]

3.25 AMSA further informed the Coroner that its preferred approach was that different types of operations should be able to calibrate their headcount procedures and requirements in accordance with the nature of their operation

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[25] Australian Transport Council, *National Standard for Commercial Vessels: Part E—Operational Practices*, 2008, cl. 2.11.2.2.

[26] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills,* 30 October 2017, p. 43.

[27] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills*, 30 October 2017, p. 44.

[28] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills*, 30 October 2017, p. 45.

[29] Shannon Hampton, 'Skipper didn't have opportunity for head count: Inquest', *The West Australian*, 7 June 2017, https://thewest.com.au/news/wa/skipper-didnt-have-opportunity-for-head-count-inquest-ng-b88500521z (accessed 20 April 2019).

and on the basis of guidance provided by AMSA as to what is appropriate and reasonable in the circumstances.

3.26 However, the Western Australian Department of Transport (DoT) disagreed with AMSA's approach and expressed the view that, for small operators, it was better to be prescriptive rather than rely on the operators' own ability to assess what they considered safe without clear guidance.[30] Similarly, the WA Water Police supported a more prescriptive approach with its recommendations that a first headcount be conducted and corroborated by another crew member and that another headcount be conducted when passengers are disembarking.[31]

## Headcount method and prescription

3.27 Alongside the concerns raised regarding the number of headcounts required to be conducted during a DCV journey, the coronial inquiry brought to light important questions about how headcounts are conducted. In the case of the *Ten-Sixty-Six*, the process of head counting was recognised by the Coroner as 'flawed' as the numbers reached by the master were incorrect.[32]

3.28 The SMS on the *Ten-Sixty-Six* set out a requirement that passengers 'will always be counted on and off the vessel and the numbers recorded in the vessel's logbook'. While there was a direction that passengers would be counted on and off the vessel, with the number recorded, there was no set procedure as to how those headcounts were to be conducted.[33]

3.29 The National Law does not mandate nor prescribe the way in which a count is to be conducted. The method by which passengers are counted on and off a DCV therefore varies from vessel to vessel. Methods include a simple counting of heads, a clicker system, and formal ticketing arrangements. Such methods can be written into a vessel's SMS. However, an SMS can also simply state that headcounts should be conducted without specifying how they should be performed.[34] AMSA indicated that it was a matter for the vessel owner to

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30 Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills*, 30 October 2017, p. 46.

31 Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills*, 30 October 2017, p. 45.

32 Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills,* 30 October 2017, p. 43.

33 Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills*, 30 October 2017, p. 43.

34 Mr Allan Schwartz, Australian Maritime Safety Authority, *Committee Hansard,* 1 April 2019, p. 7.

determine the best practice for conducting head counts on their vessel, taking into consideration the nature of their operation.[35]

## AMSA's response to the coronial inquiry

3.30 In response to the Coroner's statement that a single headcount was inadequate, AMSA noted its intention to 'undertake safety initiatives to communicate the need to undertake two headcounts for certain operations'. AMSA indicated that this would be undertaken through:

- committees—including the Domestic Commercial Vessel Industry Advisory Committee;
- publications—including the Safety Awareness Bulletin and E-news marine notices sent to over 29 000 subscribers;
- direct educational activities—including SMS workshops that were organised by vessel operation type and complexity; and
- other unspecified interventions.[36]

3.31 The Coroner was reassured that AMSA intended to take an 'active role in promoting the need for multiple headcounts in domestic charter operations'. Although she expressed a preference for multiple headcounts to be made mandatory as a means of ensuring compliance, the Coroner accepted that under the new system, 'it is difficult to legislate such a requirement in a simple way'.[37] The Coroner concluded that:

> The system proposed by AMSA of encouraging inclusion of such a system in the SMS of operators of charter operations similar to that of Mr Lippiatt, which would then require compliance, would appear to be the most practical option.[38]

3.32 In her concluding comments, Coroner Linton observed that AMSA intended to take steps to promote headcounts as a safety measure and noted that it is important that 'AMSA do its best to ensure that safety systems implemented are duly carried out by operators with care and diligence'.[39]

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[35] AMSA, Answer to question on notice from Budget Estimates 2018–2019, Question number 161, https://www.aph.gov.au/Parliamentary_Business/Senate_Estimates/rrat/2018-19_Budget_estimates (accessed 4 March 2019).

[36] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills*, 30 October 2017, p. 46.

[37] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills*, 30 October 2017, p. 47.

[38] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills*, 30 October 2017, p. 47.

[39] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills*, 30 October 2017, p. 47.

3.33 AMSA had indicated to the Coroner that it intended to maintain a 'clear compliance presence, with a focus on the headcount issue for high risk operators'.[40] Following the inquest, AMSA provided further information to the court to indicate that 'AMSA has an expectation that it will be necessary and desirable to conduct two headcounts (or more) on certain operations'. It expressed the view that this was best done in an operator's SMS, noting that as 'part of the risk assessment process an owner/operator of these types of operations will be best placed to identify that a second headcount is necessary (for example, on passenger vessels)'.[41]

## AMSA's actions since 2014

3.34 In December 2018, AMSA CEO, Mr Mick Kinley, gave evidence that AMSA had implemented a 'suite of regulatory and operational measures to improve the safety outcome in passenger operations'.[42] He stated that since 1 July 2018, AMSA had ended grandfathering of operational safety standards. Owners and operators of passenger vessels must, as a condition of their certificate of operation, now comply with contemporary safety standards for operations, including headcount requirements, as set out in Marine Order 504. He stated that:

> There is now an explicit requirement that the safety management system for the vessel specifically address these operational safety standards, giving clearer substance to safety management system obligations, and vessel owners won't be issued a certificate of operation if they don't do this.[43]

3.35 Mr Kinley also stated that AMSA had 'bolstered' the obligation to undertake at least one headcount and to be aware of the number of passengers on the vessel at any time, by requiring vessel owners to ensure the number of crew on board was adequate to ensure passengers were appropriately monitored.[44]

3.36 In terms of operational and compliance measures, AMSA also undertook a range of measures, including:

- SMS assessments in Western Australia, with particular attention given to passenger vessels operating between the mainland and Rottnest Island;
- SMS workshops in Western Australia;
- developing new guidance for an SMS;

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[40] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills,* 30 October 2017, p. 47.

[41] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills,* 30 October 2017, p. 46.

[42] Mr Mick Kinley, Australian Maritime Safety Authority, *Committee Hansard*, 4 December 2018, p. 2.

[43] Mr Mick Kinley, Australian Maritime Safety Authority, *Committee Hansard*, 4 December 2018, p. 2.

[44] Mr Mick Kinley, Australian Maritime Safety Authority, *Committee Hansard*, 4 December 2018, p. 2.

- assessing an SMS for passenger vessels considered high risk prior to the issue of a renewal of a certificate of operation; and
- planning for an SMS forum in 2019.[45]

**Enforcement and Inspector Support**

3.37 Following a review of AMSA's compliance functions and enforcement policy in 2017, it created a dedicated Enforcement and Inspector Support (EIS) Unit.[46] The unit reports directly to the CEO and has specialist resources to undertake compliance activities including detailed investigations, prosecutions and the instigation of civil penalty proceedings. AMSA informed the committee that the unit will 'investigate all fatalities relating to the operation of domestic commercial vessels and will continue to work with the CDPP'.[47]

3.38 As AMSA has taken on full regulatory responsibility for compliance of DCVs, the EIS unit will take the lead in investigating incidents under the National Law.[48] At the same time, there remain 225 state and NT agency officers appointed as National Law MSIs. In addition, state police officers remain National Law MSIs. These arrangements are supported by memoranda of understanding (MoUs) and service level agreements.

## Marine Order 504 and headcounts

3.39 As discussed in Chapter 2, the current Marine Order 504 commenced on 1 July 2018, following a number of amendments which included moving provisions contained in Part E of the NSCV into the 2018 Marine Order 504 as a schedule. Under the Order, an SMS is required to detail a vessel's operational requirements.

3.40 Further, under Marine Order 504, applications for a certificate of operation must include a written declaration that there is an SMS in place. It specifies that an offence is committed under the National Law if an owner of a vessel does not implement and maintain an SMS for a vessel.[49]

3.41 Schedule 1 of Marine Order 504 states, in relation to headcounts:

> Passenger documents
>
> (9) For a voyage that is less than 12 hours long, the master must:

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45 Mr Mick Kinley, Australian Maritime Safety Authority, *Committee Hansard*, 4 December 2018, p. 2.

46 Australian Maritime Safety Authority, Answers to questions on notice from 4 December 2018 hearing, received 20 December 2018.

47 Australian Maritime Safety Authority, Answers to questions on notice from 4 December 2018 hearing, received 20 December 2018.

48 Australian Maritime Safety Authority, Answers to questions on notice from 4 December 2018 hearing, received 20 December 2018.

49 *Marine Order 504 (Certifications of Operation and Operation Requirements—National Law) 2018*, cl. 4.

> (a) ensure that at least 1 head count is conducted of all passengers on board the vessel; and
>
> (b) know the number of passengers on the vessel at any time.
>
> (10) For a voyage that is at least 12 hours long, the owner must ensure that a readily accessible passenger manifest is kept on board the vessel.
>
> (11) The passenger manifest must include details about the following:
>
> (a) the name of the vessel;
>
> (b) an identification number for the vessel;
>
> (c) the voyage;
>
> (d) if required in an emergency — details of any medical or safety requirements of particular passengers;
>
> (e) for each person on board the vessel — name, address (local and home if a person has both), email address (if any) and phone number.

3.42 AMSA noted that Marine Order 504 requires that the owner 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 each particular operation[50] (the considerations that they must take into account are set out in the Marine Order). According to AMSA, it has extended the requirement with regard to the need for the owner to consider 'the number of persons to be carried on the vessel', to provide that the owner's evaluation must take into account the 'number of persons to be carried on the vessel and the effectiveness and timeliness arrangements for passenger monitoring by the crew'. AMSA argued that:

> 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.[51]

## *AMSA's information campaign*

3.43 In 2018, AMSA produced guidelines to improve understanding of the SMS, particularly in light of the circumstances of Mr Mills' death. The guidelines contain only the following direction with regard to headcounts:

> Key questions to consider:
>
> …
>
> How do I accurately conduct a passenger head count? How often will I do a passenger head count?
>
> …

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[50] This SMS requirement does not necessarily apply to existing vessels under the National Law; see Chapter 6.

[51] Australian Maritime Safety Authority, *Submission 1*, p. 14.

> Passenger list
>
> You are required to complete a head count, and for voyages longer than 12 hours, a passenger manifest.[52]

3.44 In terms of information and awareness-raising, AMSA also placed an article on charter boats in the December 2018 edition of its magazine, *Working Boats*. It states:

> **Headcounts**
>
> In situations where passengers get on and off there is a risk the vessel could depart for the next destination without all of the passengers.
>
> While boarding, operators should do a headcount and log the number and details of passengers. Once en route, do at least one more headcount to make sure everyone is on board, before departing any stops along the way and again when the vessel gets back to port.
>
> **Monitoring passengers**
>
> As well as the obligation to do headcounts, operators must also make sure they have enough crew to adequately monitor the number of passengers on-board.[53]

3.45 The committee has not received any evidence to indicate how many vessels have instituted a regime in their SMS to conduct more than one headcount as a consequence of this compliance and awareness-raising activity. AMSA stated that it assesses the SMS for passenger vessels considered high risk prior to the issue of a renewal of a certificate of operation. However, it is not clear how it conducts such assessments, nor what action is taken when an SMS is deemed to be inadequate.

## *Legislating for headcounts*

3.46 The WA Police acknowledged AMSA's concerns that it would be difficult to be prescriptive about head counts, given the diverse range of operations that the Schedule 1 provision covers. However, Senior Constable Brandhoff also acknowledged that for many DCVs, maintaining awareness of two to ten passengers would not be difficult. Inspector Andrew Henderson also noted the importance of maintaining an understanding of passengers throughout a journey:

> I can clearly see the benefits of conducting regular headcounts, especially if people are getting on and off the boat like they do in Queensland. Anything that contributes to the safety and welfare of the people, we

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[52] Australian Maritime Safety Authority, *Guidelines for a Safety Management System*, 2018, pp. 31–32.

[53] Australian Maritime Safety Authority, *Working Boats*, Issue 14, December 2018, p. 27, https://www.amsa.gov.au/news-community/newsletters/working-boats-issue-14 (accessed 8 March 2019).

> would certainly be happy to endorse. And anything that makes search and rescue redundant, we would be happy to support that.[54]

3.47 WA DoT officials stated, for operators of vessels similar to the *Ten-Sixty-Six*, it was necessary to be prescriptive about headcounts and other safety measures. Mr Ray Buchholz, General Manager Marine Safety, suggested that 'unless it's clearly stated that they must do X and Y on and off you'll find that they won't see that as something they must do: it's something that it would be nice to do'. Mr Buchholz continued:

> And in terms of that catch-all comment about 'must know at any given time how many are on board', if you think about that practically, how is that done? Whereas if I say to you, 'At the beginning and at the completion of your voyage,' it's crystal clear what has to be done, particularly if it has to be recorded in a logbook, because it then becomes demonstrable that you've done it.[55]

3.48 The WA Police raised similar concerns regarding the requirement under Marine Order 504 to 'know the number of passengers on the vessel at any time'. Senior Constable Brandhoff indicated that 'there is no facility to record that, to know when it was done, how it was done–any of that sort of thing–so it is too much of a grey area'.[56]

3.49 Mr Buchholz raised an additional concern that the national system places considerable emphasis on the SMS. He stated that there is a belief that the vessel operator/owner is best placed to make decisions about safety and to put in place measures to mitigate the risks. He also indicated that where an operator/owner lists various safety measures in an SMS but then doesn't apply those measures in practice, there should be a consequence. Reflecting on the *Ten-Sixty-Six* matter, Mr Buchholz continued:

> And I think that at the core of the work that we did was this belief that they did have a safety management system and they had identified the need to do a count on and off. Clearly, from the evidence presented, that was not done. There has to be a consequence to that.[57]

### *Planned Amendments to Marine Order 504 - headcounts*

3.50 At a public hearing on 1 April 2019, Mr Kinley informed the committee that AMSA had heard the concerns of witnesses, and the committee, regarding the appropriateness of having only one headcount for a DCV operation. AMSA advised it would look to revise Marine Order 504 to make it 'clearer that operators are required to ensure they have appropriate procedures and

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[54] Inspector Henderson, WA Police, *Committee Hansard*, 21 March 2019, p. 23.

[55] Mr Ray Buchholz, WA Department of Transport, *Committee Hansard*, 21 March 2019, p. 49.

[56] Senior Constable Brandhoff, WA Police, *Committee Hansard*, 21 March 2019, p. 23.

[57] Mr Ray Buchholz, WA Department of Transport, *Committee Hansard*, 21 March 2019, p. 49.

methods in place to prevent passengers being lost at sea or left behind during a voyage'.[58]

3.51 Mr Kinley, when questioned on what information AMSA was able to discuss at that stage, noted 'it's not a simple matter of saying we should do two headcounts'.[59] He went on to explain that AMSA 'are determined to have a regulation in the first quarter of next year [2020] that articulates that requirement for however many headcounts they [DCVs] have to do to make sure that they've brought back the people they need to bring back'.[60]

3.52 Mr Brad Groves, General Manager, Standards Division, further elucidated upon the feedback from the submissions on the proposed amendments, noting that 'when it comes to the example of the [*Ten-Sixty-Six*] and smaller vessels, some submissions said a headcount on and off would be appropriate. There were other submissions around using a lanyard system or a sign in and sign out'.[61]

3.53 Mr Groves continued by noting AMSA's preferred method for amending headcount legislation was a 'two-pronged approach'.[62] This would involve making the SMS across all vessels carrying passengers 'more robust in terms of looking after the passengers' as well as the implementation of 'very specific requirements in terms of counting on and off' for smaller vessels such as the *Ten-Sixty-Six*.[63]

## *Marine Safety (Domestic Commercial Vessel) National Law Amendment (Improving Safety) Bill 2019*

3.54 On 5 December 2019, Senator Sterle, Chair of the Rural and Regional Affairs and Transport References Committee, introduced a Private Senator's Bill ("the Bill")to specifically address concerns about the adequacy of the legislative requirements around headcounts.

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58 Mr Mick Kinley, Australian Maritime Safety Authority, *Committee Hansard*, 1 April 2019, p. 2.

59 Mr Mick Kinley, Australian Maritime Safety Authority, *Committee Hansard*, 11 November 2019, p. 1.

60 Mr Mick Kinley, Australian Maritime Safety Authority, *Committee Hansard*, 11 November 2019, p. 1.

61 Mr Brad Groves, Australian Maritime Safety Authority, *Committee Hansard*, 11 November 2019, p. 2. The committee was advised at a public hearing on 11 November 2019 that a public consultation period had been implemented on proposed amendments, which closed on 20 October 2019, with 32 submissions received; see Mr Mick Kinley, Australian Maritime Safety Authority, *Committee Hansard*, 11 November 2019, p. 1.

62 Mr Brad Groves, Australian Maritime Safety Authority, *Committee Hansard*, 11 November 2019, p. 2.

63 Mr Brad Groves, Australian Maritime Safety Authority, *Committee Hansard*, 11 November 2019, p. 2.

3.55 The Bill passed in the Senate on 10 February 2020 and was read a first time in the House of Representatives on 11 February 2020. It has yet to progress any further at the time of writing.

3.56 The Bill, if passed, would require masters of vessels to conduct two headcounts, one at the commencement of the voyage and one at the end.[64] The Bill excludes Class 4 vessels, vessels used for public transport, and vessels longer than 24 metres.

3.57 The purpose of the Bill is explicit, and is in direct response to the death of Mr Damien Mills.[65]

### *Marine Order 504 – Amendment Order 2020*

3.58 Concomitantly with the Private Senator's Bill, AMSA was carrying out a consultation process on proposed amendments to Marine Order 504 to provide for more robust obligations in terms of how headcounts should be managed on certain vessels.

3.59 The proposed amendments were subject to a consultation process, which involved placing the draft Order on AMSA's website on 16 December 2019 and inviting comment for a nine week period. The explanatory statement for the Order sets out the process:

> The consultation process details were posted on social media. In addition, 83 stakeholders were emailed a copy of the draft amending Order and their comment invited. Stakeholders included the Domestic Commercial Vessel Industry Advisory Committee, the Fishing Industry Advisory Committee, the Maritime Agencies Forum, charter boat and tourism industry associations, other industry associations and state and territory government departments and agencies. There were 26 submissions received and these responses were taken into account in finalising the amending Order.[66]

3.60 On 28 February 2020, Mr Kinley, as AMSA CEO, made the *Marine Order 504 (Certificates of operation and operation requirements — national law) Amendment Order 2020*. The Order, which commenced on 31 May 2020, makes several amendments intended to improve the safety of passengers on a vessel through provisions for monitoring and counting passengers. Requirements for

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[64] Marine Safety (Domestic Commercial Vessel) National Law Amendment (Improving Safety) Bill 2019, Explanatory Memorandum, p. 2, para 3.

[65] Marine Safety (Domestic Commercial Vessel) National Law Amendment (Improving Safety) Bill 2019, Explanatory Memorandum, p. 2, para 2.

[66] *Marine Order 504 (Certificates of operation and operation requirements — national law) Amendment Order 2020*, Explanatory Memorandum, p. 1.

managing situations where a passenger is unaccounted for are also strengthened.[67]

3.61 According to the Amendment Order's Explanatory Memorandum, a vessel's SMS will be utilised to include these strengthened provisions:

> The amending Order makes new requirements for all vessels carrying passengers to include procedures in the Safety Management System (SMS) for monitoring and counting passengers. All vessels must also include an emergency procedure in the SMS for responding to a situation where a person is unaccounted for. In addition, a range of passenger vessels must include a procedure for counting passengers on embarkation and disembarkation. The passenger counts must be recorded in the vessel's logbook.[68]

3.62 The procedures require operators of vessels to count all passengers on board 'at any point where one or more passengers embark or disembark the vessel'. This includes at a landing point, and/or when they undertake a water activity.[69]

3.63 The requirements are intended to apply to vessels that meet the following criteria and are specifically designed to exclude passenger ferries. In subclause 7(6) of Schedule 1 of the Order:

> …new paragraph (bb) provides that procedures must include a passenger count on embarkation and disembarkation for vessels carrying up to 75 passengers operating in certain waters and for voyages between 30 minutes and 12 hours.[70]

3.64 The provisions are not intended to be prescriptive in how a vessel carries out these checks, although examples include utilising CCTV, crew stationed to visually monitor passengers, or the use of wrist bands, and will be further expanded upon in guidance which will be developed in the coming months. In terms of counting as part of a water-based activity, a count does not have to be done during that activity, every time someone comes on and off the vessel.[71]

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[67] *Marine Order 504 (Certificates of operation and operation requirements — national law) Amendment Order* 2020, Explanatory Memorandum, p. 1.

[68] *Marine Order 504 (Certificates of operation and operation requirements — national law) Amendment Order 2020,* Explanatory Memorandum, p. 1.

[69] Australian Maritime Safety Authority, *Have your say on changes to Marine order 504 to keep passengers safe*; available at https://www.amsa.gov.au/news-community/consultations/have-your-say-changes-marine-order-504-keep-passengers-safe (accessed 8 April 2020).

[70] *Marine Order 504 (Certificates of operation and operation requirements — national law) Amendment Order* 2020, Explanatory Memorandum, p. 2.

[71] *Marine Order 504 (Certificates of operation and operation requirements — national law) Amendment Order* 2020, Explanatory Memorandum, p. 2; Australian Maritime Safety Authority, *Have your say on changes to Marine order 504 to keep passengers safe*.

3.65 The current Order already provides that there must be procedures in the vessel's SMS for managing the situation where a person is overboard. These are being extended to where a person is overboard or unaccountably missing.[72]

## Committee view

3.66 The central focus of the inquiry has always been the tragic death of Mr Damien Mills, the circumstances of his death, and how something similar could be prevented in the future.

3.67 The revelations of the coronial inquest exposed the gaps and limitations in the current requirements around headcounts and monitoring of passengers, and exposed the limitations of the self-regulating approach that underpins the National Law. The committee heard harrowing evidence that if more stringent requirements were in place, and acted upon, it would be highly likely Mr Mills would have been found alive.

3.68 To this end, the committee commends AMSA's amendments to Marine Order 504, and for enacting a prescriptive minimum requirement. It may be that there are other safety-critical areas of the National Law where a more prescriptive approach could and should be taken.

3.69 Nevertheless, the committee is of the view that there has been avoidable reluctance in implementing enhanced safety requirements for domestic vehicles. While it accepts that it is difficult to prescribe operational matters across a diverse range of vessels with diverse purposes, the length of time the committee has pressed for improvements, even to the point of Senator Sterle's efforts to expedite the process through his Private Senator's Bill, is concerning.

3.70 The committee hopes that this inquiry will lead AMSA to improve its processes, and therefore make it better placed to implement necessary regulatory improvements in a more timely and effective manner moving forward.

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[72] *Marine Order 504 (Certificates of operation and operation requirements — national law) Amendment Order 2020*, Explanatory Memorandum, p. 2.

# Chapter 4
# Investigations and scope for prosecution under the National Law

4.1 This chapter considers the work undertaken by AMSA in response to recommendations from the Western Australian Police Force (WA Police) to prosecute the master of the vessel, *Ten-Sixty-Six*. It also focuses on the decision-making process within AMSA not to proceed with a brief of evidence for possible prosecutorial action, following the death of Mr Damien Mills.

4.2 This chapter also considers investigations into Dolphin Dive Centre Fremantle (DDCF) vessels, operations certificates and safety equipment. It traces the efforts of the WA Department of Transport (DoT) to hold the owner and operator to account under the National Law.

## Western Australia Police investigation into the death of Mr Mills

4.3 On 21 March 2019, WA Police appeared before the committee in Perth. Senior Constable Bret Brandhoff, Intelligence Division, gave evidence that, at the time of Mr Mills' death, AMSA had no investigators in Western Australia. He explained that it was through necessity that the WA Water Police took on the role of investigating the death of Mr Mills as marine safety inspectors (MSIs) under the National Law.[1]

4.4 Senior Constable Brandhoff indicated that the most appropriate legislation under which to deal with the matter was in the marine environment. It was the view of WA Police at the time that there was 'no other state or criminal offences that we thought were relevant'.[2] Inspector Andrew Henderson, Emergency Management and Maritime Branch, further noted that the possibility of manslaughter charges would have been considered through the coroner's process.[3]

4.5 At the start of the police investigation at the time of Mr Mill's death, Senior Constable Brandhoff spoke with AMSA to get an understanding of breaches and offences under the National Law that could apply in the case of the death of Mr Mills. On the basis of advice provided by AMSA, Senior Constable Brandhoff wrote the WA Police report with recommendations that the master of the vessel, *Ten-Sixty-Six*, be charged under the National Law for failing to

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1 WA Police also have a responsibility under the Coroner's Act to ensure there is a thorough investigation into any death on the coroner's behalf. Senior Constable Brandhoff and Inspector Andrew Henderson, WA Police, *Committee Hansard*, 21 March 2019, pp. 15–16.

2 Senior Constable Brandhoff, WA Police, *Committee Hansard*, 21 March 2019, p. 19.

3 Inspector Andrew Henderson, WA Police, *Committee Hansard*, 21 March 2019, p. 20.

comply with the vessel safety management system (SMS) with regard to vessel induction and headcounts.[4]

*Possible charges*

4.6 Section 16(1) of Schedule 1 of the National Law, in relation to general safety duties relating to DCVs, and in particular the duty of masters of DCVs, provides that:

> The master of a domestic commercial vessel must, so far as reasonably practicable, ensure the safety of:
>
> (a) the vessel; and
> (b) marine safety equipment that relates to the vessel; and
> (c) the operation of the vessel.

4.7 On 12 February 2015, the WA Police submitted its report to AMSA. The report recommended two charges against the master of the *Ten-Sixty-Six*, for breaches of the general safety duties under section 16(1). The first charge related to a failure to comply with the master's responsibilities and induction requirements as outlined in the SMS. The second related to a failure to implement the SMS by not conducting a count of the passengers disembarking at the conclusion of the charter.[5]

4.8 In relation to the first charge, Senior Constable Brandhoff explained the basis of the recommendation:

> Under the national law, they're required to have a safety management system on the boat. That is a document which outlines the operation, safety requirements, a number of things under the act that they have to address. One of the things in his safety management system was headcounts. Under the section relating to headcounts in the safety management system, it had words to the effect that passengers will be counted on and off. From the evidence of passengers and all different accounts I was satisfied that there was no headcount at the end of the journey. The fact that one was not conducted breached the safety management system; therefore, a charge under section 12[6] of the national law, that a breach of the safety management system occurred for the headcounts.[7]

4.9 Senior Constable Brandhoff further explained the basis for the second charge in relation to crew induction:

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4 Senior Constable Brandhoff, WA Police, *Committee Hansard*, 21 March 2019, p. 16.

5 Australian Maritime Safety Authority, Answer to question on notice from Budget Estimates, Question number 161, https://www.aph.gov.au/Parliamentary_Business/Senate_Estimates/rrat/2018-19_Budget_estimates (accessed 4 March 2019).

6 Section 12(1) of the National Law is in relation to the owner of a DCV, and the provision is in the same form as section 16(1) which is in relation to the master of a DCV (that is, section 12 relates to owners, and section 16 relates to masters).

7 Senior Constable Brandhoff, WA Police, *Committee Hansard*, 21 March 2019, p. 21.

> Under the safety management system…he was required to do an induction with the crew members that were going to be working on the boat, record the induction, have the induction signed off and the document on the boat. That wasn't there and the induction wasn't done. Again, my reasoning for that was that maybe if an induction was done and the roles and responsibilities explained clearly to the crew, to look after the passengers, maybe he may have spent more time out on the back of the boat looking after passengers in his role, rather than not doing that.[8]

4.10 Senior Constable Brandhoff informed the committee that after submitting the report to the safety authority, he received an initial acknowledgment from AMSA. However, there was no follow-up or discussions on the content of the report and its recommendations thereafter.[9]

4.11 During the period February to August 2015, AMSA advised that it reviewed the report from WA Police, including its recommendation that charges be considered.[10]

## AMSA response to WA Police regarding headcount requirements

4.12 AMSA indicated to the committee that under the National Law, the obligation is on the master to follow the vessel's SMS. Ms Clare East, as AMSA's Acting General Manager, Standards, explained that:

> The obligation on the master is to implement and comply with the safety management system so far as reasonably practicable. The safety management system, among other things, set out the requirement to undertake a headcount, and that was the basis of the WA police recommendation.[11]

4.13 As noted in Chapter 3, AMSA confirmed that it had informed the WA Coroner on 2 June 2017 that there was a requirement under law to complete a head count.[12]

4.14 In addition, the Coroner noted that the SMS on the *Ten-Sixty-Six* set out that passengers 'will always be counted on and off the vessel and the numbers recorded in the vessel's logbook'. While the master of the vessel, Mr Lippiatt, agreed that the accepted procedure was to count passengers on and off the vessel and to record passenger numbers, in accordance with the SMS, there was 'no set procedure as to how those headcounts were to be conducted'.[13]

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8 Senior Constable Brandhoff, WA Police, *Committee Hansard*, 21 March 2019, p. 21.

9 Senior Constable Brandhoff, WA Police, *Committee Hansard*, 21 March 2019, pp. 17, 20.

10 Australian Maritime Safety Authority, *Submission 1*, p. 8.

11 Ms Clare East, Australian Maritime Safety Authority, *Committee Hansard*, 4 December 2018, p. 3.

12 Chapter 3, para 3.19.

13 Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills*, 30 October 2017, p. 43.

4.15 Following receipt of the WA Police report in February 2015, AMSA consulted the Commonwealth Director of Public Prosecutions (CDPP) in August of that year. Mr Kinley indicated to the committee that, at that time, the CDPP raised concerns that there was:

> …no conclusive evidence that Mr Mills actually fell overboard and no conclusive evidence as to whether or not the operator conducted a headcount of passengers on disembarkation, which is required by the safety management system but not specifically under the national law.[14]

4.16 The SMS required that headcounts be recorded in the vessel's logbook. However, according to AMSA, the master stated that he had conducted three headcounts, two of which were not recorded because the number had not changed. According to Mr Kinley, while such action did not meet the requirements of the SMS, and demonstrated 'complacency', AMSA was not able to prove beyond reasonable doubt that such actions led to general safety duties being breached. Mr Kinley continued:

> The master of the vessel was adamant that he had maintained the head counts and actually did that in his head. He counted passengers. He had been very experienced and he did this regularly and that was how he did it. So for us to be prove beyond reasonable doubt to a level of criminal evidence that those actions led to an unsafe vessel, it was thought to be not worth it; the chances of a successful prosecution were not high enough to warrant proceeding.[15]

4.17 The CDPP advised AMSA that, on the basis of the evidence 'to hand', it could not be proven beyond a reasonable doubt that the master had committed any offence under the National Law.[16] Mr Kinley indicated that AMSA accepted that advice 'because there was no evidence that would counter the master's claim that he had conducted the required headcounts'. Furthermore, according to Mr Kinley, the induction issue was 'not significant in the circumstances'.[17] AMSA had concluded that:

> 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.[18]

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[14] Mr Mick Kinley, Australian Maritime Safety Authority, *Committee Hansard*, 4 December 2018, p. 1.

[15] Mr Mick Kinley, Australian Maritime Safety Authority, *Committee Hansard*, 4 December 2018, p. 4.

[16] Mr Mick Kinley, Australian Maritime Safety Authority, *Committee Hansard*, 4 December 2018, p. 1.

[17] Mr Mick Kinley, Australian Maritime Safety Authority, *Committee Hansard*, 4 December 2018, p. 1.

[18] Australian Maritime Safety Authority, *Submission 1*, p. 8.

4.18 AMSA acknowledged that one of the primary difficulties it faced 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'.[19]

4.19 As noted in Chapter 3 of this report, the National Law does not provide a specific, preferred method of head counting or any requirement to describe a particular method of head counting. AMSA's evidence regarding its assessment of the offence is significant in this regard:

> 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 was no specific offence for undertaking an incorrect head count.
>
> If investigators can prove the required action 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.[20]

4.20 Section 18(1)(c) of the National Law provides that a person commits an offence if the person intends the act or omission to be a risk to the safety of a person or the DCV concerned. The penalty for this contravention includes two years imprisonment.[21]

4.21 AMSA noted that even if it could have proven beyond reasonable doubt that the master failed to conduct a headcount, the fundamental element missing from the offence provision under section 18(1)(c) was intent—that is, that the master omitted to conduct a headcount with the intent of causing a risk of a passenger going overboard. Mr Clinton McKenzie, AMSA General Counsel, explained how the intent provision would have to apply:

> ...that he (Mr Lippiatt) intended, by failing to conduct the headcount, to create the risk that a passenger would go overboard unnoticed at the time or at the completion of the voyage. There was no evidence to that standard…[22]

## AMSA response to WA Police recommendation regarding crew induction

4.22 Despite the crew induction requirements contained in the *Ten-Sixty-Six* SMS, the WA Police report provided evidence that the crew member on board on the day of Mr Mills' death hadn't been appropriately inducted onto the vessel.

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[19] Australian Maritime Safety Authority, Answers to written questions on notice, received 20 March 2019.

[20] Australian Maritime Safety Authority, *Submission 1*, p. 8.

[21] Section 18 of the National Law relates to offences for contraventions of sections 16 and 17 of the National Law.

[22] Mr Clinton McKenzie, Australian Maritime Safety Authority, *Committee Hansard*, 1 April 2019, p. 8.

AMSA acknowledged that there was also evidence contained in the report that the deckhand had spent some time incapacitated (possibly sea sick) because of the conditions on the voyage.[23] It should be noted that the Coroner's report indicated that the deckhand had spent most of the first part of the return journey from Rottnest Island in the wheelhouse talking to the skipper.[24]

4.23 AMSA noted that its Compliance and Enforcement Policy and associated National Law Protocol that applied at the time of Mr Mills' death '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'.[25]

4.24 AMSA also suggested that the WA Police report had not provided evidence that the master intended to, by failing to induct a crew member, put the safety of a person or the DCV at risk. Further, it noted that no evidence was provided to it to support the conclusion that the master was reckless or negligent in failing to conduct a head count and failing to induct a crew member.[26] AMSA continued:

> 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.[27]

### *CDPP brief of evidence*

4.25 AMSA concluded in its submission, dated March 2019, that the recommendations made by the police did not support and/or warrant prosecution of the master of the *Ten-Sixty-Six*.[28]

4.26 However, at a public hearing on 25 September 2019, Mr Stuart Richey, Chairman of AMSA, announced that:

> AMSA has...provided the brief of evidence to the Commonwealth Director of Public Prosecutions and is continuing to work with the CDPP.[29]

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[23] Australian Maritime Safety Authority, *Submission 1*, p. 8.

[24] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the Death of Damien Mark Mills,* 30 October 2017, p. 13.

[25] Australian Maritime Safety Authority, *Submission 1*, p. 8.

[26] Australian Maritime Safety Authority, *Submission 1*, p. 9.

[27] Australian Maritime Safety Authority, *Submission 1*, p. 9.

[28] Australian Maritime Safety Authority, *Submission 1*, p. 9.

[29] Mr Stuart Richey, Australian Maritime Safety Authority Board, *Committee Hansard*, 25 September 2019, p. 18.

4.27 Mr Kinley, when queried about the time line for the investigation, noted that the relevant information was with the CDPP and that, as of 25 September, they were filling in the gaps that would 'allow them to make a decision on whether or not they can prosecute'.[30]

4.28 On 2 December 2019 the committee wrote to AMSA seeking an update on any progress in relation to the brief of evidence provided to the CDPP. AMSA responded on 5 December 2019, informing the committee of the following developments:

> An Australian Maritime Safety Authority (AMSA) investigator was in Perth between 27 October and 1 November 2019 to conduct investigations into the allegations raised against Dolphin Dive Centre Fremantle Pty Ltd and Mr Daniel Lippiatt.
>
> As a result, additional material, including a statement of facts and a number of statements and exhibits were provided to the CDPP on 8 November 2019 for prosecution assessment.
>
> AMSA has approached the CDPP for an update on the status of the case and is currently awaiting a response.[31]

## Committee view

4.29 The chapter has thus far traced the processes undertaken by the WA Police and AMSA to investigate the matters pertaining to the DDCF and the challenges in taking disciplinary action against the owner and operator of the DDCF. At the time, responsibilities and authority for investigation, compliance and enforcement were shared between three agencies under the IGA.

4.30 The committee notes that the report by the WA Police recommended that charges should be considered against the master of the vessel for breaches of general safety duty under section 16(1) of the National Law.

4.31 It is of particular concern to the committee that in order to prosecute the master of the vessel, it had to be proved beyond a reasonable doubt that a headcount had not taken place, but that if the headcount didn't take place, prosecution under the National Law requires evidence of intent to create a risk to a person on a DCV.

4.32 It is the view of the committee that this is a very high bar to reach, in order to take enforcement action against the operator of a vessel. The committee suggests that a more preferable approach is that the National Law allows for

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[30] Mr Mick Kinley, Australian Maritime Safety Authority Board, *Committee Hansard*, 25 September 2019, p. 25.

[31] AMSA, Correspondence - Status of prosecution brief of evidence in relation to the matter of Mr Damian Mills, received 5 December 2019. Available at: https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Rural_and_Regional_Affairs_and_Transport/AMSA/Additional_Documents?docType=Correspondence

enforcement action to be taken against the operator of a vessel who acts in a reckless or negligent manner, regardless of intent.

4.33 In particular, the committee proposes that consideration be given to situations where a vessel operator has been found to be acting in a negligent manner, which has the potential to result in the loss of life. The committee therefore makes the following recommendation:

**Recommendation 1**

**4.34 The committee recommends that amendments be made to the *Marine Safety (Domestic Commercial Vessel) National Law Act 2012* (the National Law) in regards to the penalties imposed on an operator of a vessel for acting in a reckless or negligent manner, regardless of intent. In particular, the committee recommends that consideration should be given to situations where the operator of a vessel has been found to be acting in a negligent or reckless manner which has the potential to result in the loss of life.**

## Regular inspection and issue of direction notice – 2 November 2014

4.35 Along with the matters concerning the *Ten-Sixty-Six*, its SMS, and possible prosecutorial action, there were additional concerns identified regarding the safety of DDCF vessels more broadly. This led to ongoing dialogue between AMSA, and the WA DoT as the delegate, around the safety of the vessels and the need for proper enforcement action. The timeline of these events is detailed below.

### *Pia Rebecca and Takashi*

4.36 On 2 November 2014, during a regular inspection of the *Pia Rebecca* (another vessel owned by Mr Lippiatt), DoT MSIs raised concerns about the fire suppression system in the hull of the vessel. Further inspection identified a number of issues with the fire suppression systems on three of the DDCF's vessels.[32]

4.37 DoT undertook inquiries with WA Fire Protection regarding the validity and authenticity of the fire suppression inspection certificates on the vessels. At the same time, DoT also made inquiries with Survitec Group—RFD (Australia) which inspects life rafts and provides certificates to vessel owners. Survitec advised DoT verbally that the certificate numbers for the *Pia Rebecca*, *Ten-Sixty-Six* and *Takashi* did not match their official records.[33]

4.38 Two prohibition notices were subsequently issued to the DDCF by the DoT with the effect of:

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[32] Australian Maritime Safety Authority, *Submission 1*, p. 4.

[33] Raymond Buchholz, General Manager, Marine Safety, Department of Transport, Western Australia, *Committee Hansard*, 21 March 2019, p. 27.

- prohibiting operation of the vessel until specified actions in relation to specific equipment had been carried out; and
- prohibiting passenger access to the bow of the vessel and requiring minimisation of crew access and movement around the bow area of the vessel.[34]

4.39 In light of the issues identified, and as the delegate of AMSA, DoT issued a temporary direction notice on 7 November 2014 which required DDCF to operate with an additional crew member on board all vessels with the specific task of monitoring passengers on board the vessel.[35] The direction was in place for a period of 90 days.

4.40 AMSA indicated in its submission to the inquiry that it had 'no evidence as to whether this direction was complied with or whether the vessels continued to operate in accordance with the notice after the 90 day period'.[36]

## Suspension of the certificate of operation – 13 November 2014

4.41 DoT investigations continued and a number of discrepancies were identified in the logbooks, fire suppression inspection certificates and life raft inspection certificates of all three DDCF vessels.[37]

4.42 Discrepancies in the logbook of the *Ten-Sixty-Six* were of particular importance to the investigators because of limitations on the number of passengers allowed on board for certain operations. Where excess passengers are found on board a vessel, a master may be in breach of the vessel's survey conditions.[38]

### *Fire suppression systems and fire extinguishers*

4.43 On 13 November 2014, following the acquisition of further information gathered by WA MSIs, DoT issued the DDCF with a Notice of Suspension of the Certificate of Operation.[39] The operation certificate was suspended pursuant to section 52(1)(a) of the National Law, because of a number of safety problems that AMSA viewed as a serious risk to human life.[40]

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34 Australian Maritime Safety Authority, *Submission 1*, p. 4.

35 Mr Christopher Mather, WA Department of Transport, *Committee Hansard*, 21 March 2019, p. 26.

36 Australian Maritime Safety Authority, *Submission 1*, p. 4.

37 Mr Raymond Buchholz, WA Department of Transport, *Committee Hansard*, 21 March 2019, p. 27.

38 Mr Raymond Buchholz, WA Department of Transport, *Committee Hansard*, 21 March 2019, pp. 28–29.

39 Australian Maritime Safety Authority, *Submission 1*, p. 4.

40 Federal Court of Australia, Dolphin Dive Centre Fremantle Pty Ltd v Australian Maritime Safety Authority [2014] FCA 1444.

4.44 Inspectors alleged that the fire extinguishers were inoperable. Further, there was evidence to indicate that inspections had not taken place and that the certificates had been falsified. Under the National Law, it is a requirement that the fire suppression system is inspected and has a certificate.[41]

4.45 The owner and operator of the DDCF was informed that the suspension could be lifted, and his operations allowed to restart, when all the systems and fire extinguishers were upgraded and new inspection certificates were provided.[42]

### *Full investigation*

4.46 On 20 November 2014, DoT deployed its MSIs to conduct a full investigation of the DDCF vessels, *Ten-Sixty-Six*, *Pia Rebecca* and *Takashi*. For this purpose, it used a surveyor employed by DoT, but who was operating as a delegate under the National Law. The investigation revealed a number of issues:

- *Ten-Sixty-Six* – no compass adjustment card; no life raft certificate; and no fire extinguishers. The geographical location of at least one logbook entry had been altered (1 November 2014) between the time the investigation began (when a copy of the logbook was taken by DoT) and the time of this investigation.
- *Takashi* – incorrect number of flares; no fire extinguishers on board; the annual inspection certificate for the firefighting system and the life raft inspection certificate appeared fraudulent.
- *Pia Rebecca* – bilge high water alarm not operational (a skipper would not be aware the bilge was filling with water); no fire extinguishers; no legitimate certificate of annual inspection of the fixed firefighting system; life raft incorrectly mounted and may not float free if the vessel sinks. DoT also had concerns about the structural integrity of the vessel.[43]

4.47 Vessels operated by DDCF had varying passenger number requirements depending on the area of operations. DoT identified a number of occasions where it believed the vessels had been involved in whale-watching operations that exceeded maximum passenger numbers.[44] Such action could amount to a breach of the survey requirements on a vessel.

### *Issue of show cause notice – 3 December 2014*

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41 Mr Christopher Mather, WA Department of Transport, and Raymond Buchholz, General Manager, Marine Safety, Department of Transport, Western Australia, *Committee Hansard*, 21 March 2019, pp. 28, 30.

42 Mr Christopher Mather, WA Department of Transport, *Committee Hansard*, 21 March 2019, p. 28.

43 Mr Christopher Mather and Mr Raymond Buchholz, WA Department of Transport, *Committee Hansard,* 21 March 2019, pp. 30–31.

44 Mr Christopher Mather and Mr Raymond Buchholz, WA Department of Transport, *Committee Hansard,* 21 March 2019, p. 30.

4.48 On 2 December 2014, DoT held discussions with AMSA and the WA Police. In light of ongoing concerns regarding systemic failings in the safe operation of the three vessels, the decision was made by DoT as the delegate, in consultation with AMSA, to issue a show cause notice as to why the DDCF's certificate of operation should not be permanently revoked pursuant to section 71(2) of the National Law (Show Cause Decision).

4.49 During discussions between DoT, AMSA and WA Police, it was also agreed that a direction notice would be issued under the National Law pursuant to section 109. Under the notice, the operator of the DDCF was directed to undertake a full out-of-water survey of all three vessels by 31 December 2014. DoT officials informed the committee that it had identified concerns with the structural integrity of the vessels.[45]

### *Application for internal review of decision to suspend certificate of operation*

4.50 The National Law provides a right to internal review by AMSA of 'specified decisions made under the National Law'.[46] Those decisions include the suspension of the certificate of operation and the issue of the direction notice requiring out of water surveys.[47]

4.51 On 12 December 2014, the DDCF, through its legal counsel, wrote to DoT to request that the show cause notice be revoked on the basis that the issues in the notice of suspension had already been resolved or were in the process of being resolved.

4.52 The DDCF also requested a review into the decision to suspend its certificate of operation on the basis that the decision-making process lacked natural justice and because it was not confirmed that the deceased had fallen off the *Ten-Sixty-Six*. The DDCF further argued that the direction notice to have the out-of-water survey was excessive and not required as the vessels in question had not been involved in a marine incident.[48]

4.53 The suspension notice and direction notice were administrative decisions which were recognised as reviewable under section 139 of the National Law. Mr Lippiatt requested a review, and AMSA indicated to DoT that it would undertake the internal review accordingly. Thereafter, according to Mr Christopher Mather, Director of DoT Waterways Safety Management:

> We then spent considerable time and effort providing all the information that we had collected—that includes all the copies of logbooks, the

[45] Mr Christopher Mather and Mr Raymond Buchholz, WA Department of Transport, *Committee Hansard*, 21 March 2019, p. 31.

[46] Australian Maritime Safety Authority, *Submission 1*, p. 5.

[47] Australian Maritime Safety Authority, *Submission 1*, p. 5.

[48] Mr Buchholz and Mr Mather, WA Department of Transport, *Committee Hansard*, 21 March 2019, p. 32.

> certificates of fire suppression systems, the certificates of life rafts, and prior to that—to AMSA as part of our reasoning for our administrative decisions, and then that review process went on.[49]

4.54 On 22 December 2014, DoT was informed that there was an emergency injunction sought by DDCF to have the show cause notice and the direction notice lifted. On 24 December 2014, the urgent application was heard in the Federal Court. Mr Mather explained the court proceedings:

> The outcome of that hearing was that Justice McKerracher stated that it would be difficult to argue the case that the administrative decisions taken by AMSA or their delegate were invalid. However, given he believed there was no immediate threat to life with the condition imposed—and the condition he imposed was that Mr Lippiatt had to record on his log books the most westerly point of the voyage, as in degrees, minutes and seconds, to determine that he was staying within the appropriate water—he put a stay on that decision and thought a full hearing was appropriate. That hearing was scheduled for 10 and 11 February 2015. In effect that allowed Mr Lippiatt to recommence operating his vessels.[50]

4.55 Newspaper reports indicated that DDCF's counsel, Ms Karen Vernon, told the court that there had been no evidence to support AMSA's claim that the suspension of her client's operations was necessary for the protection of life. Ms Vernon argued that the suspension notice had not provided adequate details of claims that there were serious systemic deficiencies in the safety procedures aboard DDCF's vessels. Further:

> Ms Vernon said it appeared that Mr Mills' death was the event that had sparked action by AMSA but that police investigations were continuing and there was no evidence that the fatality had been linked to the manner in which Dolphin Dive operated its business.[51]

4.56 AMSA had alleged that logbooks indicated that DDCF's vessels had exceeded passenger number limits on a number of occasions. However, as DDCF's sole director, Mr Lippiatt gave evidence that all except one of the incidents had been based on a misinterpretation of the logbooks and errors in entries by staff.[52]

4.57 Justice Neil McKerracher was persuaded that DDCF had an arguable case against the suspension as the company had provided evidence to explain allegations of overloading its vessels and that its operations would be

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[49] Mr Christopher Mather, WA Department of Transport, *Committee Hansard*, 21 March 2019, p. 32.

[50] Mr Christopher Mather, WA Department of Transport, *Committee Hansard*, 21 March 2019, p. 35.

[51] Amanda Banks, 'Boat charter firm back in business after drowning', *The West Australian*, 26 December 2014, https://thewest.com.au/news/australia/boat-charter-firm-back-in-business-after-drowning-ng-ya-382906 (accessed 4 March 2019).

[52] Amanda Banks, 'Boat charter firm back in business after drowning', *The West Australian*, 26 December 2014., https://thewest.com.au/news/australia/boat-charter-firm-back-in-business-after-drowning-ng-ya-382906 (accessed 4 March 2019).

monitored closely.[53] He proposed granting some preliminary relief to DDCF to stay, on various conditions, the show cause and the direction decision until the issues could be 'more thoroughly ventilated with the benefit of further evidence and legal argument, at a hearing early in February next year'. [54] On that basis, the suspension was stayed.

4.58 Mr Buchholz informed the committee that during the court proceedings reference was made to discrepancies identified by DoT which were categorised as administrative discrepancies. He suggested that instead:

> What was lacking was the ability of someone to put to the Chief Justice that it wasn't just an administrative thing; these important systems were actually non-functional or not up to the required standard. In hindsight, had he been made aware that these weren't just administrative discrepancies but they were actually resulting in important systems not being functional, maybe he might have made a different decision. But that was never put to him.[55]

### *Direction notice for out-of-water survey overturned – 24 December 2014*

4.59 On the morning of the December court proceedings, DoT was informed by AMSA that it had completed a review of the direction notice for the out-of-water hull survey and had decided to overturn the decision.

4.60 According to AMSA, the decision was overturned because there was 'insufficient evidence' to indicate that the vessels were unsafe, or to justify their removal from the water for inspection. AMSA continued 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.[56]

4.61 AMSA similarly noted that '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'.[57]

4.62 AMSA further stated that the Federal Court's decision was 'an interim one' and was not a finding that the decisions under review were unlawful.[58] In the

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[53] Amanda Banks, 'Boat charter firm back in business after drowning', *The West Australian*, 26 December 2014. .**Error! Hyperlink reference not valid.** (accessed 4 March 2019).

[54] Federal Court of Australia, Dolphin Dive Centre Fremantle Pty Ltd v Australian Maritime Safety Authority [2014] FCA 1444.

[55] Mr Raymond Buchholz, WA Department of Transport, *Committee Hansard*, 21 March 2019, p. 35.

[56] Australian Maritime Safety Authority, *Submission 1*, p. 5.

[57] Australian Maritime Safety Authority, *Submission 1*, p. 5.

[58] Australian Maritime Safety Authority, *Submission 1*, p. 6.

Court's judgement it was also noted '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'.[59]

### *DDCF certificate of operation suspension lifted*

4.63 Around 14 January 2015, WA MSIs inspected the *Takashi* and *Ten-Sixty-Six*, which were now operational, to ensure that they had the required safety equipment. On 23 January, MSIs inspected the *Pia Rebecca* and found that all the issues of concern had been addressed. All DDCF's vessels were now compliant. On the same day, a letter lifting the suspension was sent to the DoT.[60]

4.64 The MSIs confirmed that the fire suppression systems and life rafts had been repaired and that the fire suppression certificates had been corrected. DoT sought advice from AMSA, as the DDCF had completed all of the requirements under the temporary suspension notice. On the advice of AMSA, DoT lifted the temporary suspension of the DDCF's certificate of operation.[61]

### *Show cause notice withdrawn – 3 February 2015*

4.65 The only administrative instrument still active by this time was the show cause notice. This required DDCF to provide statements to the delegate and to AMSA as to why its certificate of operation should not be withdrawn.[62]

4.66 During discussions in January 2015 it was suggested by AMSA that DoT consider withdrawing the show cause notice, arguing that such action was 'not an effective use of public money'.[63]

4.67 From 30 January to 3 February 2015, discussions between DoT and AMSA continued, as DoT still held significant concerns about the operator's ability to run the business safely and legally. DoT also voiced their concerns that DDCF would not continue to maintain these recently achieved standards in the long term.[64] The DoT continued to raise concerns that these factors could impact on the safety of the community and indicated that it would only withdraw the

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[59] Australian Maritime Safety Authority, *Submission 1*, p. 6.

[60] Australian Maritime Safety Authority, *Submission 1*, p. 6.

[61] Australian Maritime Safety Authority, *Submission 1*, p. 6; Mr Raymond Buchholz, WA Department of Transport, *Committee Hansard*, 21 March 2019, p. 37.

[62] Mr Christopher Mather, WA Department of Transport, *Committee Hansard*, 21 March 2019, pp. 37–38.

[63] Mr Raymond Buchholz, WA Department of Transport, *Committee Hansard*, 21 March 2019, p. 37.

[64] Mr Christopher Mather, WA Department of Transport, *Committee Hansard*, 21 March 2019, p. 35.

show cause notice if directed to do so by AMSA as the regulator.[65] Mr Mather of the DoT stated:

> The requirement of that show cause notice was for Mr Lippiatt to provide to the delegate and to AMSA statements as to why he should be able to retain his certificate of operation. We did not believe that this was an onerous requirement to provide some confidence to DoT, as the delegate, that he could operate effectively under a certificate of operation in conducting a commercial charter business.[66]

4.68 AMSA, however, recommended that the process be discontinued,[67] despite the serious concerns about DDCF's operations still held by the DoT. Thereafter, a 'robust telephone conversation' took place between the two agencies as explained by Mr Mather:

> The robust telephone conversation was around the fact that we believed there were systemic failings in the operation by Mr Lippiatt of this business that raised significant concerns around his ability to operate a business safely and, then, around the impact on the safety of the community. We had found a number of concerns, which, yes, he had repaired and fixed, but based on the evidence before us we still had serious doubts that he would continue to operate legally. I clearly articulated that to Mr Brightman [at AMSA], and we had a robust but polite conversation. At the end of that I said, 'As delegates, we are not prepared to withdraw that show cause notice unless we are directly instructed to do so by AMSA as the regulator'.[68]

4.69 As a follow up to this conversation, AMSA emailed DoT noting that 'it is AMSA's view that a show cause notice itself is not a decision, so continuation of this matter currently before the Federal Court may be a waste of time for all concerned, not to mention the unnecessary costs incurred by AMSA'.[69]

4.70 AMSA held the view that the DDCF had taken the necessary steps to rectify the deficiencies with regard to the fire suppression systems, logbook processes and life rafts. It did acknowledge, however, that it had 'considerable concern' about the practical effect of the operator's SMS, including the crew's capacity to prevent or respond to an incident. On the basis of these concerns, AMSA offered to send an auditor to conduct an audit of the DDCF's SMS. However, DoT declined the SMS audit process and suggested that the 'money and efforts

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65 Mr Christopher Mather, WA Department of Transport, *Committee Hansard*, 21 March 2019, p. 38.

66 Mr Christopher Mather, WA Department of Transport, *Committee Hansard*, 21 March 2019, p. 38.

67 Australian Maritime Safety Authority, *Submission 1*, p. 6.

68 Mr Christopher Mather, WA Department of Transport, *Committee Hansard*, 21 March 2019, p. 38.

69 Email from AMSA, cited in evidence by Mr Mather, WA Department of Transport, *Committee Hansard*, 21 March 2019, p. 39.

may be better focused on transferring it through to an investigation report and possible prosecution'.[70]

4.71 At the request of AMSA, DoT formally withdrew the show cause notice on 3 February 2015.

### *Internal review report of decision to suspend DDCF's certificate of operation*

4.72 On 17 February 2015, AMSA completed its internal review of DoT's decision to suspend the DDCF's certificate of operation on 13 December 2014.

4.73 This was the first administrative decision that DoT had put forward with AMSA's assistance and was subject to internal review upon Mr Lippiatt's request. Mr Mather informed the committee that the outcome of the review was to 'overturn that decision, noting the suspension had already been lifted'.[71]

## DoT report to AMSA – 21 December 2014 – 29 May 2015

4.74 Around 21 December 2014, DoT provided AMSA with a summary report. The report suggested that the master/owner may have failed to comply with the general safety duties set out in 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.[72]

4.75 DoT completed its investigation report and provided it to AMSA on 22 May 2015 to progress any potential prosecution. DoT officials informed the committee that it had completed 95 per cent of the work that was required for a brief of evidence to go to the CDPP.[73] The report recommended that a number of offences be considered, specifically offences relating to general safety duties and breaches of a condition on a certificate of survey.[74]

4.76 From February to August 2015, AMSA reviewed the respective reports of the WA Police (discussed earlier in this chapter) and the DoT. Both reports recommended that charges be considered against the master of the vessels for breach of general safety duties.[75]

4.77 In relation to the general safety duty, DoT had recommended that:

- the owner intentionally, by falsifying the records, put at risk the safety of a person or the domestic commercial vessel (DCV) concerned; and

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[70] Mr Christopher Mather, WA Department of Transport, *Committee Hansard*, 21 March 2019, p. 39.

[71] Mr Christopher Mather, WA Department of Transport, *Committee Hansard*, 21 March 2019, p. 40.

[72] Australian Maritime Safety Authority, *Submission 1*, p. 7.

[73] Mr Christopher Mather, WA Department of Transport, *Committee Hansard*, 21 March 2019, p. 46.

[74] Australian Maritime Safety Authority, *Submission 1*, p. 7.

[75] Australian Maritime Safety Authority, *Submission 1*, p. 8.

- the owner breached a condition on the certificates of survey held by the DDCF, by operating, or causing or permitting the vessels to be operated with too many passengers for certain prescribed waters; and
- the master intentionally, by operating with safety equipment that was unserviceable, put at risk the safety of a person or the DCV concerned; or
- as an alternative, that AMSA consider multiple counts of the strict liability offences associated with the breach of duties as the owner and master.[76]

4.78 However, AMSA argued that no evidence was provided by DoT to indicate that the operator or master intended, by allegedly falsifying records or operating with 'unserviceable' safety equipment, to put the safety of persons or the DCV concerned at risk. Furthermore, there was no evidence provided, according to AMSA, that falsified certification directly led to a risk to safety. It suggested as an example that the firefighting systems and life raft may still have worked at the time that the documents were shown to the surveyors on the date that they were last surveyed by DoT.[77]

4.79 Therefore, it was AMSA's view that 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.[78]

## Investigation into alleged fraudulent certificates

4.80 In July and August 2015, AMSA sought further evidence regarding the DDCF's fire suppression certificates. According to AMSA, DoT had agreed to obtain statements from the marine surveyors who had investigated the three vessels on the elements of the alleged offences.[79]

4.81 On 26 August 2015, DoT informed AMSA of further apparent fraudulent behaviour, relating to what appeared to be a false declaration made to clear a prohibition notice.[80]

4.82 AMSA responded to this new information by stating that:

> 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.[81]

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[76] Australian Maritime Safety Authority, *Submission 1*, p. 9.

[77] Australian Maritime Safety Authority, *Submission 1*, p. 9.

[78] Australian Maritime Safety Authority, *Submission 1*, p. 9.

[79] Australian Maritime Safety Authority, *Submission 1*, p. 10.

[80] Australian Maritime Safety Authority, *Submission 1*, p. 10.

[81] Australian Maritime Safety Authority, *Submission 1*, p. 10.

*Statute of limitations*

4.83 On 27 August and 2 September 2015, AMSA and the CDPP discussed the DDCF matter. On 2 September 2015, AMSA commenced the production of a brief of evidence for alleged offences set out in the following sections of the *Criminal Code Act 1995* (Criminal Code Act):

- Section 145.1 – using a forged document related to certification for fire suppression and life rafts; and
- Section 137.1 – for providing false and misleading information in relation to the clearance of the prohibition notice.[82]

4.84 AMSA noted that the DoT had 'highlighted a litany of issues in relation to fraudulent behaviour' for which some offences carry a term of 10 years imprisonment.[83] AMSA and the CDPP also considered an additional alleged offence of general dishonesty (section 135.1(1)).[84]

4.85 However, the one year statute of limitations to bring a case before the CDPP to commence prosecutorial action was due to end on 31 October 2015. The limitation period applied to any National Law charges recommended by the DoT which were still under consideration. All of the National Law offences would have expired at 12 months, because none of them carried a jail penalty of over six months.[85] However, the Criminal Code Act offences under consideration had no limitation of time due to the quantum of the possible penalty.[86]

4.86 After further investigations between AMSA and DoT officials during September and October 2015, on 30 November 2015 AMSA again discussed the DDCF matter with the CDPP. The CDPP indicated that there were significant obstacles to completing a brief of evidence with a reasonable likelihood of successful prosecution. At that time, the CDPP 'expressed concerns about the matter in general including concerns that quality control across both WADOT and AMSA was poor'.[87]

4.87 The CDPP thereafter provided AMSA with pre-brief advice specifically addressing matters relating to the *Pia Rebecca* and raising a number of issues with the evidence provided. AMSA then informed DoT on 22 February 2016

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82 Australian Maritime Safety Authority, *Submission 1*, p. 11.

83 Mr David Marsh, Australian Maritime Safety Authority, *Committee Hansard*, 1 April 2019.

84 Australian Maritime Safety Authority, *Submission 1*, p. 11.

85 Mr Mick Kinley, Australian Maritime Safety Authority, *Committee Hansard*, 1 April 2019, p. 9.

86 Australian Maritime Safety Authority, *Submission 1*, p. 11.

87 Australian Maritime Safety Authority, *Submission 1*, p. 12.

that it had decided not to complete the brief of evidence because 'pursuing charges was unlikely to be successful'.[88]

4.88 At a public hearing on 1 April 2019, Mr Kinley indicated that AMSA 'will be seeking legislative amendments...to allow at least two years to commence proceedings rather than the one year now allowed under the Crimes Act for offences warranting less than six months imprisonment'.[89]

4.89 Mr Kinley further suggested that offences under this Act be examined to consider whether they are adequate for matters involving a fatality. He further drew the committee's attention to the 'uncommenced amendments to the national law act that were intended to align the act with the health and safety laws with similar offences and penalties'.[90]

## Committee view

### *General safety duties*

4.90 The committee acknowledges that AMSA has recently undertaken further investigations in the case against DDCF, and Mr Lippiatt, and have sought a prosecution assessment from the CDPP, to which they are awaiting a response. However, the long and drawn-out process to get this far has been highly concerning to the committee, and has added to the ongoing distress endured by the Mills family.

4.91 Both the WA Police and the WA DoT concluded that the owner and operator of the *Ten-Sixty-Six* had breached the general safety duties, and recommended that charges be considered. These findings were put to AMSA shortly after the tragic death of Mr Mills. Yet, no charges resulting from a breach of the general safety duties have ever been made against Mr Lippiatt.

4.92 Further, the offences related to a breach of the general safety duties speak to offences that may unreasonably place the safety of another person at risk, but do not contemplate those circumstances where a breach may result in the loss of life.

4.93 It is therefore the view of the committee that the relevant provisions of the National Law should be amended to include a more serious offence and subsequent penalty in the case where a breach of the general safety duties could lead to a loss of life.

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88 Australian Maritime Safety Authority, *Submission 1*, p. 12.

89 Mr Mick Kinley, Australian Maritime Safety Authority, *Committee Hansard*, 1 April 2019, p. 2.

90 Mr Mick Kinley, Australian Maritime Safety Authority, *Committee Hansard*, 1 April 2019, p. 2.

**Recommendation 2**

**4.94 The committee recommends that general safety duties offences relating to domestic commercial vessels, contained with the *Marine Safety (Domestic Commercial Vessel) National Law Act 2012*, be augmented by a more serious offence and subsequent penalty in cases where a breach of the general safety duties leads to a loss of life.**

### *Statute of limitations*

4.95 The committee acknowledges the evidence given by Mr Kinley regarding the legislative amendments, to allow more time for prosecutorial action to commence. The committee supports AMSA taking this step, but points out that more prompt action on behalf of AMSA, and better engagement from it with other jurisdictions and the CDPP, may have diminished the necessity for such an amendment.

4.96 Having said that, the committee hopes that once implemented, this approach will enable AMSA to better enforce the National Law and take prosecutorial action against serious safety breaches which pose a threat to health and safety. In light of this, the committee lends its support to AMSA's proposed course of action and recommends that the National Law be amended to increase the time period for prosecution.

**Recommendation 3**

**4.97 The committee recommends that the limitation period for bringing non-custodial charges under the *Marine Safety (Domestic Commercial Vessel) National Law Act 2012* (the National Law) be extended from 12 months to two years.**

## Findings and fallout between AMSA and DoT

4.98 During the committee's public hearing in Perth on 21 March 2019, DoT officials outlined for the committee the nature of the working relationship between DoT (as the AMSA delegate) and AMSA as the regulator. During the early stages when investigations were underway and initial administrative action was taken against DDCF, the relationship between the two agencies was cooperative. Mr Buchholz noted that AMSA was initially very supportive and encouraging, recognising the DDCF case as an opportunity to test the national system.[91]

4.99 DoT noted that the first indication that there was a difference in understanding between the parties was when AMSA overturned its direction to order the

[91] Mr Raymond Buchholz, WA Department of Transport, *Committee Hansard*, 21 March 2019, p. 40.

out-of-water hull surveys on 3 December 2014.[92] Mr Buchholz explained to the committee:

> We had no indication of what was occurring behind the scenes until just prior to going into the hearing on 24 December, when suddenly we heard that they [the direction to order out-of-water hull surveys] had been overturned.[93]

4.100 Thereafter, there was a divergence in views between the two agencies. This coincided with a change in staffing at AMSA.[94] This divergence came to a head when AMSA advised DoT to withdraw the show cause notice in January 2015. Mr Buchholz noted that the response from AMSA appeared to indicate to DoT that there would not be any possible support in the future if DoT refused to withdraw the show cause notice.[95]

4.101 Mr Buchholz further explained the frustration experienced by DoT officials who had spent considerable time and effort in investigating the DDCF, only to have decisions overturned by AMSA. Thereafter, DoT advised AMSA that it would no longer issue any notices under the National Law because 'we had serious concerns about whether they would stand'.[96] Mr Buchholz continued:

> We then put all remaining effort into putting together our report, outlining, at the very least, the evidence we had against specific breaches. We also have a strategic relationship with AMSA. At that point there were discussions around how the national system is delivered and whether AMSA should be responsible for service delivery. There were lots of discussions going on. I don't recall exactly, from that point in time, whether a decision had been made that AMSA was going to be the sole provider of the service delivery. But, certainly, it influenced our relationship with them in terms of how we were going to approach future investigations, because we had put our necks on the line.[97]

4.102 In light of the difficulties faced in conducting extensive investigations and acting as the AMSA delegate, DoT decided that it would not serve as a delegate for future investigations upon the expiration of its service agreement in July 2018. Mr Buchholz indicated that DoT made a deliberate decision not to enter into a Memorandum of Understanding with AMSA.[98]

4.103 At a public hearing on 25 September 2019, Mr Kinley, however, rejected Mr Buchholz's evidence stating that 'it's not actually the case that Western

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92 Mr Raymond Buchholz, WA Department of Transport, *Committee Hansard*, 21 March 2019, p. 34.

93 Mr Raymond Buchholz, WA Department of Transport, *Committee Hansard*, 21 March 2019, p. 34.

94 Mr Raymond Buchholz, WA Department of Transport, *Committee Hansard*, 21 March 2019, p. 36.

95 Mr Raymond Buchholz, WA Department of Transport, *Committee Hansard*, 21 March 2019, p. 39.

96 Mr Raymond Buchholz, WA Department of Transport, *Committee Hansard*, 21 March 2019, p. 42.

97 Mr Raymond Buchholz, WA Department of Transport, *Committee Hansard*, 21 March 2019, p. 40.

98 Mr Raymond Buchholz, WA Department of Transport, *Committee Hansard*, 21 March 2019, p. 40.

Australia is no longer a delegate; they do have officers that remain as delegates under the national law'.[99]

4.104 When further questioned on the number of delegates in Western Australia, Mr Kinley responded 'there are about three' as well as police officers and water police who are automatically included in the act [National Law] as having powers.[100]

### *Internal review of AMSA*

4.105 AMSA undertook an internal review into the handling of the DDCF investigation and made four recommendations. It informed DoT of its recommendations on 29 May 2015. The first recommendation was that there should be a single point of contact for legal advice between an AMSA liaison officer and each state, as:

> AMSA noted that this was a key finding and that there was conflicting legal advice during the investigation.[101]

4.106 In addition, AMSA had recommended that its CEO take no part in future investigations to allow them 'to undertake an independent review if there is a review application'.[102] Thirdly, AMSA recommended that it prepare better guidance notes to delegates with regard to exercising suspension powers.[103] The final recommendation was not discussed during the hearing.

4.107 In its submission, AMSA acknowledged that the National System transitional arrangements in place at the time of the events surrounding the DDCF were 'not working as they should', and stated that:

> 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.[104]

4.108 Further, AMSA gave evidence that it 'accepts responsibility for its part in this process' as the agency 'should have communicated better with WA Police and

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[99] Mr Mick Kinley, Australian Maritime Safety Authority Board, *Committee Hansard*, 25 September 2019, p. 20.

[100] Mr Mick Kinley, Australian Maritime Safety Authority Board, *Committee Hansard*, 25 September 2019, p. 21.

[101] Mr Christopher Mather, WA Department of Transport, *Committee Hansard*, 21 March 2019, p. 44.

[102] Mr Christopher Mather, WA Department of Transport, *Committee Hansard*, 21 March 2019, p. 44.

[103] Mr Christopher Mather, WA Department of Transport, *Committee Hansard*, 21 March 2019, pp. 43–44.

[104] Australian Maritime Safety Authority, *Submission 1*, p. 15.

the WADOT, and we should have made clearer where decisions, directions and responsibilities lay'.[105]

4.109 These events raised questions about the extent to which AMSA had fulfilled the requirements of the national regulator as set out in the August 2011 IGA. In this regard, Schedule B of the IGA states:

> State and Territory maritime safety agencies and private service providers will conduct a range of activities to give operational effect to the national system. These activities will be conducted either under delegation or accreditation from the National Regulator. In consultation with maritime safety agencies, the National Regulator will provide guidelines and codes of conduct for these activities to promote consistency across the country.[106]

4.110 The COAG Council later determined, in November 2014, to end these arrangements by passing the full responsibility for all issues relating to a national system to AMSA. A 2014 review of the National System found that, despite having AMSA as the national regulator, there were still inconsistencies in service delivery between the states and territories.[107]

4.111 In recognising that it should have communicated better with DoT and WA Police, and made clearer decisions and directions, AMSA appreciated that the COAG Council decision was a result of its failings:

> The November 2014 decision of the COAG Council to end this arrangement by passing full responsibility for all matters relating to the National System to AMSA is evidence of the seriousness of these failings.[108]

## Other legal action

*Breaching liquor laws*

4.112 In December 2016, Mr Lippiatt was fined for illegally selling beer during the charter cruise on the day that Mr Mills went missing. He was fined $3000 for agreeing to sell two cartons of beer to Pepper Australia for its guests on board the boat when their supplies were running low. Pepper Australia was also fined a minimum $10 000 penalty for breaching liquor laws.[109]

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[105] Australian Maritime Safety Authority, *Submission 1*, p. 15.

[106] Council of Australian Governments, *Intergovernmental Agreement on Commercial Vessel Safety Reform*, August 2011, p. B-4.

[107] Maritime Industry Australia Limited, *Submission 4*, p. [6].

[108] Australian Maritime Safety Authority, *Submission 1*, p. 15. As previously noted, AMSA assumed full responsibility for service delivery under the national system from 1 July 2018.

[109] Kate Campbell, 'Fatal cruise: Finance company fined $10,000 for liquor laws breach', *Perth Now*, 28 August 2015 https://www.perthnow.com.au/news/wa/fatal-cruise-finance-company-fined-10000-for-liquor-laws-breach-ng-ef159c522ab9f88b47a423a8be17f875 (accessed 5 March 2019).

4.113 Mr Lippiatt and his company, the DDCF, were also fined $3500 for allowing the unlicensed premises to be used as a resort for the consumption of alcohol. Mr Lippiatt was granted a spent conviction after the court was told of his work as a volunteer paramedic in a country town. Mr Lippiatt sold his boats to pay for his legal fees and no longer works in the industry.[110]

## Committee view

4.114 This chapter has revealed a series of shortcomings with regard to AMSA's processes, brought to light by the Mills case and AMSA's interactions with WA state agencies.

4.115 AMSA indicated that since the Mills case, they had implemented new processes and procedures for investigations, including briefing the Chief Executive Officer of all serious incidents. AMSA also referred to the establishment of a new Enforcement and Inspector Support team to investigate and, if necessary, take enforcement action in relation to the most serious breaches of AMSA's regulatory framework and other incidents.[111]

4.116 In line with the views already expressed by the committee, it is hoped that AMSA's less than satisfactory interactions with the WA agencies will be instructive in guiding AMSA towards better and more collaborative practices, as it continues to improve its administration of the National Law.

[110] Elle Farcic, 'Skipper, company fined for selling beer on fatal cruise', *The West Australian*, 15 December 2016, https://thewest.com.au/news/wa/skipper-company-fined-for-selling-beer-on-fatal-cruise-ng-b88330222z (accessed 4 March 2019).

[111] Australian Maritime Safety Authority, *Submission 1*, p. 3.

# Chapter 5
# Coronial inquiries and the performance of AMSA

5.1 This chapter examines the findings and conclusions of other coroner's reports which have considered the role of AMSA.

5.2 It also considers a number of concerns raised in these coroner's reports about some of the grandfathering provisions of the National Law, and how this has applied in practice, as well as the adequacy of safety management systems.

## Inquest into the death of Ryan Harry Donoghue – Northern Territory Coroner's Court

5.3 Twenty-year old, Mr Ryan Donoghue, a First Mate, was killed while on board the *Newfish 1*, an Austral Fisheries Pty Ltd (Austral Fisheries) prawn trawler in the Gulf of Carpentaria on 29 November 2013. Dressed in shorts and a singlet, Mr Donoghue was using an angle grinder to cut rusted shackles connecting nets to otter boards. At the same time, a deckhand was holding the power lead above the deck to keep it away from water. A wave washed over the deck engulfing Donoghue and the grinder, electrocuting Donoghue.[1]

5.4 An inspection by Maritime Safety Queensland Officers and Senior Electrical Safety Inspectors found that the general purpose socket the grinder had been plugged into on the deck was not protected by a residual current device (RCD), more commonly known as a safety switch.[2]

5.5 Sri Srinivas, the Principal Marine Safety Officer with the Northern Territory Department of Transport estimated that 80 per cent of DCVs working out of Darwin Port did not have RCDs fitted, as required by NT Work Health and Safety Regulations.[3]

5.6 The Territory Coroner, Judge Greg Cavanagh, whose report was released on 3 June 2016, stated that the evidence at the inquest highlighted the:

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1 Coroner's Court of Darwin, *Inquest into the death of Ryan Harry Donoghue* [2016] NTLC 009, 3 June 2016, https://justice.nt.gov.au/__data/assets/pdf_file/0005/281777/D02102013-Donoghue-including-attachment.pdf (accessed 27 March 2019), pp. 1-5.

2 Coroner's Court of Darwin, *Inquest into the death of Ryan Harry Donoghue* [2016] NTLC 009, 3 June 2016, p. 7.

3 Coroner's Court of Darwin, *Inquest into the death of Ryan Harry Donoghue* [2016] NTLC 009, 3 June 2016, pp. 33-34.

> ...unacceptable and indeed shameful state of workplace safety on large numbers of Australian domestic fishing vessels. The lack of regulation and enforcement by authorities is of great concern.[4]

5.7 The Coroner was scathing about the lack of enforcement action undertaken by the regulators, stating that:

> Added to the apparent failure of the regulatory environment to ensure compliance, is the fact that to this date there has been no action taken (apart from investigation) by any regulatory authority arising from the death of Ryan Donoghue.[5]

5.8 The Coroner noted that AMSA took 'no compliance or enforcement action as a consequence of the death of Ryan Donoghue'.[6] This was despite the fact that possible offences pursuant to section 12 of the National Law were referred to the Office of Legal Counsel, AMSA Domestic Vessel Division for further analysis and comment. The Coroner continued:

> That no Commonwealth, State or Territory regulatory authority has pursued any action against the employer is most unsatisfactory. The lack of action beggars belief and is shameful.[7]

5.9 The Coroner made a number of recommendations including:

> ...that both Marine Safety authorities and the Work Health and Safety authorities revisit the recommendations of the Western Australian Coroner with a view to ensuring that persons conducting a business or undertaking on Domestic Commercial Vessels well understand the law and their duties to their employees and others.

5.10 With regard to offences, the Coroner went on to note:

> I believe that offences may have been committed in connection with the death of Ryan Donoghue and in accordance with section 35(3) I report my belief to the Commissioner of Police and the Director of Public Prosecutions.[8]

### *Health and safety laws*

5.11 During the investigation into Mr Donoghue's death, the Coroner found that maritime regulators believed that they were unable to enforce work health and

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4 Coroner's Court of Darwin, *Inquest into the death of Ryan Harry Donoghue* [2016] NTLC 009, 3 June 2016, p. 1.

5 Coroner's Court of Darwin, *Inquest into the death of Ryan Harry Donoghue* [2016] NTLC 009, 3 June 2016, p. 39.

6 Coroner's Court of Darwin, *Inquest into the death of Ryan Harry Donoghue* [2016] NTLC 009, 3 June 2016, p. 41.

7 Coroner's Court of Darwin, *Inquest into the death of Ryan Harry Donoghue* [2016] NTLC 009, 3 June 2016, p. 45.

8 Coroner's Court of Darwin, *Inquest into the death of Ryan Harry Donoghue* [2016] NTLC 009, 3 June 2016, p. 46.

safety laws when dealing with maritime safety, because the relevant standards and codes have 'grandfathering' clauses built into them. That is, the vessel is only required to meet the standards applicable to it at the time it was built (or first registered in Australia). The Coroner noted that there appeared to be a 'massive and systemic lack of understanding of compliance' when it came to work health and safety legislation.[9]

5.12 The Coroner suggested that this lack of clarity may have been due in part to a division between marine safety and workplace safety, noting that:

> Marine safety appears to relate primarily to whether the boat is safe to navigate the high seas. Workplace safety although somewhat related is seen as entirely different and dealt with by different Government Departments that appear to have little expertise or experience in the marine environment.[10]

5.13 Regarding the role of AMSA, the Coroner noted that under the National Law, the regulator was responsible for the standardisation and regulation of marine safety. However, the Coroner stated that the legislation does not 'provide for the merging of marine safety and workplace health and safety functions relating to DCVs' and that 'the operation of sections 6 and 7 [of the National Law] exclude the operation of the Act where inconsistent with State and Territory Law relating to workplace health and safety'.[11]

5.14 The Coroner continued that this 'artificial separation' that had been fostered between marine safety and workplace health and safety was likely to continue because Marine Order 503(8) 'continues the grandfathering of Standards and Codes and is likely to further entrench the belief that RDCs are not required to be fitted to older vessels (unless upgraded)'.[12] The Coroner continued:

> It should be stated once more, that is a myth. It is a dangerous myth that has been perpetuated by the separation of workplace safety from marine safety.[13]

## Inquest into the death of Murray Allan Turner, Mason Laurence Carter and Chad Alan Fairley – Coroner's Court of Western Australia

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[9] Coroner's Court of Darwin, *Inquest into the death of Ryan Harry Donoghue* [2016] NTLC 009, 3 June 2016, p. 35.

[10] Coroner's Court of Darwin, *Inquest into the death of Ryan Harry Donoghue* [2016] NTLC 009, 3 June 2016, p. 33.

[11] Coroner's Court of Darwin, *Inquest into the death of Ryan Harry Donoghue* [2016] NTLC 009, 3 June 2016, p. 37.

[12] Coroner's Court of Darwin, *Inquest into the death of Ryan Harry Donoghue* [2016] NTLC 009, 3 June 2016, p. 37.

[13] Coroner's Court of Darwin, *Inquest into the death of Ryan Harry Donoghue* [2016] NTLC 009, 3 June 2016, p. 37.

5.15 On 6 July 2015, a fishing boat named the *Returner* left Point Samson with Mr Murray Turner, Mr Chad Fairley and Mr Mason Carter on board. The three men were intending to head to Nickol Bay for a trawling trip and were scheduled to arrive back in Point Samson on 15 July 2015. The last contact with the vessel and its crew was shortly before 2.00 am on 11 July 2015.

5.16 On 15 July 2015, when the vessel did not arrive at the boat harbour as scheduled, Water Police were advised and an extensive air, land and sea search commenced. On 29 July, the *Returner* was located submerged in water approximately 20 kilometres from Nickol Bay. Police divers boarded the vessel the following day and located the body of Murray Turner inside. Chad Fairley and Mason Carter were not found and no sign of them was discovered. A police investigation concluded that they most likely died at sea in the period after the *Returner* sank.[14] Coroner Linton delivered her inquest report on 28 February 2018.

5.17 The owner of the vessel, Mr Turner, had made a series of major modifications to the boat including several which were not reported or reflected in the vessel's documentation. The modifications were intended to extend the vessel's period of operation at sea and to maximise the trawl catch potential. The police found that the overall effect of these modifications was to make the vessel less stable in the water. There was also evidence that the vessel was too small for its purpose, and cluttered, making it difficult to move on the deck.[15] The inquest head that:

> Mr Turner commenced the works without notifying the DoT, contrary to the DoT procedure, and did not, on the evidence, engage a naval architect or consult a shipwright in regard to the works he was undertaking. Rather, he appears to have relied upon his own judgment as to what was required and engaged individual tradespersons to carry out his instructions, albeit with an understanding that the vessel would also undergo some form of survey through the DoT when the works were completed.[16]

5.18 The DoT marine surveyor, Mr Barry Wren, informed the Coroner that when he undertook a survey of the vessel, the extent of the modifications were not apparent and that he was relying on Mr Turner's explanation of the modification as 'like for like'. Mr Wren provided the inquest with an insight into the culture with regard to owners and operators, stating that:

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[14] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the death of Murray Allan Turner and Mason Lawrence Carter and Chad Alan Fairley*, 28 February 2018, https://www.coronerscourt.wa.gov.au/_files/Turner,%20Fairley%20and%20Carter%20%20finding.pdf (accessed 27 March 2019).

[15] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the death of Murray Allan Turner and Mason Lawrence Carter and Chad Alan Fairley*, 28 February 2018, pp. 11–12.

[16] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the death of Murray Allan Turner and Mason Lawrence Carter and Chad Alan Fairley*, 28 February 2018, p. 12.

> ...in his experience owners and operators often show reluctance towards the survey process and it is plainly obvious to him on many occasions that they are not forthcoming when it comes to modifications to their vessels.[17]

5.19 Following the retrieval of the vessel, a joint investigation into the capsizing and foundering of the vessel was commenced by DoT on behalf of AMSA, with the assistance of AMSA staff. The investigation focussed on determining factors contributing to the incident, including the 'vessel's operation, design and survey'.[18]

5.20 3D modelling was undertaken via a stability software program known as MAXSURF. This program assessed the stability of the vessel in its known configuration at the time of the incident and found that the *Returner* failed all of the relevant stability criteria other than one. The model further found that the *Returner* was, on average, 35 per cent more unstable at the time that it sank than in its original configuration.[19]

5.21 Between late 2014 and early to mid-2015, when the relevant events took place with the *Returner*, the Western Australian DoT retained a delegation from AMSA (as the national regulator) to conduct the survey work for DCVs in WA.[20]

### *Grandfathering arrangements*

5.22 The Coroner noted that:

> All domestic commercial vessels in Australia are subject to a system of periodic surveys...Due to changes in the legislation, there is a difference between how older vessels, that existed before the National Law came into effect in July 2013, are treated compared to the processes for new vessels under the National Law.[21]

5.23 In particular, the Coroner commented on how grandfathering arrangements differed markedly between jurisdictions and the effect this had on ensuring vessels meet a certain standard. The Coroner stated that:

> ...grandfathering provided a politically expedient way to ensure that all the jurisdictions would adopt the National scheme, by reassuring existing operators that they wouldn't be any worse off. There was a large variation

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[17] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the death of Murray Allan Turner and Mason Lawrence Carter and Chad Alan Fairley*, 28 February 2018, p. 29.

[18] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the death of Murray Allan Turner and Mason Lawrence Carter and Chad Alan Fairley*, 28 February 2018, p. 29.

[19] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the death of Murray Allan Turner and Mason Lawrence Carter and Chad Alan Fairley*, 28 February 2018, p. 54.

[20] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the death of Murray Allan Turner and Mason Lawrence Carter and Chad Alan Fairley*, 28 February 2018, p. 16.

[21] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the death of Murray Allan Turner and Mason Lawrence Carter and Chad Alan Fairley*, 28 February 2018, p. 16.

> between regulations in different jurisdictions, so any other approach would have made it exceptionally difficult for operators in some of the regions to have their vessels meet standards.[22]

5.24 The Coroner observed that the *Returner*, having been originally constructed in 1984, was classed as an 'existing vessel' under clause 7 of Marine Order 503. As a grandfathered vessel this meant it was required to comply with the relevant standards that applied prior to the introduction of the National Law on 1 July 2013 (also known as the Uniform Shipping Laws). By comparison, new vessels are required to be surveyed in relation to the National Standard for Commercial Vessels. This is a far more stringent standard.[23]

5.25 Furthermore, the Coroner explained that a grandfathered vessel 'can be considered a new vessel under Marine Order 503 if AMSA, or its delegate, considers that the vessel has been altered to an extent that it must be reassessed against the applicable standards, or its operations have changed so that there is an increased level of risk or its operational area has changed'.[24] This did not take place in relation to the *Returner*.

5.26 The Coroner raised a number of serious concerns about National Law and grandfathering arrangements on existing vessels, noting that:

> This inquest highlighted an important difference in the National Law between how 'existing vessels' and 'new vessels' are treated, in that if the Returner had been a new vessel, it would have required an automatic stability test as part of the five year renewal survey it was undergoing, whereas as an existing vessel it did not. While there was an option for the *Returner* to have been treated as a new vessel given the modifications it had undergone, with the consequence that a stability test would be required, that places an onus on the surveyor to form a difficult judgment, as opposed to the very simple automatic requirement for a new vessel.[25]

5.27 Mr Brian Hemming, National Operations Manager for Regions at AMSA gave evidence that:

> …AMSA, as the National Regulator, has expressed some concerns with the grandfathering arrangements for existing vessels as it has slowed down industry's approach to modifying or updating the fleet. Mr Hemming indicated that some of the work AMSA is currently doing is to revise Marine Order 503 to look at things like the trigger points to describe a 'new' versus 'existing vessel'. It is aimed at allowing operators to carry out

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[22] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the death of Murray Allan Turner and Mason Lawrence Carter and Chad Alan Fairley*, 28 February 2018, p. 16.

[23] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the death of Murray Allan Turner and Mason Lawrence Carter and Chad Alan Fairley*, 28 February 2018, p. 16.

[24] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the death of Murray Allan Turner and Mason Lawrence Carter and Chad Alan Fairley*, 28 February 2018, pp. 17–18.

[25] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the death of Murray Allan Turner and Mason Lawrence Carter and Chad Alan Fairley*, 28 February 2018, p. 70.

> modifications without having to take the vessel up to full standard, because it is accepted that there would be serious financial implications or obligations to operators if the grandfathering was to end at a point in time. Nevertheless, AMSA has been quite public in saying that, as the National Regulator, they have the right to review the grandfathering scheme as safety concerns are revealed.[26]

5.28 The Coroner made two recommendations on this matter for AMSA, as follows:

> I recommend that AMSA, as the National Regulator of the National Law, should give consideration to establishing a transitional approach to ending the grandfathering of safety standards for existing vessels. Compliance with current standards in regard to vessel operations and safety equipment should be given priority.
>
> Recommendation 2:
>
> I recommend that AMSA, as the National Regulator of the National Law, should give guidance to accredited surveyors to remind them of the importance of independently verifying key information when assessing a vessel's stability, given the critical importance of the stability of a vessel in allowing a vessel to operate safely.[27]

## Inquest into the death of Mr Daniel Thomas Bradshaw

5.29 Mr Daniel Bradshaw was a 38-year-old deckhand who slipped, hit his head and died while climbing off a barge, the *Sammy Express*, to a wall (and dry land) in the Northern Territory on 8 January 2017.[28] The wall did not have a permanent gangway and Mr Bradshaw was found floating face down in the water between the barge and the wall.

5.30 On 25 May 2017, Sri Srinivas, Principal Marine Safety Officer with the NT Department of Infrastructure (and delegate of AMSA) submitted breach reports to AMSA recommending prosecutions against the owner and master of the barge. The breaches were suggested according to sections 13(2) and 18(4) of the Schedule to the National Law.[29]

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[26] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the death of Murray Allan Turner and Mason Lawrence Carter and Chad Alan Fairley*, 28 February 2018, p. 71.

[27] Coroner's Court of Western Australia, Record of Investigation into Death, *Inquest into the death of Murray Allan Turner and Mason Lawrence Carter and Chad Alan Fairley*, 28 February 2018, p. 71.

[28] Coroner's Court of Darwin, *Inquest into the Death of Daniel Thomas Bradshaw* [2018] NTLC 005, 8 February 2018, https://justice.nt.gov.au/__data/assets/pdf_file/0019/482005/D00052017-Daniel-Bradshaw.pdf (accessed 28 March 2019).

[29] Coroner's Court of Darwin, *Inquest into the Death of Daniel Thomas Bradshaw* [2018] NTLC 005, 8 February 2018, p. 13.

5.31 However, Mr Hemming of AMSA informed the Coroner that AMSA's view was that there were 'insufficient grounds to refer the matter to the Commonwealth Department of Public Prosecutions'.[30]

5.32 The Coroner made the following observation in relation to AMSA's view:

> The fact that Dan's body was found below the bridge wing and tyre used to access the wall and barge, the fact that his hat and phone were on the wall, and the fact that climbing from the vessel to the wall was clearly dangerous, did not appear to sway Mr Hemming's view that the death was a coincidence rather than connected to the unsafe access and egress to and from the vessel.
>
> However, the laceration on the back of Dan's neck is unlikely to have been caused in any other way than falling backward from the tyre while climbing to or from the wall. The presence of the hat and the phone could be indicators of climbing up or down the wall but most indicative of climbing up. Given those facts, the suggestion that his death was not connected to the unsafe access or egress is in my view ludicrous.[31]

5.33 According to Mr Hemming's evidence to the Coroner, AMSA:

> […s]eparately decided that the safety management system (SMS) in force for the *Sammy Express*…did not ensure that the vessel and the operations of the vessel were, so far as reasonably practical, safe. In particular, neither SMS made explicit provision for a safe means of access to and from the vessel where such access is affected by the rise and fall of the tide (as was the case at the time of Mr Bradshaw).[32]

5.34 Consequently, on 7 November 2017 (10 months after Mr Bradshaw's death), AMSA provided Conlon Murphy Pty Ltd (T/A Barge Express)[33] with the following Direction Notice:

> (1) The safety management system (SMS) …be altered to ensure there are arrangements in place for the safe access to and from its vessels when alongside/berthed that account for the rise and fall of the tide.
> (2) The master and crew … are given proper training and instruction to enable each master and crew member to implement and comply with each SMS.[34]

5.35 The Coroner stated that this was:

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[30] Coroner's Court of Darwin, *Inquest into the Death of Daniel Thomas Bradshaw* [2018] NTLC 005, 8 February 2018, p. 14.

[31] Coroner's Court of Darwin, *Inquest into the Death of Daniel Thomas Bradshaw* [2018] NTLC 005, 8 February 2018, pp. 14–15.

[32] Coroner's Court of Darwin, *Inquest into the Death of Daniel Thomas Bradshaw* [2018] NTLC 005, 8 February 2018, p. 16.

[33] Conlon Murphy was the owner of the *Sammy Express*.

[34] Coroner's Court of Darwin, *Inquest into the Death of Daniel Thomas Bradshaw* [2018] NTLC 005, 8 February 2018, p. 16.

> …a curious direction, given the evidence that the SMS was unable to be complied with at the Barge Express premises. There were simply no gangways with netting. Lighting was considered an issue and the only gangway other than the permanent gangway on the East wall was too short'.[35]

5.36 The date of the Notice of Direction was 27 November 2017. Three days later, the Manager of the Barge Express sent an email to staff alerting them to adhere to the following procedure:

> All staff are prohibited to access or egress a vessel once it is safely moored, if no compliant gangway or bow door arrangement is in place. No Gangway/bow door arrangement – No Access/Egress.[36]

5.37 The following day, the Manager of Compliance at AMSA wrote to indicate that he was 'satisfied that you have now taken the steps specified in Direction Notice…I will close the notice off'.[37]

5.38 The Coroner expressed concern over the lack of evidence provided, in order for AMSA to reach that decision. The Coroner said that there was:

> …no evidence provided to AMSA that the Barge Express knew what a "compliant gangway or bow door arrangement" entailed. There was no evidence that there was a compliant gangway available. There was no evidence of what the training indicated. There was no evidence of any training at all.[38]

5.39 When asked why the notice would be closed before the SMS had been changed and without any evidence of proper training and instruction, Mr Hemming responded:

> It's not the perfect practice but it is the accepted practice where a lot of notices issued on behalf of AMSA or by AMSA are done in either through self-declaration or voluntarily giving us information that they had actually done what was required.
>
> Again, it's depending on the nature and specifics of the notice itself. Again, the manager of compliance is the one that's made the decision to lift the notice. I admit that it could have made reference to what training the company intended to do and that may have been part of the discussions had with them verbally that I am unaware of.[39]

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[35] Coroner's Court of Darwin, *Inquest into the Death of Daniel Thomas Bradshaw* [2018] NTLC 005, 8 February 2018, p. 16.

[36] Coroner's Court of Darwin, *Inquest into the Death of Daniel Thomas Bradshaw* [2018] NTLC 005, 8 February 2018, p. 16.

[37] Coroner's Court of Darwin, *Inquest into the Death of Daniel Thomas Bradshaw* [2018] NTLC 005, 8 February 2018, p. 17.

[38] Coroner's Court of Darwin, *Inquest into the Death of Daniel Thomas Bradshaw* [2018] NTLC 005, 8 February 2018, p. 17.

[39] Coroner's Court of Darwin, *Inquest into the Death of Daniel Thomas Bradshaw* [2018] NTLC 005, 8 February 2018, p. 17.

5.40 Mr Hemming further listed four main considerations used when determining whether to prosecute a breach of the relevant law:

- exhibits a significant degree of criminality or disregard;
- was sufficiently serious that the Commonwealth and the community would expect it to be dealt with by prosecution;
- results in significant or real harm; and
- warrants a prosecution so as to deter future behaviour.[40]

5.41 The conversation between Mr Hemming and the Counsel Assisting was particularly pertinent to this inquiry:

> **Counsel Assisting:** Is what you are saying there are so many non-compliances in relation to the domestic commercial vessels that it's a very long list?
>
> **Mr Hemming:** Without being controversial, yes it is. We have a significant generational, cultural change ahead of us and in some cases we need to take small steps, in other cases, you know, over time we need to use the full extent of the suite of tools available to us to influence that change.[41]

5.42 The Coroner then stated that:

> The lawyer for AMSA went further and suggested that there was no offence committed due to a strict reading of the wording of Marine Order 23 (applicable because of the "grandfathering clauses"). I invited AMSA to expand on that suggestion in further written submissions. However, they did not expand that point and I am assuming AMSA realised that Marine Order 23 does not and cannot modify the requirements to have a safe means of access and egress.[42]

5.43 In the concluding comments, the Coroner further noted:

> This death illustrates the vast difference between the levels of safety existing for those that work on domestic commercial vessels and those that work on land. It also illustrates the differing expectations of the regulators.
>
> There should not be such differences. I was told that change in the industry will be "generational". However, if that means that this generation of workers are exposed to risks that legally should not exist, it is not good enough.[43]

5.44 Furthermore, the Coroner observed that this was the second such inquest relating to a DCV vessel in the NT within a period of 18 months, where the

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[40] Coroner's Court of Darwin, *Inquest into the Death of Daniel Thomas Bradshaw* [2018] NTLC 005, 8 February 2018, pp. 17–18.

[41] Coroner's Court of Darwin, *Inquest into the Death of Daniel Thomas Bradshaw* [2018] NTLC 005, 8 February 2018, p. 19.

[42] Coroner's Court of Darwin, *Inquest into the Death of Daniel Thomas Bradshaw* [2018] NTLC 005, 8 February 2018, p. 19.

[43] Coroner's Court of Darwin, *Inquest into the Death of Daniel Thomas Bradshaw* [2018] NTLC 005, 8 February 2018, pp. 22–23.

regulatory authorities appeared 'either slow or unwilling to denounce unsafe practices'. It was noted that in relation to the first, no action at all had been taken by the regulatory authority, despite it being more than two and a half years since the death of Mr Harry Donoghue.[44]

## Committee view

5.45 The evidence from these coronial inquiries is disturbing, and suggests systemic issues in the regulation and legislation for maritime safety on domestic commercial vessels. These issues should be further examined and reviewed, and prompt action taken by AMSA to address safety concerns as soon as they are identified.

5.46 The committee supports the comments made in relation to the death of Mr Bradshaw, where the Coroner remarked that it is not good enough that workers are being exposed to risks that legally should not exist. It does not appear to the committee that the 'significant generational and cultural change' spoken of by AMSA has progressed to any significant degree.

5.47 These inquests have also highlighted a number of inadequacies in the marine safety legislative framework, and a lack of adequate enforcement action by AMSA in the face of serious risks to crew and passenger safety.

[44] Coroner's Court of Darwin, *Inquest into the Death of Daniel Thomas Bradshaw* [2018] NTLC 005, 8 February 2018, p. 23.

# Chapter 6
# Grandfathering arrangements and other areas for reform

6.1 This chapter considers the evidence received during the inquiry regarding areas for further review and reform within AMSA. The creation of the national system for DCVs was initially touted as a means of reducing costs, red tape and improving safety outcomes for the sector. However, as this chapter shows, the overwhelming number of submissions to the inquiry noted that DCV operators face a more complex, costly and burdensome system which has yet to improve safety outcomes.

6.2 Additional evidence received during the inquiry has also brought to the committee's attention a range of other issues and concerns including the importance of better legislated and more enforceable safety management systems, resourcing and staffing issues within AMSA, the implementation of corporate or industrial manslaughter legislation and the production of more detailed safety data.

6.3 In particular, there are a number of concerns around legislative grandfathering arrangements and the negative impact these provisions can have on maritime safety. The grandfathering arrangements in relation to vessel standards and crewing are considered further below.

## Grandfathering arrangements

6.4 The previous chapter drew attention to a number of coronial inquests which considered the role of AMSA. Of particular importance were the recommendations of the Coroner in 2018, following the inquest into the deaths of Mr Turner, Mr Carter and Mr Fairley.

6.5 The Coroner in that instance recommended a transitional approach to ending the grandfathering of safety standards for existing vessels, with priority given to compliance with the current safety standards. The committee shares this view, as detailed below.

### *Marine Order 503 – Certificates of Survey*

6.6 *Marine Order 503 (Certificates of survey – national law) 2018* (Marine Order 503) prescribes matters for the national law in relation to the application, issue, variation, suspension and revocation of certificates of survey for domestic commercial vessels. It prescribes the standards that apply to a DCV for the

issue of a certificate of survey and also prescribes the standards to be met for the survey of a DCV.[1]

6.7 As part of the transition to the new national system, COAG agreed to allow existing vessels in operation as of 1 July 2013 to continue to operate under the design, construction and survey requirements that existed before the introduction of the new national system. The grandfathering arrangements were introduced to save existing vessel operators from having to invest immediately in the cost of bringing their vessels into line with new vessel construction and stability standards.

6.8 In light of the above agreement, under Marine Order 503, different construction and equipment standards are prescribed for 'existing vessels', 'new vessels' and 'transitional vessels'. For existing vessels, with the exception of safety equipment, the construction and equipping standards are generally those that applied to the vessel as at 30 June 2013. Some amendments were made to the Order in 2018, requiring existing vessels to comply with contemporary communication equipment standards in the National Law.[2]

6.9 However, despite these amendments, section 7 of Marine Order 503 still contains significant grandfathering provisions, and provides that the vessel and equipment standards for an existing vessel are:

> (a) for arrangement, accommodation and personal safety, watertight and weathertight integrity, construction, fire safety, engineering, stability, equipment (other than the equipment mentioned in paragraph (b) or (c)) and associated systems:
>
> **(i) if the vessel operated before 1 July 2013 — the standards that applied to the vessel on 30 June 2013** [emphasis added]

6.10 In addition, there are a number of exemptions which may apply to the Order, including exemptions in relation to periodic survey, equipment certification, compass adjustment, and life jacket lights.[3]

## *Marine Order 504 – Certificates of operation*

6.11 *Marine Order 504 (Certifications of operation and operation requirements – national law) 2018* provides requirements for the application, issue, renewal, variation, suspension and revocation of certificates of operation for domestic commercial

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1 *Marine Order 503 (Certificates of survey – national law) Amendment Order 2018*, Explanatory Memorandum, p. 1.

2 Specifically, the carriage of float-free and automatically activating emergency position indicating radio beacons (EPIRB); *Marine Order 503 (Certificates of survey – national law) Amendment Order 2018*, Explanatory Memorandum, pp. 1-2.

3 Australian Maritime Safety Authority, *Marine Order 503 – Certificates of Survey – national law,* https://www.amsa.gov.au/marine-order-503-certificates-survey-national-law (accessed 24 April 2020).

vessels. A certificate of operation must be held by a person who operates a domestic commercial vessel.[4]

6.12 Section 16 of the Order sets out the meaning of 'existing vessel' for the purpose of the Order, which includes a vessel used in connection with a commercial activity at any time in the two years ending on 30 June 2013. Existing vessels are excluded from the application of certain requirements related to crewing of a DCV.[5]

6.13 Section 6 of Schedule 1 to the Order states that an owner must determine the appropriate crewing for each kind of operation of the vessel by evaluating the risks to safety of the vessel, the environment and all persons on or near the vessel, and the number of crew must be at least equal to the minimum numbers stipulated in section 6(4) of the Schedule.

6.14 Despite this requirement, grandfathering provisions are provided in Schedule 1, section 8 of Marine Order 504 which state the circumstances where 'appropriate crewing need not comply with minimum crewing requirements'. Instead, the Order states that for existing vessels:

> (8) The appropriate crewing may be:
>
> **(a) the crewing requirements that applied to the vessel on 30 June 2013, if the vessel is an existing vessel** [emphasis added]**.**

*Views of AMSA*

6.15 It is clear that the Marine Orders which were in place at the time of Mr Mills' death, in late 2014, gave effect to grandfathering arrangements which allowed existing vessels, including the *Ten-Sixty-Six*, to comply with certain state and territory requirements that applied before 1 July 2013.

6.16 Mr Kinley drew attention to the fact that from 1 July 2018, the grandfathering arrangements in relation to some operational safety standards ceased. Thereafter, owners and operators of DCVs had to, as a condition of their certificate of operation, comply with the contemporary safety standards for operations, including headcount requirements, as set out in Marine Order 504.[6]

6.17 Notwithstanding this, grandfathering arrangements were in place regarding the operations of the *Ten-Sixty-Six.* Mr Kinley reflected on the grandfathering provisions and stated that:

> These grandfathering practices, as they were called, from each jurisdiction were agreed to by COAG under the IGA as a pragmatic way to deal with

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[4] *Marine Order 504 (Certifications of operation and operation requirements – national law) 2018*, Explanatory Memorandum, p. 1.

[5] *Marine Order 504 (Certifications of operation and operation requirements – national law) 2018*, Explanatory Memorandum, p. 5.

[6] Mr Mick Kinley, Australian Maritime Safety Authority, *Committee Hansard*, 4 December 2018, p. 2.

> variations and standards that existed across all jurisdictions; however, in AMSA's view, we really need to be prepared to examine some of these grandfather arrangements in the future.[7]

6.18 In its submission to the inquiry, AMSA indicated that it would pursue action to improve safety for high risk vessels that are 'currently operating under 'grandfathering' arrangements'.[8] AMSA informed the committee that it was '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, were consistent with contemporary safety expectations. AMSA continued:

> For example, some vessels that were constructed in accordance with grandfathered state and territory requirements were 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 1000 mm – meaning the likelihood of overbalancing is increased. The contemporary rail height requirements for a vessel of this kind is 1000 mm.[9]

6.19 In their right of reply to the submission of the Maritime Union of Australia (MUA), AMSA further noted that it 'intends to work collaboratively with government and industry to look at options for improving the standards and safety outcomes for grandfathered vessels'.[10] This position was reiterated by the AMSA Board, which noted that 'that the community's expectations is that, when a passenger or a crew member boards a boat, they expect the boat and everything on it to meet contemporary safety standards'.[11]

### *Submitter views*

6.20 A number of submitters raised concerns about the grandfathering arrangements. For example, Maritime Industry Australia Limited (MIAL) noted in its submission that the arrangements under which vessels that were grandfathered as 'existing vessels' apply indefinitely, unless subject to modification, changes in the areas of operation, or changes to the nature of its operation in a way that increases risk. According to MIAL, these arrangements have created an 'incentive for operators to hold on to older vessels with grandfathered status', rather than to upgrade to new, modern vessels that are subject to more stringent rules. It described this incentive as a 'perverse outcome for a regime intended to improve safety across the board'. Furthermore:

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7 Mr Mick Kinley, Australian Maritime Safety Authority, *Committee Hansard*, 1 April 2019, p. 2.

8 Australian Maritime Safety Authority, *Submission 1*, p. 3.

9 Australian Maritime Safety Authority, *Submission 1*, p. 16.

10 Australian Maritime Safety Authority, *Right of Reply – Maritime Union of Australia submission*, p. 6.

11 Mr Stuart Richey, Australian Maritime Safety Authority Board, *Committee Hansard*, 25 September 2019, p. 18.

> Grandfathering also maintains the inconsistencies of the previous state and territory regimes that the National System was aiming to address.[12]

6.21 Pacific Maritime Lawyers and Consultants (PML) also voiced concerns with grandfathering arrangements, expressing the view that:

> The grandfathering has been happening in the commercial vessel sector in this country for a very long time. Every time there has been a step forward in terms of the regulatory system—changes in the national standards—then grandfathering existed with the intention of course for these older vessels to be phased out over time and for the new standard to apply to anything that was built after a certain date. I agree that that is a problem. Clearly, there are vessels around where the vessels probably weren't seaworthy, and there are some examples of this that include multiple fatality examples. That's a significant regulatory problem. That regulatory problem is that those vessels deserve additional scrutiny, but they are also very often the vessels that are least resourced. There are reasons why those vessels haven't been replaced. That's a challenge.[13]

6.22 The Tasmanian Seafood Industry Council (TSIC) explained that the difficulties for Tasmanian seafood fishers in understanding the intricacy of the National Law was made more difficult by the complexity of grandfathering clauses and the unknown number of exemptions in place. These factors—coupled with the often inconsistent advice offered by AMSA—had created an 'exceptionally complex and burdensome system, which has lost any common sense approaches to decision making'.[14]

6.23 MIAL concluded, however, that as a result of the commitments made by industry prior to the commencement of the transition, there was little capacity for AMSA as the regulator to alter this approach.[15]

## Committee view

6.24 The ongoing issue around grandfathering arrangements is of significant concern to the committee. The implicit inconsistency in the treatment of older vessels should have been largely addressed by the ending of some of these arrangements on 1 July 2018. However, concerns remain around standards for the physical safety of the vessel under Marine Order 503, and the adequacy crewing arrangements under Marine Order 504.

6.25 There also remain concerns over the consistency and application of exemptions, whether the legislation in its current form can accommodate the range and diversity of vessels it is intended to, and the monitoring and enforcement regime in place.

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[12] Maritime Industry Australia Limited, *Submission 4*, p. [8].

[13] Mr John Kavanagh, Pacific Maritime Lawyers Pty Ltd, *Committee Hansard*, 25 September 2019, p. 9.

[14] Tasmanian Seafood Industry Council, *Submission 5*, p. 8.

[15] Maritime Industry Australia Limited, *Submission 4*, p. [8].

6.26 The committee is cognisant of the scale of applying modern safety standards across the 27 000 or so DCVs, and the committee expects over time the regulatory inconsistencies will dissipate as older vessels go off line, and the majority of DCVs fall under the same safety and operational standards. However the committee is mindful that the legislative and regulatory framework must keep pace with the changing industry, and to this end will be maintaining a watching brief on how he regulatory regime moves forward in ensuring the industry meets contemporary operational safety standards into the future.

## Increased red tape, centralisation and complexity

6.27 As noted in previous chapters of this report, AMSA indicated that under the 2013 arrangements whereby states and territories delivered services, 'many of the benefits that a truly national system could deliver are not being realised because service delivery is not centralised'. AMSA further argued that centralised service delivery would 'simplify how the regulatory framework is applied consistently, across Australia'.[16]

6.28 However, the committee received evidence raising a number of concerns with the national system. While many submitters noted the importance of consistent national laws to ensure greater efficiency and safety for the maritime industry and its workers, a number of issues and obstacles were highlighted.

### *Greater complexity and cost*

6.29 A number of submitters suggested that AMSA had not achieved the three main objectives of the national system: reduced costs, reduced red tape and improved safety outcomes. In fact, evidence to the committee suggested that the move to a national system had created 'excessive red tape', raised costs and alienated smaller operators.[17]

6.30 Seafood Industry Victoria held the view that AMSA's delivery of a subsidised national system had not yet passed on any of these three key performance measures. It instead indicated that the proposed costs to Victorian fishing vessels could amount to a total increase of 200 to 500 per cent.[18]

6.31 MIAL highlighted that there were, and continue to be, significant challenges in the transition to the national system which have resulted in legislation which is 'overtly complex and lacking in clarity'. It concluded that in order to create a regulatory regime that is fit for purpose and can achieve its objectives of

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[16] Australian Government, *Cost recovery for services under the National System for Domestic Commercial Vessel Safety, August – October 2016*, Australian Maritime Safety Authority, p. 10.

[17] Seafood Industry Victoria, *Submission 8*, p. [2].

[18] Seafood Industry Victoria, *Submission 8*, p. [2].

increased consistency, safety and overall efficiency in the DCV sector, an 'entire rewrite' of the National Law was necessary.[19]

6.32 MIAL acknowledged that the transitional task was significant, for reasons including the fact that an addition 27 000 DCVs came under AMSA's jurisdiction. However, the transitional arrangements required AMSA to bring a diverse range of vessel types, commercial operations and historical regulatory settings under one umbrella, while allowing maritime businesses to continue operating. According to MIAL, this process has:

> …resulted in an extremely complex and often ambiguous regulatory landscape…AMSA's remit to interpret and enforce the legislation is made very difficult as a result.[20]

6.33 MIAL further highlighted the diverse range of vessels covered under the National Law, noting that some standards which applied to small tinnies used as workboats in jetty construction, also applied to Sydney harbour ferries.[21] This diversity created its own challenges, as MIAL noted:

> To allow for this extreme variation in operation, minimal prescription and many exemptions (currently at 41 in total) to legislation has been necessary, leading to ambiguity and lack of clarity in regulation.[22]

6.34 The International Institute of Marine Surveying (IIMS) concurred with MIAL's view:

> The number of standing and ad-hoc exemptions issued to very worthy recipients in our view indicates clearly that the technical standards are out of step with the regulatory requirements of the National Law, and critically into the evolving needs of the domestic vessel fleet. AMSA has full responsibility for this suite of technical standards and whilst industry is evolving and innovating the regulatory settings are not, merely being band-aided.[23]

6.35 Similarly, the TSIC gave evidence that a one size fits all approach to regulation cannot be applied to the Australian DCV fleet given the diversity of vessels, operations and operational environments. It noted that instead of promised reduced costs, reduced red tape and improved safety outcomes, AMSA had delivered a 'more costly and complex system that does not address real safety risk in Tasmania'.[24]

### *Inadequate resources*

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[19] Maritime Industry Australia Limited, *Submission 4*, p. [9].

[20] Maritime Industry Australia Limited, *Submission 4*, p. [7].

[21] Maritime Industry Australia Limited, *Submission 4*, p. [7].

[22] Maritime Industry Australia Limited, *Submission 4*, p. [7].

[23] International Institute of Marine Surveying, *Submission 3*, p. [2].

[24] Tasmanian Seafood Industry Council, *Submission 5*, p. 2.

6.36 The TSIC also expressed concerns regarding small-scale family-owned operations and their ability to understand and comply with the complex national system. These concerns were shared by Seafood Industry Victoria, which noted that recent research and engagement with industry, at a national level, has highlighted that there has been a 'complete disengagement by grass roots fishers' from the AMSA national system.[25]

6.37 IIMS provided evidence to indicate that the reform process to a national system was not likely to be realised unless 'significant cultural and leadership change occurs'.[26] In particular, IIMS drew attention to reporting and paperwork requirements, including repeated requests for basic information, which have 'increased massively since 1 July 2018'.[27] The IIMS indicated that over 70 pages of AMSA forms were now required to bring a standard new vessel into operation, as opposed to about a dozen pages under the previous system.[28]

6.38 The MUA noted that given the increased responsibility and oversight of AMSA, its resources and funding 'were not increased sufficiently' to cope with the greater workload. The MUA stated that:

> In 2010, AMSA was responsible for regulating less than 100 Regulated Australian Vessels, approximately 4,500 international ship visits, search and rescue, aids to navigation, pollution response and other regulatory functions. On the 1st of July 2013, the Navigation Act came into force with the added responsibility of inspecting and regulating the provisions of the Maritime Labour Convention....On the same day, AMSA also became responsible for the development and enforcement of regulations under the Marine Safety (Domestic Commercial Vessel) National Law Act 2012. This new responsibility came with it...27,000 vessels and 66,000 seafarers.[29]

6.39 The MUA went on to observe that an increase in both annual and staffing expenses was 'nowhere near commensurate with the additional burden of regulating 20,000-27,000 vessels and crew'.[30] In order to remedy this, the MUA recommended that:

> …a review be made of resources available to AMSA, the allocation of those funds within AMSA, and whether further resources need to be allocated to enable AMSA to achieve their stated outcomes to the standard expected of an Australian Safety Authority.[31]

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25 Seafood Industry Victoria, *Submission 8*, p. [2].

26 International Institute of Marine Surveying, *Submission 3*, p. [2].

27 International Institute of Marine Surveying, *Submission 3*, p. [2].

28 International Institute of Marine Surveying, *Submission 3*, p. [2].

29 Maritime Union of Australia, *Submission 12*, p. 34.

30 Maritime Union of Australia, *Submission 12*, p. 34.

31 Maritime Union of Australia, *Submission 12*, p. 36.

6.40 PML further addressed resourcing concerns, stating that:

> …for the first 12 months of the AMSA supervision of the national system [there were]: 3,000 vessel permissions, 4,500 operating permissions, 3,100 exemptions, 10,300 certificates of competency, 9,000 certificates issued, reflecting the new survey regime. There were also 1,500 inspections and 400 SMS verifications.[32]

6.41 On these figures, PML specifically noted the 400 SMS verifications and suggested that:

> …if you're only looking at 400 out of tens of thousands of vessels—that's actually where the safety is and that's actually where this incident happened—I suggest that perhaps the allocation of resources needs to be looked at. We're doing the paperwork fine, there are a lot of people on boats with pieces of paper, but perhaps the safety management systems and the way that they're being conducted needs to be looked at.[33]

6.42 In response to the evidence of PML, AMSA noted that:

> The reviews of safety management systems, which is part of the permissioning process, is one part of what we do. In the over 5,000 vessels that were inspected, that's all going on board. That's actually looking at their safety management system in practice and how it's operating and looking at how they're using their safety management systems themselves.[34]

### *Data collection*

6.43 Section 10 of the National Law requires the national regulator 'to collect, analyse and disseminate data relating to marine safety'.[35] Several submissions drew attention to a perceived inadequacy in data collection methods by AMSA.

6.44 MIAL stated that the transition to the national system had been made more difficult by the variation in the quality, format and extent of historical data collected by the states and territories, which AMSA was required to obtain and process.[36]

6.45 IIMS was of the view that as the national system started on 1 July 2013, it would be expected that a well-resourced agency would be able to 'capture and discipline this data over the 5-year period to their takeover on 1 July 2018'. By way of example, the IIMS submitted that:

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[32] Mr John Kavanagh, Pacific Maritime Lawyers Pty Ltd, *Committee Hansard*, 25 September 2019, p. 3.

[33] Mr John Kavanagh, Pacific Maritime Lawyers Pty Ltd, *Committee Hansard*, 25 September 2019, p. 3.

[34] Mr Stuart Richey, Australian Maritime Safety Authority Board, *Committee Hansard*, 25 September 2019, p. 22.

[35] Maritime Union of Australia, *Submission 12*, p. 17.

[36] Maritime Industry Australia Limited, *Submission 4*, p. [7].

> A customer of one of our members stated recently that AMSA rang them and asked for clarification of their fleet composition. The AMSA officer reportedly stated that the Regulator has no records for the 7,000 vessels they believe are in the fleet. Our members regularly come across vessels without AMSA Unique ID or AMSA survey paperwork as well as incorrect information on this paperwork. Some of it is critical to the operators being able to operate safely including such things as stability limitations and justification for physical variations in vessels.[37]

6.46 In addition, the MUA was critical of AMSA's reporting of safety data, stating that AMSA wrote and implemented Marine Orders 'without any systematic data collection, analysis or dissemination of results'.[38] The MUA further criticised AMSA for displaying maritime fatality figures as a raw figure rather than as a ratio per 100 000 (as is common practice with Safe Work Australia).[39]

6.47 The MUA therefore asserted that 'AMSA must significantly improve how it reports fatality data, and ensure it is done consistently and is comparable with Safe Work Australia's reporting'. They further recommended that 'AMSA carry out publication and analysis of statistics on safety and prosecutions in line with the standards set by Safe Work Australia'.[40]

6.48 In their right of reply to the MUA submission, AMSA recognised that:

> [The] capture of maritime incident data and reporting can be improved. The limitation is, in part, a result of the inconsistencies in the way data was collected across different jurisdictions before the National System commenced.[41]

6.49 In addition, AMSA noted that it compiles and publishes a summary of serious marine incidents on their website and that it was 'investing in data analysis to learn from and produce better metrics around this data'. AMSA concluded by saying that it:

> ...would also welcome the opportunity to work with Safe Work Australia, research organisations and other peak bodies, including the MUA, to enhance reporting of marine incidents in the sector.[42]

## AMSA's regulatory approach

6.50 PML argued that AMSA's regulatory approach to any difficult situation was not based on consultation, collaboration or proportionality, as set out in its *Statement of Regulatory Approach*. Instead, PML submitted that AMSA faces

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37 International Institute of Marine Surveying, *Submission 3*, p. [2].

38 Maritime Union of Australia, *Submission 12*, p. 17.

39 Maritime Union of Australia, *Submission 12*, pp. 19–21.

40 Maritime Union of Australia, *Submission 12*, p. 25.

41 Australian Maritime Safety Authority, *Right of Reply – Maritime Union of Australia submission*, p. 6.

42 Australian Maritime Safety Authority, *Right of Reply – Maritime Union of Australia submission*, p. 6.

'three stumbling blocks'— being the assessment of true culpability, the unfounded targeting of enforcement efforts and an obstinate legal stance.[43]

**Culpability**

6.51 PML highlighted the importance of a regulator being able to assess the level of culpability and to attribute that culpability to the correct party. It argued that the process of assessing culpability by AMSA, at least in the regulation of DCVs, was 'immature at best and lacks rigour'.[44]

**Targeting of enforcement efforts**

6.52 According to PML, once AMSA considers a circumstance or party to be 'bad', it will then focus additional regulatory attention on that party or issue 'with a laser-like focus, and demonstrate a complete lack of the principles of flexibility or cooperation espoused in the aforementioned regulatory statement'. While PML argued that AMSA may not be wrong in its use of powers, it suggested that AMSA's use of discretion and flexibility was applied 'differently depending on who is seeking it'.[45]

**Obstinate legal stance**

6.53 PML further submitted that when AMSA takes a position in a dispute, it tends to be reluctant to back away from that position, even when it is clear that it is in error. PML noted that in its dealing with other agencies, there is usually a mechanism by which faulty decisions can be brought to the agency's attention to have those decisions reconsidered.[46]

6.54 PML raised a number of concerns with the focus of AMSA and its approach to prosecution. It held the view, based on its experience, that AMSA is less focused on the culpability of various parties than on the prospect of prosecution. It continued:

> ...AMSA would rather charge a person with minor involvement, with a minor offence to which they will plead guilty, than charge a more centrally-involved person with a more substantial offence which will be contested. Such an outcomes leaves the truly culpable to go free, and contributes absolutely nothing to maritime safety.[47]

6.55 PML noted in their conclusion that AMSA's regulatory approach with respect to DCVs was 'highly bureaucratic, fixed in its views, conservative and risk-averse'. It further concluded that:

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[43] Pacific Maritime Lawyers and Consultants, *Submission 7*, p. 3.

[44] Pacific Maritime Lawyers and Consultants, *Submission 7*, p. 3.

[45] Pacific Maritime Lawyers and Consultants, *Submission 7*, p. 3.

[46] Pacific Maritime Lawyers and Consultants, *Submission 7*, p. 4.

[47] Pacific Maritime Lawyers and Consultants, *Submission 7*, p. 8.

> ...the AMSA principles of "consultative and collaborative" and being "non-prescriptive" and taking a "risk-based and proportionate approach" are not applied in practice, and both the maritime industry and the regulatory outcome suffer as a consequence.[48]

### *Safety concerns*

6.56 The IIMS indicated that its 'members have repeatedly expressed deep frustration that efforts to draw AMSA's attention to safety, red tape and other concerns through official channels are constantly rebuffed and rejected'. Additionally:

> In some cases, confidential reports have not been appropriately handled which is leading to a marked reluctance for the regulated to share with the Regulator.[49]

6.57 Furthermore, information provided by AMSA staff was 'contradictory and confusing', and was communicated in 'quasi-legal language' which, in the view of IIMS, was 'presumably intended to protect the individual officers and agency but which in fact frustrates and confuses'. The IIMS additionally noted that the clear message coming back from AMSA was that the regulator 'knows best' and is 'regulating efficiently and effectively with broad stakeholder support'.[50]

6.58 The MUA took the view that AMSA's 'deregulation agenda' was having an impact on maritime safety. The MUA argued that AMSA's strategy to cope with its increased workload was to:

> Deregulate safety to reduce the workload of managing a large number of vessels. With the revision of MO 504 on 1 July 2018 AMSA has invented its own process-based safety system, 'outcomes-based safety'. This system hands over self-regulation to individual domestic commercial vessel operators, at the same time that AMSA is aware that significant sectors of this fleet do not have a good safety culture in place.[51]

**Safety Management Systems**

6.59 PML highlighted the importance of the SMS as 'crucial documents' for DCVs. They noted that the 'mere development of the SMS forces owners and operators to think systematically about risk, safety and how to mitigate the hazards of their vessels and how it is operated'.[52]

6.60 According to PML, the SMS should be the centrepiece of any conversation between owners, masters, crew and AMSA and provide for drills and

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[48] Pacific Maritime Lawyers and Consultants, *Submission 7*, p. 4.

[49] International Institute of Marine Surveying, *Submission 3*, p. [4].

[50] International Institute of Marine Surveying, *Submission 3*, p. [4].

[51] Maritime Union of Australia, *Submission 12*, p. 15

[52] Pacific Maritime Lawyers and Consultants, *Submission 7*, p. 5.

procedures, the use of equipment, management of safety, the safety of life and prevention of pollution. Ongoing discussions with AMSA and the DCV industry are crucial, because:

> [I]n the international context, it is widely understood that an SMS is not intended to be an inflexible rule book that must be slavishly followed, but rather as a breathing and organic document that provides guidance, systems and procedures for marine professions to discharge their responsibilities safely.[53]

6.61 They further stated that, internationally, the use of SMS has become mandatory following investigations into the sinking of the ferry, *Herald of Free Enterprise* off Zeebrugge in Belgium in 1987, with 193 fatalities. The investigation into the tragedy revealed that the responsible company lacked competent safety management and directions and that it was the 'failure to give clear orders about the duties of the Officers on the Zeebrugge run which contributed so greatly to the causes of the disaster'.[54] As PML indicated in its submission, the investigations found that the sinking of the vessel was more a failure in systems than it was a failure of individual personnel.[55]

6.62 PML noted, however, that AMSA provides little support for the development of an SMS beyond a set of guidelines and templates on its website. It argued the point that if vessel masters and owners had the opportunity to consult with AMSA in relation to their SMS, then not only would a superior SMS result, but AMSA would also be able to make a direct and immediate contribution to safety.[56]

## Committee view

### *Increased red tape, centralisation and complexity*

6.63 The evidence received throughout the inquiry has indicated significant issues in the transition to a national system.

6.64 The complexity and diversity of the types of vessels that AMSA is responsible for, as well as the resourcing and administration required to centralise the regulatory system, is, and was always likely to be, a huge challenge. Many submitters, while sympathetic to the challenges, were critical of AMSA's performance to date.

6.65 The committee are cognisant of the challenges AMSA has faced around data collection from state and territory jurisdictions, as well resourcing and time

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53 Pacific Maritime Lawyers and Consultants, *Submission 7*, p. 5.

54 UK Department of Transport, *mv Herald of Free Enterprise, Report of Court No. 8074*, Formal Investigation, 1987, p. 15.

55 Pacific Maritime Lawyers and Consultants, *Submission 7*, p. 5.

56 Pacific Maritime Lawyers and Consultants, *Submission 7*, pp. 5–6.

constraints. However, the committee is of the view that AMSA should continually assess whether the legislation is fit for purpose; that its resourcing is adequate to carry out its functions; and whether timelines are reasonable and achievable. If there are issues which cannot be overcome, AMSA should communicate its requirements to government, and not place the burden on the sector to work in a regulatory environment unfit for purpose, or where safety is compromised due to inadequate oversight.

6.66 Despite these expectations on AMSA, it is clear from the evidence considered during this inquiry, and the evidence considered during the numerous coronial inquests, that there are systemic issues with regard to the legislative and regulatory instruments, including the Marine Orders. This is evidenced by the fact that a number of exemptions against the primary legislative instruments have been issued, adding complexity to the technical and regulatory standards.

6.67 Any inadequacies in both the legislative framework and its application and enforcement can have an immediate and detrimental impact on safety. The committee therefore supports an independent review of whether the current marine safety legislation is fit for purpose for DCVs, particularly in light of the shift to the National Law, and the time that has elapsed since its implementation.

6.68 There have also been numerous amendments made to the legislation since its commencement, as well as inquiries and reviews into marine safety, and the committee takes the view that a holistic, independent review of the legislation is warranted. Such as review should consider the evidence received during this inquiry, suggesting that the laws are overly complex and unclear, and should have its primary focus on the improvement of safety for DCVs.

**Recommendation 4**

**6.69 The committee recommends that the Australian Government commission an independent review of the *Marine Safety (Domestic Commercial Vessel) National Law Act 2012* and any associated legislative instruments (such as Marine Orders). The review should consider whether the laws remain fit for purpose and whether they improve marine safety on domestic commercial vessels without being overly burdensome or complex.**

### *AMSA's regulatory approach*

6.70 The committee is concerned about the evidence suggesting that AMSA's general approach to enforcing and upholding its regulatory authority leaves substantial room for improvement.

6.71 While the committee does not wish to critique the internal culture of an organisation, evidence received throughout the inquiry raised serious questions specifically around AMSA's relations and interactions with its

stakeholders. For a regulatory regime to work effectively, a regulator must be seen to be applying its powers in a consistent and appropriate manner, and should be as open and transparent in its decision making as possible. One of the issues specifically concerning the committee are reports of inconsistency in how AMSA enforces regulatory breaches.

6.72 The seemingly haphazard prosecution process in the Mills case is apparently not unique. Disproportionate responses to breaches of law and regulation, inconsistent and untimely investigations, and a lack of transparency in its decision making, have led to legitimate criticism of AMSA's performance and approach.

### *Minimum requirements and safety management systems*

6.73 The evidence before the committee regarding safety management systems suggests that clearer minimum standards for their format and content could be developed. As was noted by PML, it is crucial that there are ongoing discussions between DCV owners and AMSA regarding SMS development, with clear benefits to be had from an ongoing dialogue between the two parties.

6.74 Support for stronger SMS's has also been put forward by the coronial inquests presented earlier in this report, in particular concerning the events around the *Sammy Express*. In that inquest, it was noted that the vessel's SMS did not ensure that the vessel and its operations were, so far as reasonably practicable, safe.

6.75 The committee encourages AMSA to develop mechanisms and processes that better ensure the implementation of an effective and practical SMS on a DCV. AMSA may also wish to consider whether the National Law could be amended to encourage an SMS that more effectively addresses safety risks, and better compliance with that SMS (for example, by way of a penalty system).

**Senator Susan McDonald**
**Chair**

# Labor Senators' Additional Comments

1.1 Labor Senators support Recommendation 1 which recommends amendments be made to the National Law to penalise situations where actions on a vessel have the potential to lead to a loss of life. However we are concerned that this recommendation could lead to individual seafarers being made to be scapegoats for organisational problems.

1.2 We are concerned that the term "operator" has no definition in the Marine Safety (Domestic Commercial Vessel) National Law Act 2012 (the National Law). The National Law does contain the following definition of the term "owner":

Owner of a vessel includes:

(a) a person who has a legal or beneficial interest in the vessel, other than as a mortgagee; and
(b) a person with overall general control and management of the vessel.

For this purpose, a person is not taken to have overall general control and management of a vessel merely because he or she is the master or pilot of the vessel.

1.3 It is the very strong view of Labor Senators that Recommendation 1 must refer to the "owner" of the vessel to be in keeping with the National Law and provide clarity about lines of responsibility.

1.4 With regard to the grandfathered requirements, not all grandfathering was ended on 1 July 2018. Crewing requirements for the number of crew working on board and survey standards for the physical safety of the vessel continue to be grandfathered.

1.5 Under Marine Order 503, which stipulate the survey standards for the physical safety of the vessel, Labor Senators are of the view that these arrangements should be phased out as soon as possible. In line with the Coroner's recommendation of 2018, the survey requirements should be phased out in a way that ensures all vessels comply with modern safety standards as soon as possible.

1.6 In considering Marine Order 504, Labor Senators hold serious concerns that crews on existing vessels may not be of a sufficient number to properly address the safety risks on board, and to risks to the environment or those around the vessel. The fact that an existing vessel does not have to comply with the minimum crewing requirements in the Order suggests that these vessels are not implementing the current safety standards of the National Law.

1.7 Labor Senators encourage the use of a vessel's SMS to ensure there are sufficient crew members on board to address the operational and safety requirements of the operation. The committee suggests that an additional crew member on board the Ten-Sixty-Six may have allowed for better monitoring of passenger numbers, and thus averted the tragedy which occurred.

1.8 Labor Senators also propose that in the event that specific or general exemptions are required to a Marine Order, these should only be issued based on the risk to passengers and crew, the vessel and the environment, rather than based on the cost to the operator of complying with modern safety standards.

1.9 As this report has highlighted, there is a real need to improve the marine safety legislative framework, and ensure all vessels are operating as safely as possible. In the light of this and the above views, Labor Senators make the following amendments to Recommendation 1 in the report, and add two additional recommendations:

**Recommendation 1**

**1.10 The committee recommends that amendments be made to the *Marine Safety (Domestic Commercial Vessel) National Law Act 2012* (the National Law) in regards to the penalties imposed on an owner of a vessel for acting in a reckless or negligent manner, regardless of intent. In particular, the committee recommends that consideration should be given to situations where the owner of a vessel has been found to be acting in a negligent or reckless manner which has the potential to result in the loss of life.**

**Recommendation 2**

**1.11 The committee recommends that Australian Maritime Safety Authority amend Marine Order 503 (Certificates of survey – national law) 2018 in order to phase out grandfathered survey requirements and to ensure that all domestic commercial vessels comply with modern safety standards as soon as possible.**

**Recommendation 3**

**1.12 The committee recommends that Australian Maritime Safety Authority amend Marine Order 504 (Certificates of operation and operation requirements – national law) 2018 as soon as possible in order to cease grandfathered crewing arrangements.**

1.13 Labor Senators support the recommended independent review of the National Law. We recommend that the proposed review must also consider AMSA's implementation of the Act. The proposed review should also include

consideration of whether the legislation provides clear and simple standards to improve marine safety on domestic commercial vessels, and how it relates to other maritime and workplace safety legislation, including the international maritime safety conventions.

**Senator Glenn Sterle**
**Deputy Chair**

**Senator Nita Green**
**Member**

# Appendix 1
# Submissions and additional information

*Submissions received during the 45th Parliament*

**1** Australian Maritime Safety Authority (AMSA)
**2** Mr Melville Joseph
**3** International Institute of Marine Surveying (IIMS)
**4** Maritime Industry Australia Limited
**5** Tasmanian Seafood Industry Council
**6** Western Australia Fishing Industry Council (WAFIC)
**7** Pacific Maritime Lawyers
**8** Seafood Industry Victoria
**9** Tasmanian Government
**10** Pacific Tug
**11** Mr Philip Jones-Hope
**12** Maritime Union of Australia (MUA)
- Response - AMSA

**13** Mr Ralph Stevens

*Submissions received during the 46th Parliament*

**14** Maritime Survey Australia

*Additional Information received during the 45th Parliament*

**1** Correction of evidence given by Mr Clinton McKenzie, General Counsel, AMSA, at a public hearing on 1 April 2019.

*Additional Information received during the 46th Parliament*

**1** Interpretation of Section 18(1)(c) of the Maritime Safety (Domestic Commercial Vessel) National Law Act 2012 provided by the Office of the Commonwealth Director of Public Prosecutions.

*Answers to Questions on Notice received during the 45th Parliament*

**1** Answers to written question on notice requested on 25 February 2019 and provided by Commonwealth Department of Public Prosecutions on 28 March 2019.
**2** Answers to written questions on notice requested on 8 March and provided by AMSA on 20 March 2019.
**3** Answers to written questions on nitce requested on 1 April and provided by AMSA on 12 April 2019
**4** Marine Order Amendment process - Requested at hearing on 1 April 2019
**5** AMSA prosecutions between 2014-2016 - Requested at hearing on 1 April 2019

**6** AMSA resourcing at time of investigation - Requested at hearing on 1 April 2019

*Tabled Documents received during the 45th Parliament*

**1** Mr Richard Mills - Opening statement - Tabled at hearing in Perth, Western Australia on 21 March 2019

# Appendix 2
# Public hearing and witnesses

*Thursday, 21 March 2019*
International on the Water Hotel
1 Epsom Avenue
Ascot

*Ms Nicole Mills, Private capacity*

*Mr Richard Mills, Private capacity*

*Western Australia Police Force*
- Inspector Andrew Henderson
- Sergeant Michael Wear
- Senior Constable Brett Brandhoff

*Western Australia Department of Transport*
- Mr Richard Sellars, Director General – Transport
- Mr Raymond Buchholz, General Manager Marine Safety
- Mr Christopher Mather, Director Waterways Safety Management

*Monday, 1 April 2019*
Old Parliament House
18 King George Terrace
Canberra

*Australian Maritime Safety Authority*
- Mr Mick Kinley, Chief Executive Officer
- Mr Gary Prosser, Deputy Chief Executive Officer
- Mr Allan Schwartz, General Manager Operations
- Mr Brad Groves, General Manager
- Ms Clare East, Manager, Maritime Regulation
- Mr Clinton McKenzie, General Counsel
- Mr Steve Whitesmith, Liaison Officer, Operations Division, Darwin
- Ms Mary Dean, National Manager Compliance Strategy
- Mr David Marsh, Manager, Enforcement and Inspector Support

*Wednesday, 25 September 2019*
Parliament House

2A George Street
Brisbane

*Pacific Maritime Lawyers*

- Mr John Kavanagh, Legal Practice Director
- Dr Anthony Marinac, Solicitor Advocate

*Maritime Union of Australia*

- Mr Ian Bray, Assistant National Secretary
- Mr Gary Keane, National Official (Retired)

*Australian Maritime Safety Authority Board*

- Mr Stuart Richey AM, Chairman
- Mr Mick Kinley, Chief Executive Officer

## *Monday, 11 November 2019*

Australian Parliament House
Parliament Drive
Canberra

*Australian Maritime Safety Authority*

- Mr Mick Kinley, Chief Executive Officer
- Mr Brad Groves, General Manager, Standards Division
- Mr Clinton McKenzie, General Legal Counsel
- Mr Allan Schwartz, General Manager, Standards Division