



## INVESTIGATIONS – WHAT BUSINESS IS THIS?

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*“The details of who was doing what behind the scenes during this mess have not been told, and frankly they are stunning...”*

[Attributed to a CBS Executive 2005]

## **INTRODUCTION**

My talk to you today focuses specifically on the Transport Accident Investigation Commission, its work, how it thinks about its work, and its contribution to safe and secure transport in New Zealand and abroad. The perspective I bring to bear is that of a multi-modal accident inquiry entity.

## **A CONTEMPORARY AND ENDURING ISSUE FOR THE COMMISSION**

A big issue for the Commission has been role definition. While the Transport Accident Investigation Commission Act 1990 (the TAIC Act) defines the role and functions of the Commission there has been a history of debate across the transport sector from time to time over what the Commission does when viewed alongside other safety investigation entities . Sometimes, particularly in the maritime sector, industry members have argued there has been duplication of investigations when the Commission and regulator are carrying out their functions. This perception of role duplication has sometimes lead to confusion from the industry, and I'd venture to say sometimes the Regulator, as to who has jurisdiction over accident sites and evidence.

For industry members the role confusion usually begins to manifests where Commission staff and Regulator staff meet at an accident site. Industry operators can be forgiven for bouts of head scratching as phalanxes of state officialdom bear down on them asking similar questions, saying similar things such as *“ We need to interview you so we can find out what happened, so that lessons can be learnt so it doesn't happen again.”*

In New Zealand there are four entities who can claim a state mandate to conduct an investigation into transport accidents. Depending on the mode of interest, all four can be active simultaneously. The entities are the Transport Accident Investigation Commission, the Regulator, the Police, and the Coroner. All have a different role to play, each contributing to the complement of the state's transport safety system.

## **THE COMMISSION'S BUSINESS**

The Commission is in the business of making public inquiries on behalf of the government on matters of public importance. Its role is a standing commission of inquiry convened under statute. Its field of interest is transport, and its core method of inquiry is investigation. The Commission is obliged to report back to the public on what it has found in its inquiries, and where appropriate, make recommendations for improvement when the system of interest is found wanting.

### On the Nature of Public Inquiries

To understand the work the Transport Accident Investigation Commission does, we need to understand the characteristics of public inquiries and why they exist. There are a number of forms of public inquiries. The New Zealand Law Commission identifies a “*continuum of inquiries and investigations available to Government, ranging from day to day departmental or inter-departmental work at one end of the scale, through ad hoc departmental inquiries, ministerial inquiries and specialised or narrow inquiries under other statutes, to formal commissions of inquiry under the 1908 Act and royal commissions established under the Letters Patent.*”<sup>1</sup>

Royal commissions are constituted by the Governor-General from powers derived under the Letters Patent from the Monarch. Letters Patent are a legal instrument issued by the Monarch granting powers of state. Royal commissions usually have considerable powers granted to them to support their inquiry. Royal commissions are usually chaired by judicial heads because of the powers granted to them. They are normally formed to look into matters of great importance or controversy, and are guided in their inquiries by terms of reference. The Mahon Inquiry into ZK-NZP crashing into Mount Erebus was a royal commission.

Commissions of Inquiries are convened under the CoI Act by the Governor-General. The CoI Act identifies six areas of concern where a commission of inquiry might be convened to inquire into and report on. The areas are:

1. The administration of the government
2. The working of any existing law
3. The necessity or expediency of any legislation
4. The conduct of any officer in the service of the Crown
5. Any disaster or accident (whether due to natural causes or otherwise) in which members of the public were killed or injured or were or might have been exposed to risk of death or injury
6. Any other matter of public importance.

Both royal commissions and commissions of inquiry are required to be independent.

Statutory inquiries are undertaken by statutory agencies operating under their own legislation, and may be given powers under the CoI Act. Appointments are generally made by the Minister. The scope of statutory inquiries tends to be narrower than that of commissions of inquiry.

Ministerial inquiries are just that. Inquiries established by Ministers to inquire into areas of administration for which they are responsible. Cabinet’s agreement to the inquiry is generally expected before launching an inquiry. Ministerial inquiries do not have statutory powers in the way commissions of inquiry do.

Public inquiries generally have one of four roles<sup>2</sup>. These are:

1. To find the facts
2. To inquire into the development of policy and legislation

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<sup>1</sup> See The Law Commission (2007) *The Role of Public Inquiries: Issues Paper*, p7.

<sup>2</sup> Ibid, pp11-16.

3. To provide an independent check on executive action
4. To be a form of participatory government

A substantive feature of public inquiries is that they are almost always universally unpopular. They tend to require large amounts of resources all round, from the inquirers themselves seeking to find the truth of the matter, to the affected parties seeking to deflect unwanted attention. Sometimes a dynamic emerges that lock parties into adversarial positions when the usual form of public inquiries is inquisitorial. The end result tends towards a misdirection of effort to a position of defensiveness rather than supporting community learning.

#### On the Nature of the Transport Accident Investigation Commission

The Commission is a hybrid entity – a mixture of a commission of inquiry and a statutory inquiry. Commissioners are appointed under warrant by the Governor-General in Council with their terms of reference prescribed in statute – the TAIC Act. The Commission’s specific task is to:

*“...determine the circumstances and causes of accidents and incidents with a view to avoiding similar occurrences in the future, rather than to ascribe blame to any person.”*

[s4 Transport Accident Investigation Commission Act 1990]

In this regard the Commission’s role is one of fact finding.

The Commission is not a formal commission of inquiry established through direct application of the CoI Act. The Commission’s functions are inquisitorial, with its inquisitorial powers derived from the CoI Act. Under the TAIC Act the Commission has all the powers of commissions of inquiry that are directly established under the CoI Act except the power to award costs<sup>3</sup>. The TAIC Act also requires the Commission to act independently. The Commission can make whatever inquiries it thinks appropriate. This makes for a strong and powerful Commission. The Commission may conduct hearings as if it were an ad hoc commission, and can do everything any ad hoc Commission can do, including royal commissions. This is a significant point that goes to the importance given to transport accidents and is the Commission’s point of difference in relation to other transport investigation entities.

The Commission’s duty is to the public. It has oversight of the safety of the transport system involving air, rail, and marine modes, and includes oversight of regulators. In this respect the Commission has a role in checking executive action. Its inquiry process involves, but is not limited to, investigation to ascertain the facts as to circumstance and cause, deliberation and consultation, determination of findings, and making recommendations, and publishing its findings and safety recommendations.

The published report and safety recommendations are important features of the inquiry process. The presumption underpinning the Commission’s work is that by investigating and reporting on the facts of the occurrence lessons are shared. The detail in the lessons comes out of the formulation of the safety recommendations, while the report itself tells the story of the occurrence, setting the scene around circumstances and how the findings and safety recommendations were arrived at.

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<sup>3</sup> See section 11, Transport Accident Investigation Commission Act 1990.

What is not always so obvious is whether the lessons are learnt.

## **THE COMMISSION'S ORIGINS –ECHOES OF EREBUS**

Why does the transport sector need a Commission? Why not have an independent uber regulator taking care of everything? The significance of the Commission comes out of the two inquiries into ZK-NZP's crash on Mount Erebus in 1979.

The two substantive reports into ZK-NZP's crash are:

- Aircraft Accident Report No.79-139, Air New Zealand McDonnell-Douglas DC10-30 ZK-NZP Ross Island, Antarctica 28 November 1979; and
- Report of the Royal Commission to inquire into the Crash on Mount Erebus, Antarctica of a DC10 Aircraft operated by Air New Zealand Limited 1981.

These two reports individually are icons of the burdens of public inquiry, and together form a substantive legacy in New Zealand's history as guides for scopes of inquiry, and lessons learnt. Read together, the two reports provide a rich ground of inquiry. Individually, each is a product of its mandate. The Commission's hybrid form arises from these two inquiries with a desire to take the strengths of both forms of public inquiry – the technical and particular, and the systemic, so that appropriate comprehensive coverage is achieved in transport accident inquiries – a “no stone unturned” approach. That of itself is a systemic lesson learnt by government following the fallout over the two reports.

## **THE COMMISSION TODAY**

The Commission today is reflecting on its mandate and the way it undertakes its role as a public inquiry entity. The issue of role duplication is no longer an issue for us. Our investigative activities complement those of the regulators in the wider state sector response to improve transport safety.

While the Commission is clear about our role it doesn't necessarily mean that the industries can discern any difference between the commission and other safety investigation entities, because the first point of engagement is with investigator staff whose activities are consistent with investigation practice. Industry groups can be forgiven for being confused over investigator intentions when asked the same question three or four times over by different “suits” all saying they are here to find out circumstances and causes so that lessons can be learnt. The point of difference in the Commission's activities becomes clearer through later stages in the inquiry process, remembering the Commission is not just about investigation. Investigations go to inform the inquiry process which of its is comprehensive.

Some of the confusion comes out of the scopes of inquiry undertaken. A criticism levelled at the Commission, and one the Commission is giving serious attention to, is that its inquiries are sometimes too narrow, too technical. There are two substantive aspects to this criticism. One goes to the extent of investigations – that they are vehicle focused, and do not go deeper into

organisational behaviour and arrangements. The other is the Commission does not fulfil its mandate as a public inquirer effectively because it operates in camera, not allowing for wider public or stakeholder engagement by way of formal hearings. When reviewing its mandate recently the Commission considered the criticisms and decided to refocus on what it understands is required of it as the Commission. The key strategic areas the Commission is focusing on are:

- i. the scope of its inquiries,
- ii. the scale of its inquiries
- iii. how best to advise of the lessons learnt from the investigations undertaken
- iv. whether patterns and trends in accidents and incidents are sufficient cause for the Commission to investigate.

Underpinning the Commission's refocused approach is a view about its field of activity and audience. The Commission's interest goes to whether there can be wider system learnings from discrete occurrences. The Commission supports individual operators taking remedial action to improve their own safe system performance, but the Commission's job is to ensure the lessons from discrete events that may benefit others in similar circumstances are promulgated and learnt. A significant function of the Commission is to support systemic learning through feeding back into the transport system lessons derived from its investigations. Systems behaviours and system learnings are key concepts in the Commission's current thinking.

### Thinking About Systems – the Commission's Emerging Approach

The Commission is adopting a more comprehensive approach to the application of systems thinking in its inquiry practice. If we accept that "*...a system is a collection of parts that interact with one another to function as a whole*"<sup>4</sup> then we can start to interrogate more effectively the circumstances of the occurrence of interest. This approach helps to define the scope of the inquiry. Applying systems thinking brings the quality of interactions between system agents (parts) into sharp relief. Considerations brought to bear on the inquiry go to:

- i. the events leading up, during, and immediately after the occurrence,
- ii. patterns that emerge out of the interactions of the system agents, or the system's interaction with other systems
- iii. the influence of systemic structures
- iv. the influence of peoples mental models on their interactions with the system(s).

The systems of interest to the Commission influence the scope and scale of its inquiries. The extent of the scope and scale of the inquiries derives from the circumstances of the occurrences as revealed through the elements considered above. The more comprehensive the inquiry is, the more compelling a public hearing becomes because of the wider interests involved. Also more comprehensive inquiries require different skill sets. Delving into operator or sector systems may require human and organisational factors, financial auditing, business consulting, and economic analysis skills on top of the specialist accident investigation skills sets already engaged. This is an area the Commission is beginning to explore for the future.

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<sup>4</sup> See Kambiz E. Maani & Robert Y. Cavana (2000), *Systems Thinking and Modelling*, p6, Prentice Hall.

Systems of interest to the Commission may also come out of general system behaviour revealed through patterns and trends of accidents and incidents rather than from one discrete accident or incident. For example The Commission has noticed that rail derailments appear to be on the increase. There are purportedly near to 100 derailments in New Zealand each year. Many are small shunting yard incidents involving carriage wheels slipping off the tracks as they are moved about. Some however are far more significant. The Commission currently has six derailment occurrences in its rail caseload. Can the Commission launch an investigation into the circumstances and causes of rail derailments in general? This is a matter of debate, however the Commission is of the view that it can because of the plural wording used in its legislation describing its functions – “*the principle function of the Commission shall be the investigation of accidents and incidents.*”<sup>5</sup> The Commission is beginning to monitor occurrences in its modes of interest, and where it sees a trend emerging it is speaking with the Regulator to signal an interest which may lead to the Commission investigating the next reported event of the accident or incident type.

The Commission recognises that pursuing more comprehensive inquiries may perturb some people. The Commission itself needs to prepare itself for widening its scope of inquiries because it does not have the resource or infrastructure capability in place to undertake large scale inquiries. However the Commission has begun to test its reach through selected investigations currently underway in the marine and rail sectors. The scope of inquiry has extended to incorporate operator safety management systems and the Regulators oversight of those systems.

More and more the Commission will be working through the Regulatory systems to reach system participants, taking a more comprehensive approach so that lessons are shared, and hopefully learned.

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<sup>5</sup> See The Transport Accident Investigation Commission Act 1990, s8(1).