Committee Briefing Note Michael Kingston

The Joint Committee on Transport and Communications Networks meeting on 29 January 2021 regarding Pre-legislative scrutiny of the General Scheme of the Merchant Shipping (Investigation of Marine Casualties) (Amendment) Bill 2020.

This briefing note should be read in conjunction with:

1. Letter of Michael Kingston and Ciaran McCarthy B.L dated 4th January 2021 (already received by Committee –but accessible via this link);
2. Report of Marine Hazard Limited' *'**Report into the Operation and Effectiveness of the Marine Casualty Investigation Board (MCIB)*** dated 4th January 2021 (already received by Committee –but accessible via this link);
3. 1998 Report of the Investigation of Marine Casualties Policy Review Group; (accessible via this link)
4. Minister Eamonn Ryan's letter requesting waiver dated 18th December 2020 (already received by Committee –but accessible via this link); and
5. Commentary of Michael Kingston and Ciaran McCarthy on Draft Heads of Bill attached herewith.

1 Executive Summary

1.1` In this document we outline the issues with the construction of the MCIB as it stands, as how it is organised falls short of what was intended in its establishment, how it fails to meet the standards set out in International and EU law and does not meet the standards of other administrations or even the other accident investigation units in the Transport Department. It also falls short of what the public would expect by even the most casual observer.

1.2 Currently, the MCIB is run by a part-time board and investigations are carried out by part-time investigators. This model is doomed to fail and can never improve from the low bar that has been set. By law, the board must rotate. The investigators are also appointed to a panel on a short-term basis, with minimal supports, cooperation, or training. They are, also, by the nature of their other work, mainly compromised. The quality of reports has been poor, the recommendations poorly thought out, and on the whole, are regarded by the maritime industry as very poor. This is to be expected as there is no investment or motivation to set high standards. How the Board as it stands, or in the Proposed Act could promptly and correctly respond to a major incident at home or overseas on an Irish vessel is impossible to see. Such an incident would lead to compounding an already embarrassing situation on the international stage.

1.3 This has caused legal issues for the department, repetitional damage and untold stress to families of victims at their most difficult times.

1.4 This Briefing Note will endeavour to show why a permanently staffed, competent investigation unit, similar to Aviation and Rail, and like most other countries' Maritime Sector, is the only way to address Maritime Safety seriously, that will rectify the failures of the past.

1.5 Minister Ryan has a great opportunity now to do the right thing in resourcing a proper, permanent Maritime Investigation Unit. The cost of running such a unit for a year would be equivalent to the cost of running our coastguard for just a few days. It is obvious that such an investment is not just appropriate but justified and desperately required.

1.6 As an over arching point Maritime matters have come in to sharp focus recently due to the Covid-19 pandemic and Brexit, reminding us that we are an island and depend on the sea for trade, transport, food and leisure. This arena is constantly developing and evolving with leisure use growing, offshore renewable and green energy plans and new shipping routes being regularly announced. It is entirely appropriate that we should constantly seek to improve on matters of safety by having proper, full-time, accident investigation unit in place to support our other Maritime safety infrastructure in this growing sector.

2. Alleged 'Lacuna' Situation

2.1 It is very important that it is understood that, although the Chief Surveyor and Secretary-General or his/ her nominee have had to resign from the Board, that does not mean that it cannot technically function in the interim whilst this legislation is being dealt with. A rush, therefore, will only create another mess.

2.2 To assist the Committee here is a link to the Merchant Shipping (Investigation of Marine Casualties) Act, 2000

Under Section 16 of the current Act (1) *'The Board may, from time to time, engage such consultants, advisers and investigators …as it considers necessary for the performance of its functions and any fees due to a consultant or adviser or investigator.. so engaged shall be paid by the Board out of moneys made available by the Oireachtas'*.

As we know this sudden urgency has been forced by the CJEU Judgement on 09 July 2020. Even then it has taken an inordinate period to sort this out and experts could have been consulted about the legislation months ago. As we know (paragraph 2.2.4 of MK letter 4th January) the Department first received correspondence in July 2015), five and a half years ago.

This urgency is ill-thought through, and the legislation needs to be correct.

2.3 So in the interim nothing is stopping MCIB hiring an experienced seafarer / investigator or perhaps requesting a secondment from a similar organization such as the MAIB in the UK, or elsewhere in Europe to 'run' the situation in the interim. There are experienced individuals in Ireland who could do this.

2.4 This suggestion could be made to the Minister to remind him of this provision and to Michael Kingston for elaboration.

3 1998 Report of the Investigation of Marine Casualties Policy Review Group

3.1 It is very important that the Committee understand the extensive work of the Investigation of Marine Casualties Policy Review Group initiated by Sean Barrett T.D in 1996, that was highlighted by Dr Michael Woods when introducing the current Act in Dail Eireann on 27th January 2000,[1] as referenced in M. Kingston's letter of 4th January at paragraph 3.1. Understanding what has happened in practice under the Current Act is essential in order to understand the accompanying commentary regarding the Current Proposed Act, and as referenced in paragraph 4 herein, i.e. - why the failings need to be addressed. It is important to remember that the 1996 - 1998 Review Group carried out a lengthy and expensive consultation at a great expense to the Irish taxpayer. Subsequently, the issues identified, surrounding the failure in the approach to investigations in the previous decades are highly relevant to the analysis of the Proposed Act. I will do my best, in this limited time available, to assist the Committee in understanding these issues.

3.2 Independence essential

3.2.1 The Report analysed international systems, across the world, and recommended that the system needed to be 'independent'.

3.2.2 *"some parties commented that it is imperative that a marine casualty investigation system should be independent and impartial"* (4.15 page 57)

3.2.3 *"The Group Recommends the establishment of an 'independent' marine casualty investigation Board"* (Recommendation 7 Page 8).

3.2.4 It is clear to all concerned in the Maritime community and generally, that the investigator needs to be independent of the regulator. The main purpose of such an investigative mechanism is to find out every aspect of an accident in order to make recommendations to prevent it from happening again. Critical to such investigations is the analysis of the regulations surrounding the incident: Were they suitable? Could they be improved? Were they enforced properly? As all maritime safety regulation is set by the Transport

[1] https://www.oireachtas.ie/en/debates/debate/dail/2000-01-27/5/

Department this effectively means that MCIB Board Members have been investigating their own work and have been (or not as the case may be) making recommendations to themselves.

3.2.5 The requirement for independence was clear international best practice when the Review Group carried out their work. It is important that the Committee read paragraphs 3.28 and 3.29 of the 1998 Report:

3.28 The law and practices on marine casualties in the UK were radically altered with the enactment of the Merchant Shipping Act, 1988 and the establishment of the Marine Accident Investigation Branch (the "MAIB") in July, 1989. The MAIB is an independent body which investigates marine casualties. It is distinct from the Marine Safety Agency which regulates safety.

3.29 The purpose of the MAIB is to investigate casualties involving or occurring on board UK-registered ships worldwide and any ship within UK territorial or internal waters. The establishment of the MAIB meant that the regulation of safety was divorced from the investigations of marine casualties: safety regulation became a matter for what is now the Marine Safety Agency ("MSA") while marine casualty investigation is a matter for the MAIB. The MAIB is under the direction of the Chief Inspector of Marine Accidents. The MAIB is a distinct and separate branch within the Department of Transport. The Chief Inspector of Marine Accidents reports directly to the UK's Secretary of State for Transport (i.e. the Chief Inspector reports directly to the Minister and does not report within the civil service structure). This is for the purposes of ensuring the independence of the MAIB. Furthermore, the MAIB is based in Southampton as opposed to London where the Department of Transport is based. It is understood that the purpose of this geographical separation is to further enhance the separateness of the MAIB and the Department.

3.2.6 The MAIB was established following the recommendations of the public enquiry after the Herald of Free Enterprise accident (Zeebrugge tragedy) in March 1987 with the loss of 193 people. It was deemed essential to separate the 'Regulator' from the 'Accident Investigator'.

3.2.7 The Review Group also looked at other jurisdictions, but the above example demonstrates the obviousness of the need for total separation. The Group's recommendation was that

"the Irish regime must be operated in accordance with best international practice and should not unnecessarily depart from such practices" (Recommendation 18, page 9)

The Group stated in their letter to then Minister Michael Woods on 29 May 1998 (page 5)

"the opportunity now exists to introduce legislative and procedural reforms to ensure that, as we enter a new millennium, Ireland's marine casualty investigation regime conforms with the best international practice while meeting the needs of the Irish marine community"

They went on to say in Recommendation 29 and 30 (page 10):

29. Ireland should take all appropriate steps to give effect to the IMO's Code for the Investigation of Marine Casualties and Incidents which was adopted by the Twentieth Assembly of the IMO;

30. any further amendment of the Irish marine casualty investigation system should be in line with the IMO's recommended policy and practice on investigations;

3.2.8 Unfortunately, the MCIB was defeated before it even started by putting the Chief Surveyor and Secretary-General or his/her Nominee into the draft 2000 Legislation, with the Group inexplicably going against their own findings, and declaring that:

"given the small size of the administration in Ireland, this notion was deemed too impractical" (5.8 page 61); and

"Given the limited resources and the relatively small maritime community such a regime would be inappropriate in the Irish context" (5.21, page 64)

3.2.9 This approach is quite extraordinary, and amounts to an extraordinary dereliction of duty to the Irish maritime community, and it must be questioned as to how the Group was swayed into this total contradiction vis a vis independence, with attention by the Transport and Communications Committee as to who was on the Group:

COMPOSITION OF THE GROUP

1.3 The Group was composed of:

Vincent Power, Solicitor, Partner, A&L Goodbody Solicitors (Chairman of the Group);

George O'Doherty, Maritime Safety Division, Department of the Marine and Natural Resources (Secretary to the Group);

Edwin Alkin, Legal Advisor, Office of the Attorney General;

Tony Fitzpatrick, Assistant Principal, Maritime Safety Division, Department of the Marine and Natural Resources;

Capt. James Kelly, Chief Surveyor, Marine Survey Office;

Capt. Liam Kirwan, Director, Irish Marine Emergency Service;

Seamus McLoughlin, Deputy Chief Surveyor, Marine Survey Office;

Dermot McNulty, Director, P&I Shipping Services Ltd., Dublin;

Brendan Neville, Assistant Director General, Health and Safety Authority; and

Mary Spollen, Manager, Legal and Marine, Irish National Petroleum Corporation.

3.2.10 For whatever reason in the Transport Department, as demonstrated by the European Judgment, there is an inherent cultural refusal to 'let go' of maritime accident investigation and do the right thing. Now is the time to address this cultural problem head-on. I remind the Committee of paragraphs 2.2.1 – 2.2.8 of Michael Kingston's letter of 4th January 2021. It is clear that the Department knowingly deviated from international best practice, deliberately breached the EU Directive when transposing it in Irish law in 2011 and avoided correcting the position when instructed to by Minister Noel Dempsey in 2009.

3.2.11 The inexplicable move to put the Chief Surveyor and Secretary-General or his/her nominee on the Board by the Review Group amounts to a waste of taxpayers' money both in terms of the actual cost of the report itself, and in relation to the subsequent repercussions. We all know that best practice does not amount to the Irish regulators investigating themselves, and it was clearly understood by the Group before going against themselves in the Current 2000 Act. It can now in hindsight be described as a failed report on this fundamental aspect alone. However, the report's preceding findings and recommendations are still extremely important and stand.

This issue of this failure could be put to the Minister and to Michael Kingston for elaboration.

3.3 Current Best Practice Internationally

3.3.1 The whole concept of a Board, with part-time Board Members that have no maritime experience needs to be changed. What is required is a Marine Accident Investigation Unit, with a Principal Investigator. I refer to paragraph 2.2.5 and 2.2.6 of M. Kingston's letter wherein it is explained that this proposal was made, to the point of a Job Specification prepared in 2010, but never actioned by the Department. Below, I refer to a comparison with Aviation and Rail, which have a separate Unit.

3.3.2 The MAIB in the UK, as referenced in paragraph 2.2.5 above involves a Chief Inspector who heads up the Unit and a team of investigators with relevant competences, which I elaborate on below. The MAIB Chief Inspector reports directly to the Minister, with no political interference, and is thereby empowered to make all operational decisions. The offices are separate, in Southampton.

3.3.4 Many other countries operate similar models such as Iceland, Finland, and so many others. Sweden goes a step further and by-passes the Transport Department altogether, reporting to the Ministry for Justice, which makes great sense.

3.3.5 The Netherland go a step further again and have an Independent 'National Safety Board' encompassing Transport, Defence, Healthcare, and other areas, thus avoiding any political interference in accident investigation. This would be an ultimate aim in Ireland,

3.3.6 To echo what the review Group said to Dr Michael Woods and ought to have done, but did not, 'now is the time to *ensure that Ireland's marine casualty investigation regime conforms with the best international practice while meeting the needs of the Irish marine community"*

3.3.7 Accordingly, we should in the very least follow the MAIB model in the Proposed Act, with a view to, at a later date creating a 'Dutch' system.

This issue could be put to the Minister and to Michael Kingston for elaboration.

3.4 Competence of Investigators

3.4.1 It was clearly identified in the 1998 Report what competence Investigators should have:

3.4.2 *"Marine casualty investigation is a complex and complicated combination of skills. Such investigation requires various skills including the three main marine disciplines (i.e., marine engineering, nautical science/navigation and naval architecture). Investigations may require input from other disciplines as the need arises"* (1.17, page 17)

"At present marine investigations in the MSO are: (a) former ship's masters; (b) former chief engineers; or (c) naval architects" (2.63, page 38)

3.4.4 Whilst an obvious conflict of interest existed, in MSO Surveyors investigating their own colleagues work, at least at the outset, from 2002 until 2010 before an 'MCIB Investigators Panel' was established, there was 'competence' in the skill of MSO investigators who could rely on the experience of their colleagues. (See Marine Hazard Report, Section 6, pages 23-25).

3.4.5 As can be seen from Marine Hazards Report when the External Panel was created in 2010 competence was lost. In effect panel investigators were left out on a limb, and it raised all sorts of further conflicts as panel investigators are drawn from industry, with MCIB investigations being only a small part of their income, their mainstay income derived from the very industry they are charged with investigating, working as surveyors on behalf of fishing vessel owners, merchant vessel owners, or insurers. Their tenure on the MCIB panel is for a short period (3 years) and their ability to build up knowledge of accident investigations is short-term, and they are easily dispensable, as per Marine Hazards Report (paragraphs 6.3.1 and 6,3,2, Page 24):

"6.3.1 After 2010 the MCIB contracted commercial surveyors to carry out investigations. The significant differences between the two groups of surveyors are contrary to what might be expected. It would be reasonable to think that after 2010 investigations would be more independent. However, MSO surveyors had been less receptive to any request to alter their initial reports. They were not financially dependent on the MCIB in any way and most could not be cajoled into making changes to a report.

6.3.2 By contrast the independent commercial surveyors post 2010 have alleged that if reports did not satisfy the Chief Surveyor, they would not get further commissions from the MCIB. "

This issue could be put to the Minister and to Michael Kingston for elaboration.

3.5 Adequate Resources

3.5.1 It is clear from the 1998 report as per recommendation 14, Page 9 that investigators must have adequate resources, both technical and financial:

14. investigators engaged in marine casualty investigation should have access to all reasonably necessary resources (whether internal or external, financial or technical) to adequately conduct investigations;

3.5.2 However, this has not happened. It is worth comparing, indeed essential when considering solutions and amendments to the Proposed Act, marine investigations with accident and rail in Ireland. The expenditure of the MCIB in 2019 as per the Annual Report is as follows:

Statement of Income & Expenditure & Retained Revenue Reserves

Statement of Income & Expenditure and Retained Revenue Reserves for the year ended 31st December, 2019.

	Notes	31 Dec 2019 €	31 Dec 2018 €
Income			
Oireachtas Grants (Vote 31, subhead C3)		200,590	237,392
		200,590	237,392
Expenditure			
Staff Salaries	4	100,442	122,623
Board Members Fees	5	20,948	20,948
Printing, Postage and Stationery		6,998	25,778
Advertising		-	4,933
Website Design		1,137	584
Accident Investigation Expenses	3	27,864	40,199
Office Expenses		480	-
Safety Equipment		503	-
Translation		1,534	-
Maps/Charts		1,937	1,273
Legal & Professional Fees		13,537	10,668
Accountancy		7,134	8,364
Audit Fees		6,000	7,000
Bank Charges		264	401
Training		2,400	3,250
Sundry Expenses		810	855
		191,988	246,876
Surplus/(Deficit) for the Year		8,602	(9,484)
Accumulated Deficit 1 January		(51,331)	(41,847)
Accumulated Deficit 31 December		(42,729)	(51,331)

3.5.3 There were 10 incidents investigated in 2019 with 6 fatalities. Staff Salaries expenditure amounts to E100,442 for clerical staff, and only E27,864 of the total expenditure of E191,988 was spent on the investigations. This amounts to an average of Euro 2,786 per investigator in the field. This is a ridiculously low figure for the investigation of someone's death, and the consequence is the poor quality of reports, as highlighted by Marine Hazard's Report. (see in particular paragraph 6.3.5 and 6.3.6)

3.5.4 The following is a comparison with the Ireland's rail and aviation permanent investigatory units, headed by a principal investigator:

Air Accident Investigation Unit		Rail Accident Investigation Unit		Marine Casualty Investigation Board	
	Approximate Salary		Approximate Salary		Approximate Salary
1 x Chief Aeronautical Officer	**E110.00**	1 x Chief Accident Investigator	**E110.00**	1 x Higher Executive Officer	
1 x Inspector of Air Accidents	**E 80.00**	3 x Senior Investigators	**E240.00**	1 x Executive Officer	
7 x Aeronautical officers	**E560.00**	1 x Clerical Officer		3 x Clerical Officers	
1 x Higher Executive Officer					
1 x Executive Officer					
1 x Clerical Officer					
Total Spend on Full time investigators	**E 750,000**	**Total Spend on Full time investigators**	**E 350.00**	**Total Spend on Full time investigators**	**0**
Fatalities 2019 0		**Fatalities 2019 0**		**Fatalities 2019 6**	

3.5.5 Leaving aside Executive and Clerical Officers, the total spent on investigators in the field for 2019, using approximate figures by Departmental pay grade for Rail and Aviation, is as follows:

Aviation	E 750,000	**0** Fatalities
Rail	E 350,000	**0** Fatalities
Marine	E 27,863	**6** Fatalities

3.5.6 When analysing these statistics, it is also important to remember that there are many incidents that, despite the MCIB's statutory mandate to do so, have not been investigated as set out clearly at paragraph 4.2 of Marine Hazard's Report, so the actual annual spend per death in the marine sector is negligible. This, I am sure Committee Members will agree, is a ludicrous situation and demonstrates an unbelievable and incorrect approach to the significance of maritime in Ireland. There are fishermen who have died, and their deaths have, basically, not been worth looking into, nor their families' questions in grief, not to mind the statutory obligation to investigate to learn lessons and prevent further deaths. See Marine Hazard Report, paragraph 4.2 (page 19)

3.5.7 In addition to this clear and obvious shortfall in maritime, aviation and rail accident investigators, due to their full-time role, have built up immense corporate knowledge and are on hand to respond immediately to accidents. They can discuss issues with each other and think collectively. It is small wonder that through this professional approach in their 'investigation units' they have a very good safety record.

This issue could be put to the Minister and to Michael Kingston for elaboration.

3.6. Ongoing Training

3.6.1 To compound this, the 1998 Report clearly recommended that, in addition to investigators' competence, they must receive on-going training as per Recommendation 14 (Page 9) and paragraph 5.52 (Page71).

14. investigators engaged in marine casualty investigation should have access to all reasonably necessary resources (whether internal or external, financial or technical) to adequately conduct investigations;

TRAINING OF INVESTIGATORS

5.52 There is a clear need for comprehensive initial and on-going training of marine casualty investigators. The training should relate to interview techniques, investigation techniques, report writing, on-going technical developments, standards, best maritime practices, legal issues and related matters. This training may take the form of courses, consultations and dialogue with their counterparts in other administrations nationally and internationally. Such training should be adequately funded and resourced.

3.6.2 I will set out here the IMO Resolution (A.1075(28) Adopted by IMO States on **4 December 2013**, reflecting the requirements of EU Directive 2009/16 for the minimum qualification for inspectors

GUIDELINES TO ASSIST INVESTIGATORS IN THE IMPLEMENTATION OF THE CASUALTY INVESTIGATION CODE (RESOLUTION MSC.255(84))

ANNEX XI

MINIMUM CRITERIA FOR INSPECTORS

(referred to in Article 22(1) and (5))

1. Inspectors must have appropriate theoretical knowledge and practical experience of ships and their operation. They must be competent in the enforcement of the requirements of Conventions and of the relevant port State control procedures. This knowledge and competence in enforcing international and Community requirements must be acquired through documented training programs.

2. Inspectors must, as a minimum, have either:

(a) appropriate qualifications from a marine or nautical institution and relevant seagoing experience as a certificated ship officer holding or having held a valid STCW II/2 or III/2 certificate of competency not limited as regards the operating area or propulsion power or tonnage; or

(b) passed an examination recognized by the competent Authority as a naval architect, mechanical engineer or an engineer related to the maritime fields and worked in that capacity for at least five years; or

(c) a relevant university degree or equivalent and have properly trained and qualified as ship safety inspectors.

3.6.3 This has not happened in practice. Having spoken to MCIB investigators, it is clear that they have no proper training, and very little support when requesting documents from the MSO when carrying out investigations, little information in the way of policies' application, or checklists. The investigators indicate that they have just received a limited one-day seminar with other investigators and were handed a few documents with legislation to read.

3.6.4 And this is supported by the MCIB Annual Report Financial figures as follows:

	Annual Expenditure	**No of Investigations**	**Accident Investigation Expenses**	**Training**
2019	191,988	10	27,864	2400
2018	246,876	5	40,199	3250
2017	270,539	5	97,005	0
2016	233,371	15	57,565	1194
2015	315,092	7	102,383	480

3.6.5 The paltry sums spent on Training is a total failure to implement the findings of the 1998 Report, or follow the above-mentioned IMO regulation, and is unfair to the investigators. Adequate Resources includes training support. Particularly, when these Investigators are operating alone. Contributing to this failure is the lack of international investigative understanding, dealt with further below.

3.6.6 It is important by way of comparison to explain to the Committee that upon joining the MSO as a surveyor, even though the individual would be a Master Mariner, Chief Engineer, or Naval Architect with years of experience, they still have to undergo 12 months training before they receive a warrant to operate as a Surveyor to survey domestic vessels, and a further 12 months before they can carry out Port State Control Duties to inspect foreign ships.

This issue could be put to the Minister and to Michael Kingston for elaboration.

3.7 International Interaction – Marine Accident Investigators International Forum (MAIIF)

3.7.1 To compound this failure, it was additionally stated in the 1998 report that Ireland must attend international meetings of investigation experts as per 5.57, (page 72) of the 1998 report, and the aforementioned paragraph 5.52 of the 1998 Report:

5.57 The Group believes that a forum of EU Member States Chief Inspectors would be a very useful forum for the exchange of information and experience. A comparable model would be the Committee of Senior Labour Inspectors which is operated by Directorate-General V of the European Commission.

3.7.2 Whilst it does not take the 1998 report to tell us this, the simple fact is that the MICB Board Members or Investigators do not attend the MAIIF meetings. One Surveyor did attend and pro-actively attempted to educate the MCIB and Investigators (fellow MSO Surveyors) between 2003 – 2008.

3.7.3 In preparation for this Committee Hearing, the General Secretary of MAIIF, Captain Steve Clinch, confirms that Ireland (MCIB) have never paid a subscription to MAIIF, and have not attended since 2008. This is an appalling approach.

This issue could be put to the Minister and to Michael Kingston for elaboration.

3.8 Competence of Chairperson in Maritime Matters

3.8.1 The 1998 Report was also very clear about the competence of the Chairperson of the Board stating at paragraph 5.22 (Page 64) that:

"The Chairperson should have some understanding of maritime matters"

3.8.2 [redacted]

3.8.3 [redacted]

[2] I welcome Ms Claire Callanan. The...: 30 Jan 2019: Oireachtas Joint and Select Committees (KildareStreet.com)

[redacted]

3.8.4 [redacted]

3.8.5 What all this amounts to, in light of our task to make the proposed legislation fit for purpose, is that a part-time Board does not work. It has no real authority because of such a dearth of maritime knowledge and experience, and it needs to be disbanded, in favour of the aforementioned Maritime Investigation Unit.

3.9 Implementation and Log of Recommendations with Yearbook Issued each year by MCIB and Booklet by Department

3.9.1 The Review Group's focus on this issue and the reality of what has happened in practice is extremely important for the Committee to understand.

3.9.2 The Review Group stated at paragraph 2.49 (page 33) and 2.52 (page 34) as follows:

Dissemination of Lessons

2.49 The purpose of marine casualty investigation is to determine the cause of a marine casualty so as to try to ensure that a similar casualty does not recur (in so far as it is possible). It is therefore vital that the lessons of such an investigation are disseminated expeditiously, appropriately, conveniently and thoroughly among those who need to learn the lessons of the investigation.

Implementation of Recommendations

2.52 It is recognised that the lessons of a casualty report must be learned and acted upon. At present, if a report makes recommendations, there is no formal system to monitor the implementation (if any) of those recommendations. Nor is there any formal system for the assessment (including the assessment of the feasibility and cost) of recommendations. Nor is there any comprehensive publication containing details of all of the recommendations made over time.

3.9.3 The Review Group went on to state at paragraphs 4.11 and 4.13 (page 56) as follows:

4.11 It was believed that the lessons learned in an investigation should not be lost. Instead, the information should be compiled in a centralised forum. In this regard, it was suggested that Ireland should follow the example of jurisdictions which have established databases so as to study trends and advise the marine community of the lessons learned over time.

4.13 The report of a marine casualty investigation will normally include specific recommendations. For example, the report may recommend that a particular practice be discontinued or that a new practice be adopted. The view was expressed that it is imperative that all appropriate and practical recommendations of an investigation are implemented speedily and effectively. There is little point in investigating casualties and making recommendations if the recommendations are not implemented. It was stated by some parties that there must be an adequate system of monitoring so as to ensure that recommendations are implemented.

3.9.4 The Review Group went on to state at paragraph 5.54 (page 71) as follows:

IMPLEMENTATION OF THE LESSONS LEARNED FROM A CASUALTY

5.54 The Department should ensure the prompt implementation of the recommendations which are made by the MCIB. The MCIB should not make recommendations unless such recommendations are reasonable, feasible and appropriate. The MCIB should monitor the implementation of the recommendations and comment as appropriate in the annual report/yearbook on marine casualty investigations.

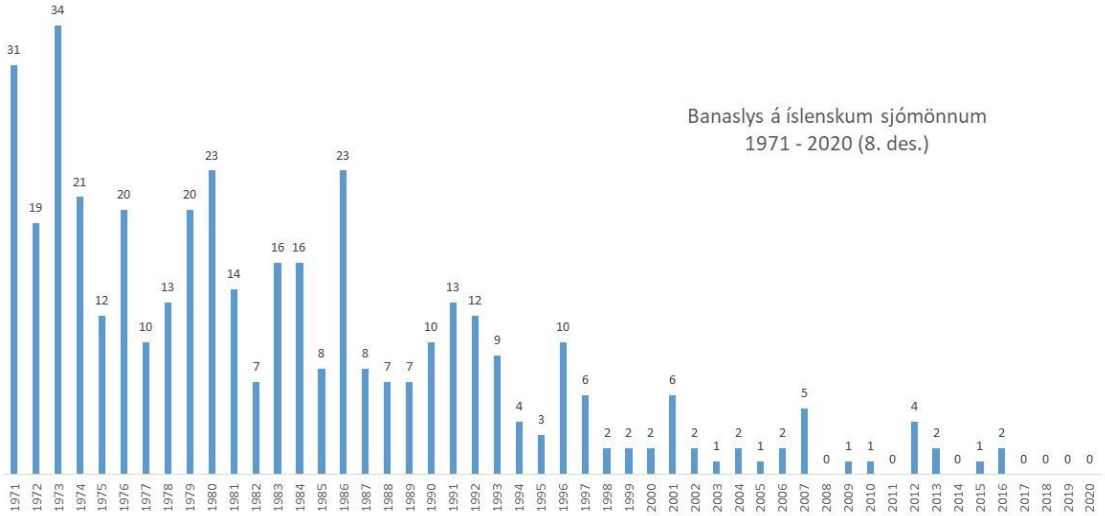
3.9.5 The 1998 Report also recommended details of what the MCIB should set out annually regarding recommendations at paragraph 5.80 (page 76):

YEARBOOK

5.80 The Group recommends that the MCIB should produce an annual publication summarising the reports of investigations and relevant Marine Notices published during the year. This publication would contain general safety advice as well as specific lessons gathered from casualty investigations over the year. There should be a specific section in the yearbook relating to the fishing industry. The reports should not contain the names of the individuals involved. The yearbook would also act as the annual report of the MCIB.

3.9.6 It is vital that recommendations are acted upon, and a logging system kept. There are serious shortcomings in practice. I refer the Committee to Section 9 (pages 29-34) of Marine Hazard's Report which sets out in detail how lessons have failed to be learned and recommendations have not been acted upon. The Committee should also look at Section 2 (pages 5 -6) of M. Kingston's letter 4th January 2021 which refers to serious issues regarding recommendations and information provided by former investigators, and current investigators. The letter links to a Letter to Garda Commissioner Harris dated 08 January 2020.

3.9.7 It is also, in this regard important to draw on international experience. One of the leading nations in tackling maritime accidents and the approach to interacting with stakeholders is Iceland. The following graph demonstrates how Iceland have reduced accidents, radically overhauling their approach, working with industry and implementing appropriate regulations, building on recommendations. The graph, evidencing reduction in death in all maritime activities, speaks for itself.



3.9.8 It is also important to point out that the Section of the Transport Department that deals with regulatory issues and enforcement, the Marine Survey Office, is underfunded, and in

fairness to that office it does not have the resources to achieve what it could. One of the key inputs for Iceland's achievement has been appropriate financial resources. The Irish Coastguard has approximately 83 staff, and an annual cost of approximately Euro 4,000,000.00 and an additional Euro 40,000,000.00 to runs assets including ICG helicopters. The MSO has 33 staff, of which approximately 75% are administrative, with the balance inspecting vessels and enforcing regulation. The MSO's annual staffing cost is approximately Euro 3,000,000.00. It would be highly advantageous to reduce costs surrounding accidents, including the very expensive use of ICG helicopters, if further and appropriate funding was provided to the MSO. Proper regulation and proper implementation of regulation prevents accidents, and huge cost associated with such accidents, as evidenced in Iceland.

3.9.9 It is also critical that we have the correct regulatory structure in place for our maritime sector to prosper.

This issue could be put to the Minister and to Michael Kingston for elaboration. In particular, what are the procedures for monitoring recommendations and their implementation to ascertain whether we are saving a life or not, both by the MCIB and the Department, with reference to Marine Hazard's Report, and the issues raised in M Kingston letter both 4th January and 08 January 2020.

3.10 Department 'Casualty Management Approach'

3.10.1 There is particular emphasis on the concerns of the bereaved in the 1998 Group Report, as referenced at paragraphs 3.2 and 3.3 of M. Kingston's letter dated 4th January 2021 (pages 7-10), where Dr Woods emphasis on this aspect of the Group's findings was highlighted on 27th January 2000 when introducing the Current Act in Dail Eireann. The following sections of the 1998 Report are important, in addition to several other references to the importance of this issue:

3.10.2 Paragraph 2.52 (page 34) states as follows:

Marine Casualty Management

2.51 The marine casualty investigators establish the technical cause of the casualty. However, they are not trained (nor would it be appropriate) in such skills as counselling grieving relatives. The Group is mindful of the needs of bereaved families and injured persons and makes recommendations to deal with the situation below in Chapter 5. Casualty management, as such, fell outside the scope of the remit of this Group and would be best dealt with separately by the Department which may need to examine the issue separately.

3.10.3 Paragraph 5.79 (page 76) goes on to say:

RELATIONS BETWEEN THE DEPARTMENT AND THOSE INVOLVED IN A CASUALTY

5.79 The Group recommends that the Department assigns at least two of its staff to act as liaison officers with those involved in a casualty - these staff members would not be involved in the investigation. These staff members would help relatives to understand the investigation process. The Group supports the establishment by the industry of a support group which could advise relatives on financial/social welfare matters etc.

3.10.4 This has not happened in practice. The thought for the victims' family has been a low priority by the Department. Moreover, the Department have constantly used Section 8 of the 2000 Act to dismiss victims' families appeals for help, as per Section 8, (page27) of Marine Hazard's Report. Multiple letters of reply from the Ministers' office contain the following or a similar paragraph: *"Section 8 of the 2000 Act states that the board [MCIB] shall be independent of the Minister in the performance of its functions and it is independent of any other person or body whose interest could conflict with the functions of the board [MCIB], therefore I regret that I am not in the position to intercede on your behalf...."*

3.10.5 This section of Marine Hazard's Report is 1.5 pages, and it is very important that the

Committee read it in conjunction with the recommendations of the 1998 Review Group.

This issue could be put to the Minister and to Michael Kingston for elaboration. In particular, what are the procedures for helping bereaved families within the Department, what 2 officers are responsible for this following the 1998 Report recommendations, with reference to Marine Hazard's Report, and the issues raised in M Kingston letter of 4th January.

3.11 Memorandum of Understanding with the HSA

3.11.1 The 1998 Report at paragraph 5.13 (page 62) states that there should be coordination with the HSA:

5.13 Given the potential overlap of jurisdiction between different agencies, the Group recommends that the MCIB and the Health and Safety Authority should adopt a memorandum of understanding on the casualties which each would investigate between the two bodies so as to ensure efficient and effective investigations.

3.11.2 It is understood that this is not happening in practice. As it is a clear, and indeed an obvious, recommendation, it is a very important consideration for any new investigative Board /

Unit, that needs to be catered for in the Proposed Act. This is especially important in light of the fact that many fishing deaths in ports have not been investigated, as per Marine Hazard's Report at paragraph 4.2 (page 19). How has this happened? Many maritime casualties involve accidents in the workplace. Such co-ordination and positive collaboration are extremely important, and indeed critical.

This issue could be put to the Minister and to Michael Kingston for elaboration. In particular, is there a Memorandum of understanding in place with the HSA

3.12 Importance of Listening to Witnesses and Correcting Reports

3.12.1 [redacted]

3.12.2 Paragraph 5.46 (page 69) of the 1998 Review Group's Report states as follows:

PRIOR CONSULTATION

5.46 If any party is about to be criticised in a report to be published by the MCIB then the MCIB must provide a copy of the report or any relevant extract to the party and afford that party 21 days in which to comment. It may be that the report's conclusions are altered by virtue of the party's comment. The party's comment should be reprinted in the report unless the party does not want its comment published and the MCIB agrees that the comment should not be published. The law of defamation should apply to any comment made in bad faith but the law on defamation should otherwise not apply.

3.12.3 It is clear that this has not happened in practice. Many errors have not been rectified following later submissions after the Investigator's Draft Report has been circulated, and this cannot be allowed to continue. Material facts that give rise to the obvious need for correction or even re-investigation have simply been ignored in the main body of the Report, the submissions just appended to the Report. This is of course directly linked to the lack of resources provided to the maritime investigative process as explained herein, and investigators simply have not had the resources required to do the job properly.

This issue could be put to the Minister and to Michael Kingston for elaboration. In particular, is there a Memorandum of understanding in place with the HSA

3.13 Use of MCIB Reports in Litigation

3.13.1 The 1998 Review Group recommended as follows at paragraph 5,17 (page 63)

> 5.17 The Group recommends that neither (a) the reports of investigations nor (b) the investigation process itself should be used for the purposes of founding a claim for compensation or pursuing retribution.

3.13.2 I refer Committee Members to Section 11 of Marine Hazard's Report (page 37), and Appendix III (page 49) which is self-explanatory. The MCIB and the instigation of a report were used by the MSO as a median to leverage their position in Court litigation. This is a very serious conflict of interest. Additionally, the 1998 Policy Review Group's recommendation is well-founded in law. The Proposed Act must ensure that this is set out clearly, as it compromises the independence of the investigative process that ensures the 'no blame no fault' principle is not undermined. If not, this may preclude key witnesses coming forward in investigations because of fear of self-incrimination, thereby preventing us from getting to the bottom of accidents and learning from them.

This issue could be put to the Minister and to Michael Kingston for elaboration.

3.14 Codification of Irish Maritime Law

3.14.1 This is an important issue as the Proposed Act seeks to include matters concerning updates to the Safety of Life at Sea Convention (SOLAS1974) dating back to 2014, not relevant to the Investigation Code. This is a further example, not only of our failure to implement international regulation in a timely manner but of the hap-hazardous way in which we are doing it. There needs to be an immediate review of all Irish maritime regulation. I refer to paragraph 5.4 and 5.5 of M. Kingston's letter 04.01.2021.

3.14.2 In this regard it is noteworthy to read Recommendation 36 (page 11) of the 1998 Review Group, and paragraph 5.68 (page 74):

> 36. the new legislation should not conflict with other merchant shipping legislation and, in time, a consolidation statute would be appropriate to bring together all Irish maritime law;

MARINE LEGISLATION

5.68 The Bill proposed in this report will involve the repeal of certain provisions of the Merchant Shipping Act, 1894. The 1894 Act was a codification statute which provided a convenient single source of the statutory rules on shipping. The 1894 Act has been amended over time such that there is now no single source of statutory rules. It is acknowledged that this Bill will add yet another legislative instrument but it is recommended that a single codification statute is needed in Ireland to replace the existing panoply of maritime legislation in any event.

3.14.3 That was 23 years ago and here we are in the same position. It is also important for the Committee to understand that we are about to be audited by the United Nations International Maritime Organization as to how we are implementing their regulation. Accordingly, it is very important to get the Proposed Act right and be seen to be getting it right.

This issue could be put to the Minister and to Michael Kingston for elaboration. In particular why it is that Ireland cannot get its house in order in relation to International Maritime Regulations, ending up instead with CJEU Judgments against us, and embarrassing us on the world stage, as well as the adverse consequences for Irish society.

And how are we going to deal with the IMO audit given all these failings.

4 Comments on Proposed Heads of Bill

In light of the above analysis on the Current Act's failings and its intentions in the 1998 Review Group Report, it is a clear recommendation that the Board needs to be disbanded and an independent Marine Investigation Unit established. This will result in further amendments to the Proposed Act and I submit that the Committee give further consideration to the issue.

In the meantime, I attach a Commentary on the Heads of Bill.

Please do not hesitate to contact me for further information in advance of the Meeting.

My mobile number is 083 4409 735.

I will be accompanied by Barrister, Ciaran McCarthy.

We are at the Committee's disposal to help in any way, and indeed the Departments.

With king regards,

Yours sincerely

Michael Kingston

28. 01.2021