Nō te rere moana Aotearoa
MARITIME NEW ZEALAND

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22 April 2024

Marie
fyi-request-25856-79bf59f4@requests.fyi.org.nz

By email
Our ref: F34351

Dear Marie

Request for information regarding investigations

I refer to your request of 23 February 2023 via the FYI site for the following information:

> *1. The policy/manual used to "triage" MTA s31 incident reports and any associated procedure manuals. I understand there is a 1-4 scale for this. Include the explanation of what each stage would entail.*
>
> *2. Please provide the previous "triage" documents/policy manuals used prior to implementing this new system.*
>
> *3. Please advise what triage ranking (1-4) that the July 2022 Riverton accident was given. MNZ said this incident didn't meet the threshold for them to investigate.*
>
> *4. Please provide investigation manual/policy and procedures documents outlining each step of an investigation, including preliminary initial enquires by a Maritime Officer. Ie Would a Maritime officer talk to the skipper before recommending to his superior to investigate.*

Response

1. *The policy/manual used to "triage" MTA s31 incident reports and any associated procedure manuals. I understand there is a 1-4 scale for this. Include the explanation of what each stage would entail.*

Attached is a document which provides guidance on Maritime NZ's triage process. The document is in draft, but is available for staff to use.

2. *Please provide the previous "triage" documents/policy manuals used prior to implementing this new system.*

There was no previous policy prior to the attached guidance, therefore we are refusing this question under section 18(e) of the Act on the grounds that the information does not exist.

3. *Please advise what triage ranking (1-4) that the July 2022 Riverton accident was given. MNZ said this incident didn't meet the threshold for them to investigate.*

The initial information we received led to us making a decision to send a Maritime Officer to make initial enquires to determine what happened. Once our initial enquires were complete we determined this was in the level 4 category, that no further action was required from Maritime NZ, and that the most appropriate action was for the harbourmaster to investigate the incident.

4. *Please provide investigation manual/policy and procedures documents outlining each step of an investigation, including preliminary initial enquires by a Maritime Officer. Ie Would a Maritime officer talk to the skipper before recommending to his superior to investigate.*

Maritime NZ does not have investigation manuals or policies outlining each step of an investigation. We are therefore refusing this question under section 18(e) of the Act because the information sought does not exist.

We hire suitably qualified Investigators with the experience to conduct investigations. Our Specialist Investigators have strong investigation backgrounds. They then train Maritime Officers in investigation – several of whom also come from a regulatory background and have conducted investigations in previous roles. All Investigators attend courses and ongoing training to ensure their methodology and skills are current and relevant to our sector.

In regards to whether a Maritime Officer would speak with the skipper prior to making a recommendation to their superior – this is managed on a case-by-case basis. In certain situations, the Maritime Officer may speak with someone involved to obtain more information before making a recommendation on any further action.

I trust this fulfils your information request. Under section 28(3) of the Act, you have the right to ask the Ombudsman to review any decisions made under this request. The Ombudsman may be contacted by email at: info@ombudsman.parliament.nz or by calling 0800 802 602.

If you wish to discuss this request, please do not hesitate to contact ministerial.services@maritimenz.govt.nz

Yours sincerely

Christine Ross
Manager, Communication and Ministerial Services

Maritime Memo Template

Purpose

1. Maritime New Zealand (MNZ) is responsible for developing and monitoring maritime safety and protection rules, and investigates maritime incidents to determine:

    1.1. Causes of an accident or incident.

    1.2. Actions needed to avoid reoccurrence.

    1.3. Actions needed to secure compliance with the law.

    1.4. Actions needed to deliver safety messages from lessons learnt.

    1.5. The response appropriate for any breach of the law.

2. The Incident Triage Guidance (the Guidance) provides high level triage principles, and a triage matrix and process to use when making decisions on whether or not to investigate incidents that have been brought to our attention.

3. The Guidance is intended to support good decision making, in support of better outcomes in respect of our focus on safe, secure and clean seas and waterways. It has been designed to:

    3.1. Facilitate transparent decision making and prioritisation of incidents/cases in line with MNZ responsibilities.

    3.2. Deliver consistency and clarity around the decision to investigate and the approach that will be taken.

    3.3. Provide a level of flexibility to account for changes in priorities and the uniqueness of each incident/case.

    3.4. Provide information to drive proactive and consistent activities.

4. We must remember that reducing harm, putting the greatest focus on the biggest risks, and using an intelligence-led process are the three important elements of our approach to compliance (and to preventing non-compliance).

5. Our monitoring, investigation and enforcement activities help to make sure that people who are not inclined to meet their obligations will do so, and we hold them to account, if they do not.

6. The Guidance complements and should be read in line with MNZ's Policy on Decision Making and Compliance Strategy including the Compliance Intervention Guidelines.

7. The Policy on Decision Making states:

> As a regulatory, compliance and response organisation, our "business" involves receiving information, considering that information, making decisions and taking action. [Para 1.1]
>
> Decisions are made, and actions taken, by people according to their job responsibilities and accountabilities, and in many cases delegations, under the laws that provide authority to Maritime NZ and its staff". [Para 1.2]
>
> Making good decisions is as much an art as a science in many cases, as we often deal with matters that are ambiguous and/or multi-faceted and/or requiring professional judgement and/or involving the balancing of risks. [Para 2.1]
>
> This [Policy on Decision Making] is applicable to all decision making relating to job responsibilities, accountabilities and delegations. [Para 3.1] [1]

8. The Compliance Intervention Guidelines ensure a risk- based, transparent, consistent, fair, and robust decision-making process is followed in addressing compliance issues.

Triaging Principles

9. We aim to undertake our triage decision making responsibilities in accordance with the following principles.

Principle	What this means
Proportionality	We aim to ensure our decisions/responses are proportionate to the issue/incident being considered and the outcome/impact that can be attained. We also aim to ensure our resources are responsibly managed so that work is assigned as proportionately as possible taking into account the capability and capacity of our staff. This means that: - matters involving serious conduct/harm will be likely always be investigated unless good reason exists not to;

[1] Policy on Decision Making Version 3. [insert link to Policy]

	- we will actively manage the workloads of our staff to ensure they are not overloaded but that we still able to progress high priority and urgent matters.
Transparency	We understand that we are a public agency. Our goal is to be as open and transparent as we can be taking into account the nature of our work. This means: - our processes, assessment criteria and decisions (where possible) are transparent so that our stakeholders know what to expect when they engage with us; and - staff know what is expected of them and are able to seek to guidance when needed.
Consistency / Fairness	We approach each incident in a consistent, fair and impartial way. This means: - our stakeholders can be confident and comfortable with the process of our decision making; - all communications are professional, both internally and externally; the people who engage with Maritime NZ have a right to be treated fairly, with respect, and to be kept informed (where possible) - staff know what they have to do and how to do it. They also know that workloads will be managed appropriately and that they will be supported to do the job expected of them. *Note: Consistency in approach does not mean the same decision will be made every time. Fairness does not mean treating every person/situation the same way.*
Flexibility	We are an evidence based, risk focused and intelligence led organisation. We must be able to adapt to changes in our environment to ensure we can address the matters with the highest priority and account to the uniqueness of each incident/case. This means: - we may need to re-prioritise and/or re-categorise our planned investigative work or specific investigation files if the situation calls for it (e.g. changes to resources, new information, emerging issues, matters of higher seriousness arising); - the Priority rating assigned to an incident may change as further information/evidence comes to ;

	- staff understand and acknowledge that their work and workload may change depending on the needs of the organisation at any given time.
Accountability	We are a public agency and must be accountable for our actions and decisions. This means: - our staff know they will be accountable for their decisions and therefore must commit to following the principles and processes provided to them; - our decisions must be based on evidence available, be robustly considered and we must document the rationale for the decisions we make (this includes decisions to investigate and decisions not to investigate). It might take a little more time to do a thorough job, but doing a 'once over lightly' can take a lot more time in the long run, not just for CSD but the wider organisation; - if our staff are unclear on what they should do – they will be accountable and seek out the information they require to do the job.

Triaging Criteria

10. Triaging involves making a decision as to whether or not to investigate and the depth to which the incident will be investigated (at least initially).

11. After initial triaging, some matters will move on to be investigated and some may not. Matters can be re-triaged at a later date, for example following additional information being received. This means the incident file can re-opened for investigation and other matters subsequently de-prioritised/closed.

12. In line with the Compliance Intervention Guidelines, when deciding whether to investigate an incident consideration must be given to:

    12.1. The seriousness of the conduct including repeat offending.

    12.2. The extent / severity / scale of actual or potential harm including to individuals, assets, organisations, and/or industry.

    12.3. The public interest to investigate including the practicality of achieving a positive outcome/impact with our intervention.

    12.4. The attitude to compliance including the knowledge and past performance of the subject/s.

13. In addition, we will consider:

    13.1. MNZ priorities and risk appetite

13.2. Wider relevance of the event

14. These criteria are incorporated into our triage matrix as 'key consequence areas' below.

Triaging Roles & Process

Triaging roles

Incident recipient (DCM or other)

15. The Incident recipient is the person who first receives the incident notification and is responsible for making a decision on whether or not to investigate. This will typically be a DCM or Principal Investigator.

16. The Incident recipient will initially triage the incident using the evidence available at the time and the triaging matrix found in this guidance. If further information is required to inform a decision the triaging process can be put on hold temporarily whilst this information is sought.

17. If in doubt assign for fact finding and reassess as further information is gathered. In this case update file notes in ETG file until decision made whether to open INV file.

18. If the Incident recipient cannot decide whether the incident should be investigated, or wants further assistance in making that decision, they should contact a member of the Triaging Group.

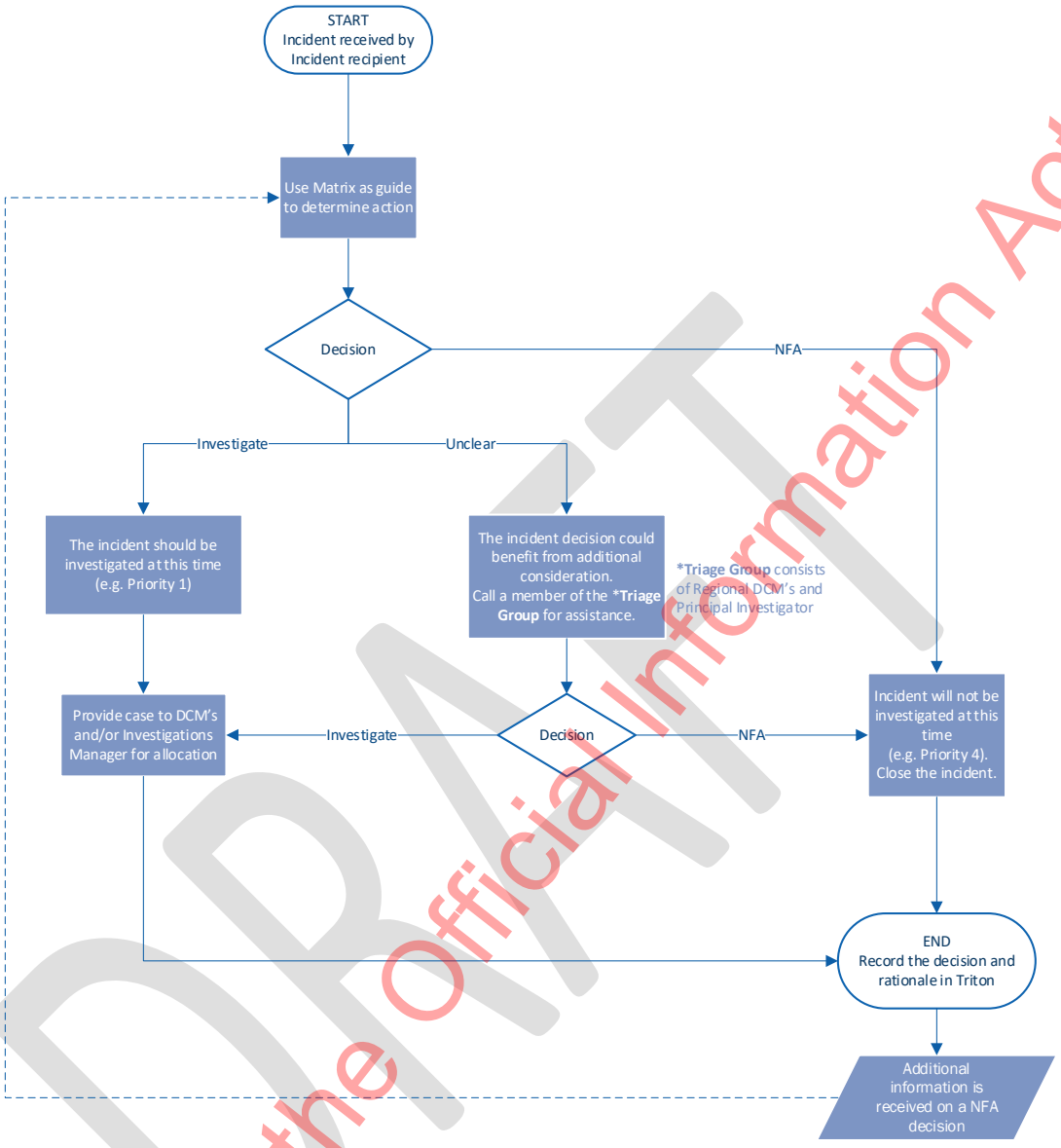
Triaging Group

19. The Triaging Group is made up of the Regional DCMs and the Principal Investigator. A member of the Triaging Group will likely be the Incident recipient when an incident is received.

20. The Group act as a resource for the Incident recipient if and when needed.

21. The Group also meets on an as needed basis to moderate and discuss triaging decisions that have been made over time. The purpose of these meetings is to develop consistency of decision making and to share learnings. These meetings can also be used to re-triage or re-prioritise incidents.

Triaging process[2]



Triaging Matrix

22. The Matrix below allows an initial priority to be assigned to an incident based on an evaluation of key consequence areas.

23. The matrix assesses each consequence against the likelihood of reoccurrence. The numbers are not added; rather the Priority Rating is based on the highest score selected for any one of the criteria. For example where a matter rates as a 3 when considering the 'people' factor, but rates as a 2 when weighed against the 'severity potential' the matter will be a Priority 2. Definitions for each consequence area are provided in **Appendix 1**.

2 As part of the Investigations process, investigations are reviewed at regular status update meetings. These meetings can result in re-prioritisation of investigations as a result of the triaging process.

CONSEQUENCE CONSIDERATIONS					LIKELIHOOD of REOCCURRANCE					
People	Assets	Environment	MNZ Reputation	Severity Potential	Practically Impossible	Not likely to occur	Could occur again	Known or likely to occur	Occurs frequently	PRIORITY
First Aid	Slight Damage	Slight effect	Slight Impact	Minor	4	4	4	3	2	
Medical Treatment	Component level replacement/repair ($10K-$100k)	Minor effect	Limited Impact	Moderate	4	3	3	3	2	
Serious Harm	Equipment replacement/repair ($100k-$5m)	Localised Effect	Local area impact	Significant	3	3	2	2	1	
Fatality	Unit level damage ($5m-$50m)	Major effect	Provincial wide impact	Major	2	2	1	1	1	
Multiple Fatalities	Multiple unit capability damage (450m+)	Massive effect	National impact	Catastrophic	1	1	1	1	1	
Score					1 - Highest Priority 4 - Lowest Priority					

24. Note that matters may be elevated:

    24.1. where there is a concerning trend of incidents

    24.2. where the incident involves a PCBU that is already under investigation, or there is a pattern of recurring notifications from the PCBU

    24.3. on a case by case basis with reference to the MNZ Compliance Intervention Guideline

Triaging Matrix – Priority level actions

25. There are some general actions that will likely occur for each Priority level. These are outlined below.

Priority 1

26. At Priority level 1 the following actions are generally expected:

- MNZ will investigate and attend the scene as soon as possible, unless there are extenuating circumstances
- DCM and Principal Investigator to discuss which team will take the lead and what other resources required for initial scene examination
- Scene should have been secured / preserved immediately however PCBU / Master to be reminded of this when MNZ notified
- If for any reason MNZ unable to attend the scene this must be documented and alternative arrangements made to access evidence as soon as possible
- PCBU / Master of vessel to be promptly advised on likely timing for MNZ to attend the scene and what other actions required in the interim

- If MNZ attendance will be delayed for any reason (i.e. location of incident, travel limitations, available resources, etc) then a HSWA Non-Disturbance Notice should be placed on the scene, and/or the vessel detained under MTA s.59 in the interim
- WorkSafe to be notified in accordance with HSWA s.198
- TAIC to be notified (if not already via receipt of s.31 online notice)

Priority 2

27. At Priority level 2 the following actions are generally expected:

- MNZ likely to investigate
- DCM and Principal Investigator to discuss which team will take the lead and what other resources required for initial scene examination
- Scene should have been secured / preserved immediately if meets threshold of a 'Notifiable Event' under HSWA, however PCBU / Master to be reminded of this when MNZ notified
- If for any reason MNZ unable to attend the scene this must be documented and alternative arrangements made to access evidence as soon as possible
- PCBU / Master of vessel to be advised as soon as possible by an appointed HSWA Inspector whether scene should remain preserved and not disturbed, or if can be released where decision has been made not to investigate
- If in doubt, the scene should not be disturbed whilst further decisions are made within CSD re attendance / scene examination
- If MNZ attendance will be delayed for any reason (i.e. location of incident, travel limitations, available resources, etc) then a HSWA Non-Disturbance Notice should be placed on the scene, and/or the vessel detained under MTA s.59 in the interim
- If incident meets the threshold of a 'Notifiable Event' under HSWA, WorkSafe to be notified in accordance with HSWA s.198
- TAIC to be notified (if not already via receipt of s.31 online notice)

Priority 3

28. At Priority level 3 the following actions are generally expected:

- MNZ may investigate subject to level of harm, specific circumstances and available resources. Any investigation likely to be handled at the Regional / MO level rather than through the Investigations Team
- Scene should have been secured / preserved immediately if meets threshold of a 'Notifiable Event' under HSWA, however PCBU to be reminded of this when MNZ notified. If for any reason MNZ unable to attend the scene this must be documented and alternative arrangements made to access evidence as soon as possible

- PCBU to be advised as soon as possible whether MNZ will be investigating
- Where the incident meets the threshold of a 'Notifiable Event' under HSWA, and MNZ is not investigating, an appointed HSWA Inspector from MNZ to authorise the PCBU / Master that the scene is released
- If incident meets the threshold of a 'Notifiable Event' under HSWA, WorkSafe to be notified in accordance with HSWA s.198
- TAIC likely required to be notified (see Appendix 1 below)
- May require MNZ attendance or further enquiries to fully inform a decision whether to investigate or not
- Incident may be referred to other Agency, Regional Council, VAL, PSC Inspection, etc in line with Triton Review Outcome options
- In reality a Priority 3 incident will likely require a more detailed analysis of the event details, and possible discussion with the Tier 3 manager, to inform the decision whether to investigate or not

Priority 4

29. At Priority level 4 the following actions are generally expected:

- MNZ unlikely to investigate at this time
- Incident may be referred to other Agency, Regional Council, VAL, PSC Inspection, etc in line with Triton Review Outcome options
- If incident meets the threshold of a 'Notifiable Event' under HSWA, WorkSafe to be notified in accordance with HSWA s.198
- TAIC unlikely to require notification (see Appendix 1 below)
- May require MNZ attendance or further enquiries to fully inform a decision whether to investigate or not

Triaging Matrix – Priority level scenario examples

- Stevedore on a foreign ship has fallen 4 meters when a hold access ladder failed, resulting in broken leg / spinal injury suspected
  - Major severity potential / likely to occur again – **Priority 1**
- Crewmember on foreign ship working at edge of log stack on deck without fall-arrest gear. Has fallen onto wharf suffering fatal injuries
  - Fatality / likely to occur again – **Priority 1**
- Near grounding of container ship during pilotage into port. Potential for major environmental impact. Navigation under Pilotage on TAIC Watchlist
  - National impact / could occur again **– Priority 1**

- Near miss in NZ waters between a NZ commercial ship and recreational vessel. No injuries
    - Significant severity potential / could occur again – **Priority 2**

- Crewmember slips and falls overboard from mussel barge whilst underway. Not wearing a lifejacket at time, serious injuries
    - Significant severity potential / could occur again – **Priority 2**

- Crewmember on foreign ship hospitalised after losing consciousness working in a cargo hold (non-fatal)
    - Significant severity potential / could occur again – **Priority 2**

- Small fuel spill into water during bunkering of MOSS vessel. Tier 2 spill
    - Minor environmental impact / could occur again – **Priority 3**

- Report from MPI Fisheries Observer Services of commercial F/V crew discharging garbage captured in trawl net back into sea
    - Minor environmental impact / could occur again – **Priority 3**

- Pilot ladder trap-door arrangement not complying with MR Part 53. Pilots have notified Master of issues and educated on NZ maritime rule requirements
    - Moderate severity potential / could occur again – **Priority 3**

- Gear failure loading logs onto ship. Logs have fallen into hold. No persons exposed to any risk of harm
    - Minor severity potential / likely to occur again – **Priority 3**

- Complaint of speeding close to shore on a lake by un-known recreational vessel
    - Minor severity potential / could occur again – **Priority 4**

- Recreational vessel collides with navigation aid during darkness (no injuries / minor damage)
    - Slight asset damage / minor severity potential / could occur again – **Priority 4**

- Recreational vessel grounding during hours of darkness (no injuries or pollution)
    - Slight asset damage / could occur again – **Priority 4**

- NZ commercial ship engine failure requiring tow back to shore
    - Minor severity potential / could occur again – **Priority 4**

Related Policies and Guidance

- Maritime NZ's Code of Conduct
- Maritime NZ Compliance Strategy (including Intervention Guidelines)
- Maritime NZ Investigation and Prosecution Procedure (*Draft in progress*)
- Policy on Decision Making
- Approach to decision making
- What Does Good Regulatory Decision Making Look Like?
- Case Assessment & Prioritisation model

Appendix 1 - Terminology used in the Triaging Model

CONSEQUENCE CONSIDERATIONS					LIKELIHOOD of REOCCURRANCE				
People	Assets	Environment	MNZ Reputation	Severity Potential	Practically Impossible	Not likely to occur	Could occur again	Known or likely to occur	Occurs frequently
First Aid	Slight Damage	Slight effect	Slight Impact	Minor	4	4	4	3	2
Medical Treatment	Component level replacement/repair ($10K-$100k)	Minor effect	Limited Impact	Moderate	4	3	3	3	2
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Fatality	Unit level damage ($5m-$50m)	Major effect	Provincial wide impact	Major	2	2	1	1	1
Multiple Fatalities	Multiple unit capability damage (450m+)	Massive effect	National impact	Catastrophic	1	1	1	1	1
Score					1 - Highest Priority 4 - Lowest Priority				PRIORITY

People

This relates to the people actually involved in the matter and is focused around the level of harm caused. In situations where there are several injured persons with a variety of injuries, the higher level of harm should be used in the assessment.

Examples:

- **First Aid** – a sticking plaster, ice pack, non-professional care
- **Medical Treatment** – a visit to Accident and Emergency, physiotherapist, doctor
- **Serious Harm** –
- **Fatality** – one deceased person
- **Multiple Fatality** – more than one deceased person

Assets

It is anticipated that this would generally cover the amount of damage concerning a vessel, but could extend to include such things as wharves, cargo or for example a mussel farm destroyed by a diesel spill. The dollar figures are only a guide and do not necessarily have to be read in conjunction with the level of damage.

Examples:

- **Slight Damage** – a scratched hull, a bent hand rail
- **Component level replacement or repair** – replacing a fuel pump, fixing a broken lever or handle, an occasion where part of something is fixed or replaced.

- **Equipment replacement or repair** – a new engine, repairs to a life raft, somewhere an entire thing is required to be fixed or replaced.
- **Unit level damage** – a vessel is sunk and destroyed, an entire wharf is destroyed
- **Multiple Unit Capability Damage** – Two vessels are sunk, an entire fleet of commercial vessels is destroyed by fire.

Environment

This relates to the physical environment in which an incident occurs.

Examples:

- **Negligible** – engine oil from a small recreational outboard engine leaks when the vessel is sunk
- **Minor** – diesel from a larger commercial fishing vessel leaks when it is grounded and requires an initial assessment, but no follow up action.
- **Localised Effect** - A diesel spill in a small lake where the spill is contained.
- **National Effect** - a vessel leaking a bio toxin as it travels from port to port or a large drifting oil spill that cannot be easily contained.

MNZ Reputation

This addresses the 'so what if we don't do anything' issue as well as the 'how bad does this/will this make us look' not only in the media, but amongst industry, the IMO or other interested parties.

- **Negligible** – one or two individuals are disgruntled and think poorly of MNZ.
- **Limited Impact** – may cause some repercussions, but these will not really affect MNZ
- **Local Area Impact** – cray fisherman in a small fishing village become unhappy with MNZ and complain
- **Provincial Wide Impact** – a larger community of people lose faith with MNZ, a provincial MSI becomes the focus of numerous complaints
- **National Impact** – something that is likely to make the front page of newspapers across the country.

Severity Potential

This should be determined directly from the information known and weighed on a balance of probabilities. This marries with the people, assets and environment columns but assesses these on what could have occurred not what actually occurred. For example, a large passenger ferry rolls over; there are no passengers on board and the five crew all survive. The test is not 'what if it was full of passengers', the test is 'what is the worst that could have happened, which in this case is the five crew being killed. Had that happened, it would rate as a 'Multiple Fatality' so the correct corresponding severity potential rating should be Major. In other words, the 'that was lucky' or 'all

but' test should be kept to the facts as they were at the time. This definition is intended to cover 'near-miss' situations.

Likelihood

The likelihood definitions are somewhat subjective and there is some discretionary scope on how they can be applied. The test may be directly related to the incident or where appropriate it may take a broader approach. For example, a fisherman loses his hand in a piece of machinery. As a result, guards are added to the piece of machinery making it practically impossible to ever occur again. It could be left at that however; these types of machines are known to be common and there have been two other similar accidents reported in the last year, so the view could be taken that this is known or likely to occur again. In this instance it is recommended that the higher safety standard is adopted.

Practically Impossible

In other words, it is most likely physically impossible to occur and covers situations where the primary hazard causing the accident on longer exists.

Not likely to occur

Where it is physically possible but not probable. For example, a yacht collides with a barge at night because the barge is not displaying the correct lights, the yachts radar is set incorrectly and the yacht skipper was wearing the wrong prescription glasses. It is not impossible that this could never occur again, but a replication of the same circumstances would be required and this is highly unlikely.

Where the circumstances and contributing factors of an accident could physically occur without any stretch of the imagination. The broadness of the test and the discretion on how to apply it is highly relevant to this situation. For example, the exact situation where a dinghy with two drunk fisherman sinks on the Waitemata Harbour and they both die, could never actually happen again, because the dinghy has sunk and the two fishermen are dead. However, the circumstances of the accident could be replicated by two other drunk fishermen in another dinghy in any harbour and the decision on how this should be assessed would have to be on a case by case basis. Again, it is recommended that the higher standard is adopted in the first instance.

Known or likely to occur

Where something, given the common occurrence of the same or similar circumstances, makes it likely to occur again. Take for example, a semi-submerged rock in a channel of water used by hundreds of recreational boaters that has been left off a chart and is not marked. The matter may also be known to occur. This is rather broad and again there is some scope for discretion. Again, it could be viewed on the actual accident, such as Waiheke Shipping hitting the wharf, or it viewed in a wider context of passenger vessels in general hitting wharves. The application of this discretionary view would depend on the nature of each case.

Occurs frequently

This is where a specific incident or incidents with common causative factors occurs with regularity, or on numerous occasions.

Appendix 2 - WHEN TO NOTIFY TAIC

30. TAIC should be notified in the follow instances:

- Any loss, presumed loss or abandonment of a vessel (SOLAS, fishing and other commercial)
- Death, or person missing, presumed dead (SOLAS, Fishing, and other commercial vessels)
- Multiple serious injuries on board SOLAS, Fishing, and other commercial vessels
- Any severe damage to the environment caused through the operation of a vessel
- Collision, grounding or fire involving a SOLAS vessel or large fishing vessel (typically over 20 metres in length) or domestic passenger vessel.
- Death of a person on board a recreational vessel resulting from the operation of the vessel
- Multiple serious injuries on board a recreational vessel resulting from the operation of the vessel
- Serious structural failure of a major shipboard component (such as a ships crane for example)
- Failure of a shipboard system that requires the ship to be assisted to a port of refuge (SOLAS ships)

MNZ & TAIC OVERLAP

Key points on the MNZ and TAIC overlap[3]:

- MNZ does not need TAIC's permission to independently investigate an incident that is also being investigated by TAIC, **but** if TAIC is also conducting an investigation we do need consent from TAIC to complete a site examination or to examine anything removed from the site. This consent cannot be unreasonably withheld by TAIC.
- TAIC consent is not needed to interview witnesses or take statements. However, the timing of their consent to access the site, uplift exhibits, or examine exhibits (if it is given) will affect when MNZ investigators will be able to access the site and may also affect timing for interviews.
- Under the MTA the Director and TAIC are required to co-ordinate – under the TAIC legislation and the MTA - the Director and TAIC must "take all reasonable measures to ensure that the investigations are co-ordinated". This means that there is an obligation on both MNZ and TAIC to work together to the extent possible to each achieve our individual outcomes. Where it comes to down to accessing a site or exhibits though, this will largely be at TAIC's discretion.

[3] Email from L. Fellows to P. Dwen on 14 November 2018. Subject MNZ & TAIC Overlap

- TAIC undertakes safety investigations that might result in recommendations, whereas MNZ's investigations can potentially result in criminal proceedings. While it is unlikely the MNZ's investigation would prejudice TAIC's investigation, theirs could well prejudice ours as the standards around evidence are that much higher for a court proceeding, and the time requirements are different. This can lead to issues in relation to matters such as chain of custody for evidence and timing for MNZ to complete an investigation in order to make a decision within the 12 month limitation period. A way of addressing some of these issues could be for MNZ to access the exhibits first before providing them to TAIC, which might allow both of us to achieve our purposes. But again, this would be subject to TAIC's agreement, and they may see this issue from an entirely different perspective to us. Ultimately, the call will always be theirs.