



# THAMES SAFETY INQUIRY

Final Report by Lord Justice Clarke

*Presented to Parliament by the Secretary of State for the  
Environment, Transport and the Regions by Command of Her Majesty  
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# A Introduction

- 1.1 On 26<sup>th</sup> November 1999 I finished my interim report and sent it to the Deputy Prime Minister under cover of a letter of that date. It was subsequently published on 2<sup>nd</sup> December. This final report should be read together with that report. With very few exceptions, I shall not repeat here what I said there because it would be superfluous to do so. Annexed to that report are a number of documents which are relevant to this report. I shall not annex them again to this report. References in this report to Annexes 1 to 34 are references to the annexes to my interim report. The annexes to this report will be referred to as Annex A, Annex B and so on. Annex A is a list of those who have contributed to the Inquiry in addition to those listed in Annex 5 (at volume 2 page 247). I shall use the same abbreviations as in my interim report, where they are set out in the glossary.
- 1.2 This report will be divided into two parts. Part One is my final report on Part One of the Inquiry. It has two purposes. The first is to correct errors in my interim report which have been pointed out to me. The second is to set out such further conclusions as I have reached in the light of submissions which I have received since I made my interim report. Part Two of this report is my one and only report on the issues raised by Part Two of the Inquiry.

# B Part One

## 2 Errata

- 2.1 A number of errata in my interim report have been drawn to my attention. None of them strikes me as of any great significance, but I have set them out, with my comments, in Annex B.

## 3 Further Conclusions

- 3.1 Since making my interim report I have received a number of submissions relevant to Part One of the Inquiry. All of them are included in Annex A. Most of them relate to matters to which I have referred in my interim report but were not sent in response to it and do not call for detailed comment.
- 3.2 One example is an interesting submission from the Association of Riparian Owners on the Avon River, which is, however, outside the area with which I am concerned, namely the part of the tidal Thames described in paragraph 1.4 of my interim report. See also the caveat entered at paragraph 26.7 of that report.
- 3.3 Other examples include submissions relating to pilotage. I made some reference to pilotage in paragraphs 1.5 and 12.25 to 12.29. As I see it, most of the problems relating to pilotage arise in the part of the Thames which is downriver of the Inquiry area. In these circumstances, while not wishing to belittle them in any way, I do not think that it would be appropriate for me to make any further comment in this regard.
- 3.4 Other examples include a submission from City Cruises, which I found of considerable interest, but which does not call for any further comment, except in two respects. The first is that potential difficulties are mentioned with regard to applying the ordinary licensing laws to vessels on the river. I have discussed this point briefly in paragraphs 13.31 and 13.32 of my interim report. I adhere to the views I expressed there, although I recognise that there are differences between licensing premises ashore and afloat and that any change in the law would have to take those differences into account. These are matters for discussion with the industry, since I entirely accept that it is important to have a flexible approach to the licensing of vessels, which sometimes operate for much of the night.
- 3.5 The second point arising out of the City Cruises submission which I would mention shortly is their concern at the suggestion that the cost of SAR should be paid by passenger vessel operators, when they pay pier fees to LRSL. I referred to the question of who should pay for SAR facilities on the Thames in paragraphs 21.33 and 21.34 of my interim report. I simply repeat the point made there that who should pay is really a political question.
- 3.6 I turn to a number of areas which do call for some further comment. The first is the question who should owe a statutory duty of the kind identified in paragraphs 21.22 to 21.24 of the interim report. The second concerns the role of the PLA, the third concerns VTS and the fourth relates to access to and from the river.

## **SAR – Who Should Owe a Statutory Duty?**

- 3.7 I discussed this question in paragraphs 21.25 to 21.32 and 27.43. I made it clear that it is really a political question, and therefore not for me to say, although (subject to that) I did express the view that it should either be the GLA or the PLA. The PLA has now suggested that the appropriate body upon whom to impose such a duty would be the Department or the MCA. As I see it, the PLA correctly identifies potentially relevant criteria as including democratic accountability, expertise, capability, jurisdiction (along the whole of the tidal river) and access to appropriate funding. It then submits that the PLA meets three of the criteria, namely marine expertise specific to the Thames, jurisdiction and capability, that the GLA meets two of them, namely democratic accountability and access to direct funding, but that the Department meets all five.
- 3.8 The PLA submits that in these circumstances the option of allocating the appropriate statutory duty to the Department merits further consideration. I agree that it does. I would only say this. The reason why it seemed to me that, if democratic accountability were not the crucial factor, the PLA would be the appropriate body upon which to impose the duty was that it has specific expertise on the Thames and would be the best entity to carry out a risk assessment and to keep it under review from time to time. It seemed to me that such a duty would fit in well with its duties as a CHA, especially in the light of the detailed provisions of the Port Marine Safety Code. In short, it seemed to me that the PLA was best placed in practice to devise and provide an appropriate system. I am still of that view, although I recognise that a final conclusion will only be reached after considering the problem in the context of the provision of SAR services elsewhere and of democratic accountability.
- 3.9 One possible solution would be for the duty to be placed on the Secretary of State or the GLA (as thought appropriate) but for the body with the duty then to make arrangements with the PLA, perhaps by way of a legally binding MOU, to enable the PLA to devise and provide the appropriate system on behalf of that body. I also recognise that there are other possible views, as noted in another valuable submission from Mr Nigel Spearing, but I do not think that I can usefully add further to the debate at this stage.

## **Role of the PLA**

- 3.10 In the course of another helpful submission, Mr Chris Pond MP, in addition to returning to concerns about pilotage, has reiterated his concern about a conflict between the regulatory duties of the PLA and its commercial activities. I have not, however, changed the views which I expressed in paragraphs 5.15 and 5.16. It seems to me that there is no real conflict between the notion of promoting the Port of London, which is what is referred to in the passage from the 1997 Handbook quoted in paragraph 5.15, and the role of the PLA as CHA. In any event, I have seen no evidence that the PLA is not discharging its statutory duties properly because of any conflict of interest of this, or indeed any, kind.

## **VTS**

- 3.11 Mr Pond has also suggested that the reference in paragraph 12.48 to an occasion when the VTS system was not working was to understate the problems involved in having a system without any alternative backup. I entirely take the point that it is vital that a system without

backup should not fail. I can only urge the PLA to make every effort to ensure that it does not. Otherwise, I do not think that I can usefully add to what I have written in section 12 of my interim report.

### **Access to and from the River and Grab Chains**

- 3.12 Since the interim report was published, both the London Rivers Association and Mr Donald Davies have reverted to the question of river steps and stairs as an aid both to SAR and to safety in general. I have also received a submission in this regard from Lt Cmdr Len Crickmar, who successfully complained to the Ombudsman about the access points in the London Borough of Tower Hamlets. I stress, as I did in paragraph 26.5, that I am not concerned with issues of planning, but I accept the submission that steps and stairs can be a valuable aid to the rescue of and escape by those in the river.
- 3.13 In these circumstances it seems to me (as submitted by Mr Davies) that consideration should be given, not only to the provision of appropriate bankside facilities, as suggested in paragraphs 19.37 to 19.42 and 21.35 to 21.36, but also to the provision of appropriate steps and stairs. This proposal (like all proposals) must, however, be subject to what is practicable and I can well envisage that in some areas the provision of such stairs would not be practicable.
- 3.14 The remaining question is who should have the relevant responsibility in this regard. The PLA has submitted that if the Department is to have the statutory duty envisaged above, it should have this duty too. I see the force of that, but otherwise I see no reason to resile from the conclusion which I stated in paragraph 21.36 of my interim report. In the light of the submissions which I have received since my interim report, I would restate it in this way.
- 3.15 In the absence of a general duty of the kind which I have proposed, it seems to me that the best course would be to give the PLA statutory power to require local authorities and other riparian owners to make such provision for life-saving appliances and means of escape from the river as the PLA thinks fit, at the authorities' and owners' expense. I remain of the view expressed in that paragraph that such a course would be practicable, although it would need legislation.

### **Conclusion**

- 3.16 I have tried to meet some of the points made by correspondents. I am conscious that I have not met them all. I am sorry if, as Mr Spearing suggests, there are those who were unaware of the Inquiry. As I tried to make clear in paragraphs 1.6, 1.7 and 26.1 to 26.3 of my interim report, however, issues of safety on the Thames raise ongoing questions. It follows that, if anyone has any representation which he or she wishes to make from now, it should be made to the Secretary of State, the MCA, the PLA, the GLA, the appropriate local authority, LRSI or indeed any other authority or body which may be able to help. It is, after all, in the interests of everyone that all reasonable steps should be taken to ensure that the Thames is as safe as possible in the next century.

## **Fireboats**

- 3.17 Since I wrote my interim report, I have become aware of discussions between the LFCDA and the Fire Brigades Union (“FBU”) about training for the new fireboats, the FIREDART and the FIREFLASH. There have been technical teething problems with them which were said to have disrupted training, but, as I understand it, it has now been agreed that more training will be given to the crews. It is clear from the correspondence which the Inquiry has had with both the FBU and the LFCDA that both are committed to the full use and operation of the two rapid response boats. I understand that there have been continuing problems with the FIREFLASH, which involve the necessity to obtain a replacement part, but I was told in a letter dated 16<sup>th</sup> December that the replacement part is expected shortly.
- 3.18 I have no doubt that the LFCDA and the FBU are both aware of the great importance of the fireboats being available for the Millennium Celebrations. In the letter of 16<sup>th</sup> December, Deputy Chief Officer Martin Coffey wrote that in his professional opinion the new boats would be fully functional and operational, with all essential equipment and properly trained crews, for the Millennium Celebrations. It is thus clear that every effort is being made by all concerned to ensure that that will indeed be the case, and I see no reason to doubt it.

## **Millennium Celebrations – November Exercise**

- 3.19 Since writing my interim report I have received a report from the PLA on the exercise which took place on 29<sup>th</sup> November. The PLA Marine Emergency Planning Officer concluded as follows:

The exercise was successful. All participating agencies gained benefit and have expressed their satisfaction. Several lessons were learned and, where applicable, will be actioned in time for the London River Event on 31 December.

I have no reason to disagree with that conclusion and can only hope that the celebrations will be a great success and that they will proceed without mishap.

## **Alcohol Consultation Paper**

- 3.20 I have received a copy of the consultation paper on alcohol, which was published on 2<sup>nd</sup> December, the same date as the publication of my interim report. It might have been better to delay publication of the paper for a few days. In that way, it would have been possible to include at least some reference to the points which I made in section 13 of my report, assuming of course that any of them were thought to be worthy of discussion with interested parties. I recommend that the consultees now be sent a copy of that part of my interim report, perhaps with the views of the Department upon it.

# C Part Two

## 4 Introduction

- 4.1 The paragraph of my terms of reference which is relevant under this head asks me to advise whether there is a case for a further investigation or inquiry into the circumstances surrounding the MARCHIONESS disaster and its causes on 20<sup>th</sup> August 1989.
- 4.2 It should be noted that, on their face, the terms of reference do not ask me to carry out such a further investigation or inquiry. In this regard they are to be contrasted with the terms in which this Inquiry was reported in the press in August and, indeed, in the Deputy Prime Minister's speech at the Labour Party Conference on 29<sup>th</sup> September 1999, when he said that he had announced a public inquiry so that at last the full story could be told of the MARCHIONESS disaster, where 51 people died ten years ago. As appears from the Deputy Prime Minister's letter to me dated 20<sup>th</sup> September (Annex 1 at volume 2 page 3) I agreed to consider all the issues pertaining to the disaster, but as I read the terms of reference they nevertheless require me to consider whether there should be a further inquiry and, if so, what, rather than to carry out such an inquiry.
- 4.3 There is a stark difference of approach between those who have made representations on this part of the Inquiry. Many survivors and relatives of those who died and their representatives say that there should now be a full public inquiry, whereas the representatives of the master and owners of the BOWBELLE and of the late skipper and mate of the MARCHIONESS say that there should not. I have also received other representations in support of both views. Indeed, I have received a large number of written submissions and I held a hearing on 8<sup>th</sup> November at which many people made oral representations. I have tried to take all the representations which I received into account. I am grateful for them all.
- 4.4 The first question is how I should approach my task. There appear to me to be three main issues for consideration, firstly whether any further inquiry should be held, secondly what issues any such inquiry should consider and thirdly what type of inquiry it should be. It may be noted that in the letter from the Deputy Prime Minister dated 22<sup>nd</sup> September (Annex 1 at volume 2 page 4) I was expressly asked to consider what form any further inquiry should take and whether it should be invested with statutory powers. I shall try to address those issues. There is some overlap between them.
- 4.5 In this context, the question whether a further inquiry should be held is really asking whether a *public* inquiry should be held. So far as I am aware, no-one suggests that an inquiry into the causes of the disaster should now be held in private. In order to consider whether a public inquiry should be held, it is (I think) helpful to ask the following questions. What is the purpose of a public inquiry? Was this a suitable case for such an inquiry in the first place? Why was no such inquiry held? Should it have been? If so, should such an inquiry be held now? If so, what should the inquiry investigate and what form should it take? The first question raises a point of general importance. The other questions involve a consideration of some at least of the events which have occurred since the collision. They also involve a series of further questions or sub-questions. Thus the question whether an inquiry should be held now involves identifying the criteria against which the question should be answered. In

particular, what is the relevance of further evidence or the lack of it? What effect will such an inquiry be likely to have on those concerned, in particular Captain Douglas Henderson, the master of the BOWBELLE? Is it now too late for any useful inquiry to be held? Where does the balance lie?

## 5 Purpose of a Public Inquiry

- 5.1 No member of the public has a right to a public inquiry. Whether such an inquiry should be ordered will (as ever) depend upon all the circumstances of the case. It will depend upon where the public interest lies. The public interest is not of course the same as the interest of the public. The public may be interested in many things which it would not be in the public interest to investigate publicly. Sheen J to my mind put his finger on one of the reasons why it may be appropriate to order a public inquiry, when he said in paragraph 60 of his report into the capsizing of the HERALD OF FREE ENTERPRISE:

In every formal investigation it is of great importance that members of the public should feel confident that a searching investigation has been held, that nothing has been swept under the carpet and that no punches have been pulled.

- 5.2 It is true that in that passage Sheen J was not considering the circumstances in which a public inquiry should be ordered, but rather how a formal investigation should be conducted. It nevertheless seems to me that he was describing one of the purposes of a public inquiry, namely to carry out a searching inquiry into the facts so that everyone may know what actually happened without anything being held back. Both the public at large and those intimately concerned have a legitimate interest in ascertaining the truth of what occurred. To my mind that is an important purpose of such an inquiry, although another important purpose of any inquiry (whether public or not) is to enable lessons to be learned which will minimise, or even eradicate, the risk of a similar casualty happening in the future.
- 5.3 There are therefore two purposes of a public inquiry, namely ascertaining the facts and learning lessons for the future. In the vast majority of cases the second is a very important ingredient, especially in the sphere of transport, because it is to be hoped and indeed expected that the detailed examination of the causes of a particular casualty will yield valuable information from which lessons can be learned. It does not follow that it is a necessary ingredient, because of the public interest identified above, namely the ascertainment of the truth. The public (and especially the survivors and the relatives and friends of those who lost their lives) has a legitimate interest in learning the truth of what happened, without anything being swept under the carpet. In some cases that will necessitate a public inquiry, whereas in others it will not.
- 5.4 It is submitted by some that there are other purposes of a public inquiry, such as ascertaining where fault for the accident lies and whether a criminal offence has been committed. I accept those submissions only to a limited extent. Any investigation of the facts is bound to involve a consideration of responsibility for the casualty. Almost all casualties are caused by a combination of circumstances. Failure to take proper care on the part of one or (more likely) a number of people or entities is likely to be one of them. It follows that questions of responsibility, including whether there was any, and if so what, failure or failures to take care, are bound to be considered in any public inquiry, just as they are likely to form part of any investigation.

- 5.5 It is not, however, the role of an inquiry to establish civil liability or to consider whether a crime has been committed. It is not in the public interest that it should do either. The former is the role of the civil courts and may involve many questions of fact and law which it would not be appropriate to debate at an inquiry. The latter is the role of the police, the CPS and the DPP. The role of an inquiry is simply to find the facts, although I recognise that those facts may form the basis of civil liability or indeed of an allegation that a crime has been committed.
- 5.6 I attended a number of formal investigations as counsel in the 1970s and 1980s, some of which lasted a long time and cost the public purse a great deal. That was at least in part because parties (and their counsel) were inclined to use them to further their interests or perceived interests in the litigation which is almost always contemplated after a serious casualty. I have little doubt that it was one of the reasons why the MAIB was set up. I do not think that it is in the public interest to allow parties to use public inquiries as a dry run for their civil litigation or to prepare a case for later prosecution.
- 5.7 In this context, one of the matters which seems to me to be in need of detailed consideration is the relationship between the various investigations and inquiries which inevitably take place after a serious casualty like that of the MARCHIONESS. I shall consider below whether this is one of the matters which should be considered at a public inquiry or by some other appropriate means.
- 5.8 The purpose of a public inquiry is simply to ascertain the facts and to make recommendations for the future. A public inquiry should only be ordered in exceptional cases. Public inquiries are very expensive in terms of time and money and in very many cases the facts can be established and lessons learned without such an inquiry. There are, however, some cases in which the public properly expects a public inquiry to take place.
- 5.9 In such a case, the question will arise what form the inquiry should take, to which I shall return below. The significant feature of a public inquiry, by contrast with an investigation such as that carried out by the MAIB is that it is in public. In *R v Inner London coroner ex p Dallaglio* [1994] 4 All ER 139 the Court of Appeal heard an appeal from a decision of the Divisional Court with regard to the inquest in this very case. Sir Thomas Bingham MR drew attention (at p 164) to the fact that in an earlier case, namely *R v North Humberside and Scunthorpe coroner ex p Jamieson* [1995] QB 1 at p 26, the court had emphasised the need

for full, fair and fearless investigation and the exposure of relevant facts to public scrutiny.

That was said in the context of an inquest, the powers and functions of which are different from and narrower than a public inquiry, but the principle seems to me to be equally, if not more, applicable to a public inquiry.

- 5.10 The purpose of a public inquiry is thus to carry out a full, fair and fearless investigation into the relevant events and to expose the facts to public scrutiny. That is or should be the purpose of every public inquiry. It has always been the purpose of a formal investigation of a shipping casualty: see *The Speedlink Vanguard* [1986] 2 Lloyd's Rep 265, which contains a valuable discussion of the purpose of a formal investigation by Steyn J. I shall return to that discussion below because it identifies, not only the two purposes of a public inquiry to which I have referred, but a third disciplinary purpose relating to the conduct of certificated officers. I turn first to the question whether this was a suitable case for a public inquiry.

## 6 Was This a Suitable Case for a Public Inquiry?

- 6.1 This was an appalling disaster. It involved a collision between two vessels on a clear warm August night in the middle of London which resulted in the loss of 51 lives and many injuries. It was a shock to the public as a whole. I have no doubt that if such a tragedy happened today, there would be a widespread public demand for an inquiry. In my opinion such a demand would be entirely justified.
- 6.2 The MARCHIONESS was a Class V passenger vessel. She was hired for the evening and, although used for a private party, she was being used as a form of public transport. In this regard she was perhaps like a coach which is hired to take a party of people for an outing. As I see it, in terms of safety, no distinction is to be drawn between public travel on a vessel like the MARCHIONESS or on a coach or on a train. In each case the passenger is entitled to expect that he or she will be transported safely from A to B. If anything goes wrong and serious injury or death occurs, the public is entitled to expect that the accident will be fully and properly investigated.
- 6.3 What amounts to a full and proper investigation will depend on the circumstances. In many cases (as stated in section 5 above) there will be no public interest in a public inquiry being held. It will be sufficient if the accident is investigated by the relevant authority, which may be the HSE in the case of a rail accident or the MAIB in the case of a maritime accident or the Air Accident Investigation Branch (“AAIB”) in the case of an air accident. Where the accident has led to loss of life, it may be appropriate for an inquest to be held. In some cases it will be appropriate for the police to carry out an investigation in order to decide whether or not a crime has been committed and to act appropriately. Nothing I say in this report is intended to apply to every case in which there is serious injury or loss of life, but there are cases in which the public interest is best served by a public inquiry.
- 6.4 In my opinion, viewed as at 1989, this was such a case. I accept the submission that the answer to the question whether to hold a public inquiry does not depend solely upon the number of people who were injured or who lost their lives, because (for example) the cause of the casualty may be obvious, so that a public inquiry would serve no useful purpose and such an inquiry may well not be necessary in order to learn lessons for the future. The number of casualties is, however, a relevant and may be an important factor. So are the overall circumstances of the case. Here the sense of shock felt by the public and the feeling that such an accident should not be possible on the Thames in the conditions which prevailed on 20<sup>th</sup> August 1989 are important factors. In my opinion, both the public at large on the one hand, and the survivors of the collision and the relatives of those who lost their lives on the other hand, were entitled to an open public inquiry into what happened.
- 6.5 This was a disaster on a similar scale to previous casualties in which a public inquiry had been held. It is never easy to compare the scale of one tragedy with another, but, as a number of correspondents have pointed out, in the two years prior to August 1989 three disasters had taken place, namely the capsizing of the HERALD OF FREE ENTERPRISE, the King’s Cross fire and the Piper Alpha explosion, in which 192, 31 and 165 people respectively lost their lives. Public inquiries were held into all three. Most people must I think have been very surprised, not to say astonished, when they heard that, unlike in those cases, there was to be no public inquiry into this collision and its consequences.

- 6.6 I recognise that there were two particular air accidents in the late 1980s which caused loss of life but which did not lead to a public inquiry. They were the Manchester air disaster on 22<sup>nd</sup> August 1985 and the accident to a British Midland jet at Kegworth in January 1989, in which 55 and 47 people respectively lost their lives. Both disasters were investigated by the AAIB, which, as many correspondents have pointed out, had acquired an international reputation for full and fair investigation such that its reports were accepted by those concerned. The same is true today. It certainly seems to be the case that there do not seem to have been the same calls for public inquiries into air disasters as there have been in this case and in the case of the railway disasters referred to below. There may well be good reasons why public inquiries were not ordered in those and other air disaster cases. Such inquiries may, for example, raise technical issues rather than issues of credibility, although I can certainly imagine cases in which it would be appropriate to order a public inquiry into an air disaster. All would depend on the circumstances, although I note that the provisions relating to public inquiries in the Civil Aviation (Investigation of Air Accidents) Regulations 1989 were omitted when those regulations were replaced by the Civil Aviation (Investigations of Air Accidents and Incidents) Regulations 1996.
- 6.7 Whatever the position might have been in the case of an air disaster, it is my view that the collision between the BOWBELLE and the MARCHIONESS was a suitable case for a public inquiry, if the problem is considered as at 1989, just as it would be regarded as a suitable case for a public inquiry if it happened today and a decision had to be made now. In recent times there have been a number of public inquiries into serious transport accidents, notably in the sphere of rail transport into the Clapham, Southall and Paddington rail crashes.
- 6.8 That view is supported by the reaction of judges sitting both in the Divisional Court and in the Court of Appeal in the judicial review proceedings in *ex p Dallaglio*, which is unreported in the Divisional Court but reported in the Court of Appeal at [1994] 4 All ER 139. In the Divisional Court Neill LJ said that anyone who had studied the case of the MARCHIONESS

can understand the strength of the argument that this disaster merited detailed investigation by means of a public inquiry.

In the Court of Appeal Sir Thomas Bingham MR said of the original coroner, Dr Paul Knapman (at p 164):

He was, it would seem, and understandably, concerned that the death of over 50 young adults in the heart of London on a fine August night had not been thought to merit a full public inquiry contrary to the almost invariable practice when such casualties occur.

I entirely share those sentiments.

- 6.9 They echo remarks of Nolan J on an earlier application for judicial review, which was heard on 30<sup>th</sup> October 1990. In *R v DPP ex p Langlands-Pearse* (unreported) the applicant sought an order of mandamus to compel the DPP to prosecute the master and owners of the BOWBELLE for manslaughter. Nolan J said:

The sinking of the MARCHIONESS was an appalling tragedy. It is entirely understandable that the survivors and the other relatives and friends of those who died, and all who are concerned with the safe passage of vessels on the Thames, should seek a full public inquiry into its causes. This application, though most persuasively put by Mr Sedley, does not afford the right means of securing such an inquiry.

Finally in this regard, on 23<sup>rd</sup> January 1993 Sheen J wrote a letter to The Times, which included the following:

The loss of the ‘Braer’<sup>1</sup> had serious consequences. Fortunately these did not include any loss of human life. Those who were affected have been promised compensation. In due course life will go on as before. A public inquiry with wide terms of reference has been ordered.

In August 1989 the MARCHIONESS sank in the river Thames with the loss of 51 lives, mostly young. For the bereaved and others affected, life will never be the same again. Naturally they wanted a public inquiry, but it was not thought appropriate to hold one. Have we got our priorities right?

Many would share that view. I am one. Although it is fair to say that Lord Donaldson’s inquiry into the BRAER was not a public inquiry into the causes of her grounding, that does not seem to me to detract from the point made in the letter.

## 7 Why Was a Public Inquiry Not Held?

### Formal Investigations and the MAIB

- 7.1 There is I think no doubt that, if a public inquiry had been ordered at the outset, it would have been a formal investigation (“FI”) under section 56 of the Merchant Shipping Act 1970 (“the 1970 Act”). All of the internal Department and MAIB materials which I have seen show that to be the case. In fact an FI was not ordered, but the matter was investigated by the MAIB. This was the first investigation carried out by the MAIB, which had only just been set up when the collision occurred: see chapter 7 of the Hayes Report (Annex 3 at volume 2 pages 122 to 124). The MAIB was set up in July 1989 under section 33 of the Merchant Shipping Act 1988 (“the 1988 Act”). The Merchant Shipping (Accident Investigation) Regulations 1989 (“the 1989 Regulations”) came into force on 7<sup>th</sup> August 1989, just under two weeks before the collision. They provided by regulation 6(1) that where a relevant accident (of which this was an example) occurred, the Chief Inspector of the MAIB must decide whether or not an investigation is required. They also contained detailed provisions as to how the investigation should proceed and as to the powers of those appointed to conduct it.
- 7.2 The new system was a departure from the system which had preceded it and was modelled on that which governed the investigation of air accidents. They were and are investigated by the AAIB and there has been no public inquiry into an air accident since the 1973 inquiry into the Trident crash at Staines. The AAIB was and is an independent agency within the Department and the MAIB was set up in the same way. It was I think hoped that the creation of the MAIB would avoid the need for public inquiries and thus save both time and cost, while nevertheless ensuring that the facts of an accident were properly investigated and the necessary lessons learned for the future.

<sup>1</sup> An oil tanker which ran aground on 5<sup>th</sup> January 1993 off Sumburgh Head in Shetland.

- 7.3 The 1988 Act, which created the MAIB, did not affect the provisions relating to FIs, which had been in existence largely unchanged for very many years. For a long time they had been governed by section 466 of the Merchant Shipping Act 1894 (“the 1894 Act”). When this collision occurred they were governed by section 56 of the 1970 Act, as amended by section 48 (and schedule 5) and section 57(4) (and schedule 6) of the 1988 Act. Section 56(1), as so amended, gave the Secretary of State power to order an FI whether or not an investigation had been carried out under section 33 of the 1988 Act, that is whether or not an MAIB investigation had been carried out. Section 56(1A) provided that the wreck commissioner appointed to conduct an FI should do so under rules made under section 58(1).
- 7.4 So far as I am aware, only one FI has been ordered under section 56(1) of the 1970 Act since the enactment of the 1988 Act. That was an FI held in March 1990 into the loss of the fishing vessel BOY ANDREW. The last two FIs held under the 1970 Act before the amendment in 1988 were into the sinking of the HERALD OF FREE ENTERPRISE and of the DERBYSHIRE respectively. I acted as counsel for the owners of the HERALD OF FREE ENTERPRISE at that FI. The relevant statutory provisions at that time were slightly different. Section 55(1) of the 1970 Act gave power to the Secretary of State to order a preliminary inquiry and (whether or not a preliminary inquiry was held) to order an FI. By section 55(2), a person appointed to conduct a preliminary inquiry was given the powers conferred on an inspector under section 729 of the 1894 Act. Those were wide powers, which included the powers to take declarations under oath and to require the production of documents.
- 7.5 In cases in which the Secretary of State ordered an FI, he would either do so after a preliminary inquiry or would do so at the same time, so that in practice inspectors always carried out a preliminary inquiry. Moreover, the inspectors retained their powers during the FI, so that, if any matter required further investigation, it could be investigated by them, if necessary using their wide powers under section 729 of the 1894 Act, which were retained by section 55(2) of the 1970 Act. Section 55 was repealed by the 1988 Act. It follows that the formal position became somewhat different, although in practice the position would have remained much the same.
- 7.6 Section 55(2) was in effect replaced by regulation 6(2) of the 1989 Regulations, which gave the Chief Inspector power to order “in view of the seriousness of the accident” that the investigation take the form of an Inspector’s Inquiry, in which event the inspector or inspectors appointed by him was or were to have the powers conferred on an inspector by section 27 of the Merchant Shipping Act 1979. Those powers were similar to the powers originally conferred on inspectors by section 729 of the 1894 Act. I shall return below to the position today because it is affected by more recent regulations which were not in force at the time that an FI was being considered after the casualty.
- 7.7 The power to order an FI contained in section 56(1) of the 1970 Act, as amended by the 1988 Act, was expressed in substantially the same terms as it had been before. It was not restricted by the terms of the statute and was not expressly limited by any provision such as that contained in regulation 4 of the 1989 Regulations quoted above. The nature and purpose of an FI under section 466 of the 1894 Act were (as already stated) discussed by Steyn J in *The Speedlink Vanguard* [1986] 2 Lloyd’s Rep 265. See also McMillan on *Shipping Inquiries and Courts* (1929), which discussed the origin of FIs and the rules which governed them for many years, namely the Shipping Casualties and Appeals and Rehearings Rules 1923 (“the 1923 Rules”). Steyn J discussed the 1923 Rules extensively. He described the purposes of an FI in this way (at p 270):

There is, however, not a great deal of dispute about the purpose of such an inquiry. It is common ground that the primary purpose of such an inquiry is ... to assist in the preservation of a reasonable standard of safety of life and property at sea. The second purpose is to determine why a casualty occurred. The third purpose is to consider whether the casualty was caused by the wrongful act or default of any person and, if so, whether the court should impose penalties on those at fault. See McMillan ... pp 1-8.

The expression “wrongful act or default” is derived from section 470(1) (a) of the 1894 Act, which gave the FI power to cancel or suspend an officer’s certificate of competency if it held that, say, loss of life or serious damage was caused by his wrongful act or default. That expression was subsequently construed as meaning the same as a breach of a duty of care: see eg *The Princess Victoria* [1953] 2 Lloyd’s Rep 265. It was replaced by the expression “serious negligence”: see sections 56(4) and 52(1) (b) of the 1970 Act.

- 7.8 As I see it, the purpose of that change was to make it more difficult to suspend or cancel an officer’s certificate. It thus affected the third of the purposes identified by Steyn J, which was and is essentially a disciplinary function applicable only to certificated officers. The amendment in section 56 of the 1970 Act did not, however, affect the first two of the purposes referred to by Steyn J, which seem to me to be the same as those identified in section 5 above. Thus one of the purposes of an FI, both before and after the 1970 Act, was to establish the cause of the casualty.
- 7.9 The position remained the same at the time of this casualty, by which time the 1988 Act was in force. Section 56(1) as amended was in wide terms. One of the purposes of an FI ordered under it remained in my view to ascertain the cause of the collision. Thus, although the preliminary inquiry had been replaced by an MAIB investigation ordered by the Chief Inspector and he could order an Inspector’s Inquiry under regulation 6(2) of the 1989 Regulations, there was no change in the legal provisions, so far as an FI was concerned, as compared with the position immediately before the 1988 Act came into force. The 1989 Regulations themselves expressly recognised the possibility of an FI.
- 7.10 It may be noted in this regard that regulation 11 of the 1989 Regulations gave the Chief Inspector an express power to cause an investigation to be re-opened either in whole or in part if, after the completion of the investigation, in his opinion new and important evidence was discovered, or if for any reason there was ground for suspecting that a miscarriage of justice had occurred. The power of the Chief Inspector to reopen an investigation was thus restricted. There was no similar restriction on the power of the Secretary of State to order an FI.
- 7.11 The rules governing an FI at that time were the Merchant Shipping (Formal Investigations) Rules 1985 (“the 1985 FI Rules”), which are perhaps less formal than the 1923 Rules, but which nevertheless retain the adversarial nature of an FI under those rules. They were subsequently amended by the Merchant Shipping (Formal Investigations) (Amendment) Rules 1990 (“the 1990 Amendment Rules”). Those rules were not made until 25<sup>th</sup> January 1990 and did not come into force until 26<sup>th</sup> February 1990, but they must I think have been in preparation before the collision. They made two principal changes. The first derived from the HERALD OF FREE ENTERPRISE inquiry. Until then the case had always been presented to the FI by counsel for the Department. This was curious because it was not uncommon after a casualty for some criticism to be levelled at some aspect of the Department’s own activities.

- 7.12 This problem was addressed by the report of the FI in the investigation into the collision between the EUROPEAN GATEWAY and the SPEEDLINK VANGUARD. The wreck commissioner was Mr Nicholas Phillips QC and I took part in the FI as counsel for the owners of the EUROPEAN GATEWAY. The report, which was dated 3<sup>rd</sup> August 1984, included the observation that it would be preferable for a wreck inquiry to be conducted by counsel to the tribunal who is independent of the Department. At the FI into the HERALD OF FREE ENTERPRISE Mr David Steel QC expressed concern that he was counsel for the Department. In the report Sheen J essentially reiterated the view expressed by Mr Phillips. He said (at paragraph 60):

Further consideration should be given to the question of appointing counsel to the tribunal, and *not* on behalf of the Secretary of State, so that he can be seen to be wholly independent of the Department.

- 7.13 As a result, if somewhat belatedly, the rules were changed in the 1990 Amendment Rules. Paragraph 2(d) of those rules inserted a new rule 4A into the 1985 FI Rules as follows:

Where the Secretary of State has directed a formal investigation to be held, he shall remit the case to the Attorney General, and thereafter the preparation and presentation of the case shall be conducted by the Treasury Solicitor under the direction of the Attorney General; ...

The effect of those rules is that the case at an FI was (and is) to be presented by counsel, not for the Department, but for the Attorney General. As I see it, the effect of the change is that the Attorney General, or counsel on his behalf, while no doubt retaining his independence to make such submissions to the FI as he thinks appropriate, is now (as both Mr Phillips and Sheen J put it) to be counsel to the tribunal. I shall return to this point below.

- 7.14 The second principal change introduced by the 1990 Amendment Rules was that the new rule 4A which was inserted into the 1985 FI Rules continued as follows:

... the Chief Inspector of Marine Accidents shall render such assistance to the wreck commissioner and to the Attorney General as is in his power.

As I read that rule, its effect was to put the powers of inspectors appointed by the Chief Inspector at the disposal of the wreck commissioner and the Attorney General, so that they could ensure that all relevant matters were properly investigated. I shall also return to this point below in the context of this case because the position has been affected to some extent by the Merchant Shipping Act 1995 ("the 1995 Act") and the Merchant Shipping (Accident Reporting and Investigation) Regulations 1999 ("the 1999 Regulations").

- 7.15 I return first to the position as it was when the collision occurred. Although the legal position as to the ordering of an FI remained the same both before and after the MAIB came into existence, it is clear that the approach of the Department to the question whether an FI should be ordered was affected by the fact that the MAIB had recently been set up. But for that fact I have no doubt that an FI would have been ordered at the outset.

- 7.16 Even given the birth of the MAIB, it is to my mind surprising that an FI was not ordered. Captain Marriott was the first person to be appointed as Chief Inspector of Marine Accidents. A press notice announcing his appointment was issued on 8<sup>th</sup> December 1988. It announced the impending creation of the new system, and at the end of the notes for editors added this:

The arrangements for holding Formal Investigations into the most serious accidents will be unaffected.

Although it was subsequently suggested to Mr Hayes that that was a reference to the procedural aspects of FIs, I do not think that that is a convincing explanation. As I have already indicated, the power to order an FI remained essentially the same as before. I can see that there were now likely to be cases in which it would be sufficient to leave the investigation to the new body, which was intended, like the AAIB, to be independent of the Department, but there remained cases which cried out for a public inquiry. In my opinion this was one of them.

- 7.17 I note in this regard that, in a recent letter received by the Inquiry from Captain de Coverly, who was the Deputy Chief Inspector at the time and who (with Captain Vale and Captain Winbow) carried out the investigation in this case as inspectors, he said this:

Plainly there was a strong case for a Formal Investigation after the accident and although my colleagues and I eventually recommended otherwise, I do not think that my colleagues and I would have been greatly surprised or strongly resistant if one had been ordered. Certainly, speaking for myself, I think an investigation into any major accident should be open to some form of public scrutiny – though not necessarily a public inquiry of Formal Investigation type – and I welcomed the opportunity to explain our Report under examination at the Inquest. I regretted that it was so long after the event that this became possible. But I seriously question the value of proceedings now.

I shall of course return to the question whether an FI should be ordered now, but otherwise it seems to me that Captain de Coverly's instincts were right, no doubt because of his previous long experience of FIs.

- 7.18 I agree with him that an investigation of a major accident should be open to public scrutiny. As appears below, I have reached the conclusion that in this case the facts have at no time been open to the kind of public scrutiny which would be appropriate. It does not follow that the public scrutiny should take the form of an FI of the traditional kind. Indeed, for the reasons which I shall try to give below, there seems to me to be much to be said for the view that a new procedure should be adopted of a less adversarial kind than that at present envisaged by the 1985 FI Rules as amended by the 1990 Amendment Rules. The position as at August 1989 was, however, that the statute in force, namely section 56 of the 1970 Act (as amended), provided for public inquiries in cases of this kind to be by way of FI. In my opinion, if there was ever to be a case for an FI under that statutory regime, this was it.

### **Decisions Made Immediately and Events to the End of 1989**

- 7.19 The collision occurred in the early hours of 20<sup>th</sup> August 1989. At that time both the Secretary of State and Captain Marriott were on holiday. Captain de Coverly had been Principal Nautical Surveyor in the Marine Survey Service, which was part of the Department. For some years he had been Principal Nautical Surveyor and in that capacity had been involved with marine accident investigations, although he had of course only been at the MAIB for a very short time. Because Captain Marriott was away, Captain de Coverly was not only Deputy Chief Inspector but was acting as Chief Inspector and was temporarily in charge of the MAIB. The co-ordinating inspector, Mr Matthewson, was told of the casualty in the early hours of 20<sup>th</sup> August and almost immediately, at about 0400, telephoned Captain de Coverly.

7.20 Captain de Coverly decided that he should investigate the casualty himself and made arrangements for Captain Vale, who was the Principal Nautical Surveyor in the section of the Department responsible for the Thames, to work with him, at least initially. As Captain de Coverly explained to Mr Hayes, the MAIB was by no means fully staffed at that time. It was no doubt for that reason that it used surveyors from the Department, namely Captain Vale and Captain Winbow, who were seconded from the London Marine Office. Captain de Coverly started work immediately. He described the steps which he took initially in the evidence which he subsequently gave at the inquest in 1995. In this part of the report I am not concerned with the steps which he took to investigate the casualty, but with the reasons why no FI was ordered.

7.21 During the morning of 20<sup>th</sup> August Captain de Coverly was asked to go to 10 Downing Street to see the Prime Minister, who was of course then Mrs Thatcher. Before that, the question how they should proceed, including the question whether there should be a public inquiry, had been discussed with the Minister of State at the Department, who was Mr Michael Portillo. A decision had by then in effect been made under regulation 6(1) and (2) of the 1989 Regulations that the MAIB should conduct an investigation and that it should be an Inspector's Inquiry. When Captain de Coverly and Captain Marriott attended an oral session of the Hayes Inquiry, the following exchange occurred:

CAPTAIN RUTHERFORD: Was this an attempt to let the new department in fact or the new branch have a major investigation into the thing? I mean, why was the recommendation not have a public inquiry.

CAPTAIN DE COVERLY: Well, you say a recommendation not to have a public inquiry. That wasn't strictly speaking what the recommendation was. The recommendation was not to order a public inquiry at that stage. I mean, it would have made no practical difference to what we did because, even if you are going to have a public inquiry, there is still an investigation carried out under the old system, and the same would apply to the new system, to lay the ground for an investigation, as happened in the HERALD, for example.

THE CHAIRMAN: And that is then fed into the public inquiry, or as a separate investigation?

A: It is a separate investigation, but it is used as the basis for the presentation of what used to be the Secretary of State's case. It is now the Attorney General.

Q: Yes; the Counsel to the inquiry?

A: Yes, indeed.

Q: OK. That's very helpful. But what was the basis on which you gave the advice that it should be done the way it was?

A: Essentially, as Captain Rutherford has suggested, to give the new system a trial, see how it worked and see then if it was necessary to go further by way of a public inquiry, as opposed to, as was done on the HERALD, announcing forthwith that there should be a public inquiry. That is very unusual.

Q: Sorry; which was unusual, the HERALD?

A: Yes.

CAPTAIN RUTHERFORD: Unusual because of the high profile of the case?

A: That's right. The usual thing, even with a major case, is to wait, but the HERALD was such a serious case that the Secretary of State then decided, virtually at once, there ought to be a formal investigation.

THE CHAIRMAN: Because there was a press release when the branch was set up which said that it would carry out most investigations, except the most major. Do you remember that?

CAPTAIN MARRIOTT: No, I must admit I can't remember that.

Q: I think it announced, maybe in the same breath, your appointment and what the branch was doing. Maybe you will want to have a look at it when you get back. Certainly it's not unknown to the MARCHIONESS group, because they are asking us "Well, if this wasn't major, what was?" Your answer is that your discussion didn't exclude the possibility that ultimately there would be a public inquiry, but at the first stage at least there should be a normal investigation by this new branch?

CAPTAIN DE COVERLY: Yes, indeed, which there would have been anyway.

Q: Right. Did the Prime Minister utter any view on whether she would ever contemplate a public inquiry?

A. I honestly don't remember her doing so. The Secretary of State was not actually in this country at the time, so it didn't literally fall to him. Mr Portillo was the duty Minister and, as a matter of fact, we discussed it with him before we went into her presence and I don't think it was much discussed with Mrs Thatcher really. She accepted the recommendation.

It may be noted in passing that the press release referred to is the one which I quoted above.

- 7.22 Although that passage is rather long, I have included it because it seems to me to show reasonably clearly the reasoning behind the decision not to order an FI immediately. In short, Captain de Coverly advised the Minister, and then, in effect, the Prime Minister that the appropriate course was to have an MAIB investigation and not to order an FI at that stage. His view was that an FI could be ordered later if necessary, which was what had ordinarily happened before the setting up of the MAIB. He thought that it would make no difference because his investigation would be the same whether or not an FI was ordered at that stage. An Inspector's Inquiry was no different from the old preliminary inquiry, with which he was very familiar from his past experience in the Department.
- 7.23 We have seen a good deal of contemporary material from the period immediately after the collision, and I have no reason to doubt that the account given by Captain de Coverly is correct and that Ministers proceeded on that basis at that time. I have annexed to this report as Annex C a chronology which shows in outline the requests made from time to time for a public inquiry and the responses of various ministers over the years. The chronology was developed from a much more detailed chronology which has been prepared by Diana Weir

from the plethora of material sent to the Inquiry. I would like to thank her for all her work, but any errors in Annex C are entirely mine. In addition to the above, Annex C also contains the dates upon which the MAIB reported to the Department and the dates of the various prosecutions and the inquests. I have also seen a great deal of material which shows how the inspectors proceeded with their investigation and how (as one might perhaps expect) the final version of the MAIB Report went through a number of drafts. It is not, however, relevant to analyse that material in this section of the report. I shall refer to it to the limited extent that it seems to me to be relevant to the particular questions which I have been asked to consider in section 8 below.

- 7.24 Calls for a public inquiry began from the outset. For example, in a letter dated 21<sup>st</sup> August to Mr Portillo, Mr John Prescott MP referred to his belief that the preliminary inquiry would justify a fuller public inquiry. However, a number of safety measures were decided upon by the Department very shortly after the collision and the Secretary of State, Mr Cecil Parkinson, issued a statement to that effect on 21<sup>st</sup> August. In a note dated 22<sup>nd</sup> August, his assistant private secretary noted that the Secretary of State was pleased with the response to the package of measures, which had been widely welcomed, and that he would therefore resist for the time being any call for an FI beyond the remit of the MAIB. He would however consider it further in the light of public pressure.
- 7.25 On 29<sup>th</sup> August Captain de Coverly issued an interim report of his Inspector's Inquiry, setting out preliminary conclusions and making six recommendations. The covering note to the Secretary of State concluded by saying that he was making no recommendation relating to a public inquiry or a criminal prosecution on the basis that it seemed wise at that stage to leave the matter open. The Secretary of State decided to publish the six recommendations but not at that time the interim report.
- 7.26 The view of the MAIB can be seen from two notes of an official at the MAIB dated 27<sup>th</sup> September and 2<sup>nd</sup> October 1989 to the same effect. They both include the following:

The Inspector's Inquiry already underway is considered to be the appropriate form of investigation under the [1989 Regulations], taking account the "importance and seriousness of the accident". This does not rule out the possibility of a full [FI] under section 56 of the Merchant Shipping Act 1970. However, the new regulations provide for the Chief Inspector's Report to the Secretary of State on an Inspector's Inquiry case to be published. That seems to be the right time to assess whether or not an [FI] should be ordered.

We need to be careful. There have been other major disasters, for example the HERALD OF FREE ENTERPRISE, and the Clapham rail crash, where the full public inquiry procedure was ordered immediately. But given the recently introduced regulations governing marine accident investigation, it seems right to give the new measures a fair chance.

That view seems to me to be broadly consistent with the views of Captain de Coverly described above, although (reading between the lines) it perhaps suggests a distinct reluctance to recommend an FI, even after the conclusion of the MAIB investigation. So does a memorandum sent by Captain Marriott to Captain de Coverly and others on 9<sup>th</sup> October 1989 referring to a proposed response to be sent by the Minister to an MP concerning a letter from a constituent calling for a public inquiry. It included the following:

In no way does he disagree with our response, but he proposes an additional argument we can use. MAIB is modelled on AAIB. There is no great call for public inquiries into air disasters because AAIB enjoy widespread public confidence. Their investigation reports are published in the same way as it is intended ours will be, therefore there is no logical argument to hold formal investigations into marine accidents now that MAIB is operational.

As I see it, the difficulty with that argument is that it disregards the public nature of an FI as compared with the private nature of an MAIB investigation.

- 7.27 Annex C shows the progress of events thereafter. The police continued to investigate, as did the MAIB. The CPS was considering whether a prosecution should be brought. Consideration was also being given to whether any inquest could be opened. It was accepted I think that, if a prosecution were brought, no substantive inquest could take place and the MAIB Report could not be published, but there was pressure for a public inquiry. An example of such pressure is a letter from Pannone Napier dated 15<sup>th</sup> December 1989, written by Mr Michael Napier on behalf of the MARCHIONESS Disaster Solicitors' Group to the Secretary of State.

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- 7.28 On 19<sup>th</sup> January 1990 Mr Patrick McLoughlin, the Parliamentary Under Secretary for Aviation and Shipping, said, in answer to a parliamentary question asking for the reasons why an FI had not been ordered, that the MAIB investigation was the appropriate form of inquiry, that the lead inspector's findings were expected very soon and that the MAIB Report would be published. On 24<sup>th</sup> January the Secretary of State replied to Mr Napier's letter of 15<sup>th</sup> December along similar lines. His letter included the statement that the 1989 Regulations provided for the investigation into serious accidents to take the form of an Inspector's Inquiry. He wrote in similar terms to Mr Prescott.
- 7.29 On 26<sup>th</sup> January the Inspectors' Report was delivered to the Chief Inspector with a covering memorandum signed by the three inspectors in these terms:

We submit herewith the Report of our Inquiry. We believe that we have established the essential facts of the accident and we have made a number of recommendations which, if acted upon, will we trust prevent a repetition and will improve the safety of small passenger vessels generally. If our findings and recommendations are given suitable publicity we see no need for a further Public Inquiry. Furthermore, a Public Inquiry would take considerable time and therefore lead to undesirable delay in the release of a report on the accident. We recommend, therefore, against holding such an Inquiry. We also recommend against any other form of court action. While undoubtedly there were serious faults, the fundamental causes of the accident embrace so broad a field that to single out any individual for prosecution seems to us invidious. In this connection, the Police have asked to see a copy of our Report. We see no objection to this, given that it be supplied on the usual confidential basis and for background information only.

The form of the report is discussed in section 8 below. The reference to the delay in publishing the report if a public inquiry were to be ordered, by which I think that they probably meant the MAIB Report itself (ie the final Chief Inspector's Report), no doubt derives from regulation 9(1) of the 1989 Regulations, which suggests that that is the position. It should however be noted that by regulation 9(7) the Chief Inspector has power,

notwithstanding regulation 9(1), at any time during the course of an investigation to release information and recommendations if in his opinion it is necessary or desirable to do so in the interests of safety. That regulation seems to me largely to nullify the point about delay in the above quotation because it ensures that information relevant to future safety can be made public at once.

- 7.30 On 5<sup>th</sup> February the Chief Inspector sent the Inspectors' Report to the Secretary of State with the annexes but without the appendices, and thus (as explained in section 8 below) without the evidence in support of the conclusions. On 12<sup>th</sup> February Mr McLoughlin told the House of Commons that the Secretary of State would decide whether to order an FI when he had the Chief Inspector's Report. On 15<sup>th</sup> February Mr Napier wrote to the Secretary of State objecting that in his letter of 24<sup>th</sup> January the Secretary of State had suggested that an MAIB inquiry was an adequate substitute for an FI. I note in passing that Mr Napier correctly recognised that an FI would be the appropriate form of public inquiry. On 2<sup>nd</sup> March the Secretary of State replied saying that he would make his decision on receipt of the Chief Inspector's Report.
- 7.31 On 1<sup>st</sup> March Captain de Coverly and Captain Marriott discussed the position with the Secretary of State and Mr McLoughlin. According to the note of the meeting, the Secretary of State congratulated Captain de Coverly on producing an excellent and detailed report. He and Mr McLoughlin were satisfied that no useful purpose would be served by a public inquiry as the report had covered the ground so thoroughly. It was noted that there was at present no great pressure for a public inquiry but some concern at the length of time taken to produce the MAIB Report. It was agreed that they should therefore press ahead to get the MAIB Report published as soon as possible. The Chief Inspector explained that his report would be almost identical to the Inspectors' Report. The most important difference would be that it would include the Chief Inspector's observations on the inspectors' findings. The Chief Inspector's Report had now been completed and the next step would be to send it to any person whose reputation was likely to be affected by the report as required under Regulation 9(4) of the 1989 Regulations. Any such person would then have 28 days to comment after which a further 28 days could be allowed if changes were needed to the report.
- 7.32 It was agreed that the covering letter to recipients of the report should be drafted tactfully to avoid causing offence and should stress the need for strict confidentiality at this stage. Captain de Coverly reported that the DPP had not yet reached a decision on whether or not to mount a prosecution. He expected to do so by the time the report was finalised. Should he decide to prosecute, progress on the report would be suspended pending completion of legal proceedings. It was noted that the criticisms of the Department in the report – particularly of decisions on watch-keeping rules following accidents in 1982/83, and on the design standards for ships such as the MARCHIONESS – would need careful handling. In response to an oral question tabled by Mrs Joan Ruddock MP, Mr McLoughlin would say that the Chief Inspector's Report was complete subject to the statutory consultation required under the regulations. He would also take the opportunity to report that Ministers had decided not to hold a public inquiry.
- 7.33 In the event the answer given in the House of Commons on 12<sup>th</sup> March was slightly different. Mr McLoughlin said the MAIB Report would be available in about seven weeks after those concerned had been asked to comment on it. As Annex C shows, it had in fact just been sent to various people and bodies for comment in accordance with the 1989 Regulations. Mr McLoughlin said that they (by whom I think he must have meant Ministers) were satisfied of the extremely thorough nature of the inquiry, that they were also

satisfied that the report would be based on the evidence and that they did not want to delay publication, whereas if a public inquiry were ordered they would not be able to publish the report. He added that if something serious came forward it would still be open to the Secretary of State to set up a public inquiry.

- 7.34 On 15<sup>th</sup> March Captain de Coverly prepared a detailed reply for the Secretary of State to send to Dr David Owen MP. I quote part of his draft because it shows the thinking of the MAIB at the time:

Thank you for your letter of 7 March about the loss of the MARCHIONESS on the river Thames last August. I entirely agree that it is important that those who suffered as a result of the tragedy should know the facts of the accident as soon as is possible; but you, I am sure, will agree that it is vital that the investigation should be painstaking, and this means that it does take time. You will know from what was said in the House on 12 March, that my present intention is to publish the Report by the Chief Inspector of Marine Accidents as soon as possible. The Report is based upon a very thorough investigation, as you will see when it is made public. If I were to order a Formal Investigation, the Accident Investigation Regulations do not permit the Chief Inspector's Report to be published, so that there would be a longer delay before the causes of the accident could be published; I understand your view on the value of a public inquiry, but I feel sure that when you see the Report you will agree that in this instance it is unlikely that such proceedings would add to the Inspectors comprehensive findings. The Chief Inspector's Report has been sent, as the Regulations require, to those parties who are the subject of critical comment; they have one month in which to respond and, if necessary, a further month in which they can submit an alternative text (which must be published as an Appendix to the Report) for any passages still in issue. Provided that there is no prosecution pending, and that nothing has occurred to decide me after all to order a Formal Investigation, the Report will be published as quickly as is practicable after this process is complete.

I have little doubt that those views were shared by the Department.

- 7.35 Shortly after that, on 19<sup>th</sup> March, the draft MAIB Report was leaked to the press. As a result, both the MAIB and the Department appreciated the need to publish the report as soon as possible. A number of comments were received, as shown in Annex C, although I am not concerned with them at present. On 29<sup>th</sup> March Mr McLoughlin told the House that he had received several requests for a public inquiry but that he preferred to publish the MAIB Report as soon as possible. I shall not repeat here the detailed events set out in Annex C.
- 7.36 On 19<sup>th</sup> April Captain Marriott sent the Department a briefing note, which was further to an earlier note expressing concern about the leak. It described the process, but also included the following:

The Secretary of State proposes to publish the Report in full as soon as possible after he has received it. However if the Director of Public Prosecutions decides to prosecute, a decision he has not yet taken, the Report may not be published until the case, including any appeal, is concluded.

That is what in fact happened.

- 7.37 Between 23<sup>rd</sup> and 26<sup>th</sup> April Dr Knapman heard evidence in inquests in 44 cases, although very little evidence about how the collision occurred was given at that stage. On 26<sup>th</sup> April the DPP announced a charge against Captain Henderson under section 24(4)(b) of the 1970 Act, as substituted by section 30 of the 1988 Act, of “failing properly to discharge a duty, namely to ensure that a proper lookout was kept by all available means, to such an extent as to be likely to cause the loss or destruction of or serious damage to another ship or the death of or serious injury to another person”. The DPP also indicated that no other charges would be brought against any other person or company and wrote to the coroner, requesting an adjournment of the inquests under section 16(1)(b) of the Coroners Act 1988. The coroner accordingly adjourned the inquests.
- 7.38 The events thereafter are set out in some detail in Annex C, so that it is not necessary to do more than refer to them briefly in the body of this report. From 8<sup>th</sup> May there was set up a system for all claims to be paid in full after being either settled or determined. Committal proceedings against Captain Henderson took place and he was committed for trial. Pending that trial, the full MAIB Report was not published in spite of many attempts to persuade the Secretary of State to publish it. The only parts that were published were those containing the recommendations for future safety. There was no question of an FI being ordered pending publication of the MAIB Report and I do not think that, even if an FI had been ordered, it would or could have taken place until the criminal proceedings had been completed. As I indicated at the end of section 6, an application for judicial review of the DPP’s decision to refuse to prosecute Captain Henderson or the owners of the BOWBELLE for other offences, including manslaughter, was dismissed by Nolan J on 30<sup>th</sup> October 1990. He held that there was no legal basis for challenging that decision. The application was not renewed in the Court of Appeal.
- 7.39 The attitude of the new Secretary of State, Mr Malcolm Rifkind QC MP, was essentially the same as that of his predecessor. Thus, in his letter to Mr Napier dated 6<sup>th</sup> December 1990, he said that he remained convinced that a further inquiry could only be justified if more information was likely to emerge which might help prevent a future tragedy.

## 1991

- 7.40 Mr Rifkind’s approach can be seen from this paragraph from his letter to Mr William Gorman, then chairman of the MARCHIONESS Action Group (“MAG”), dated 23<sup>rd</sup> January 1991:

On the point about the adequacy of the MAIB Inquiry, I can assure you that the Inspectors carried out a most thorough investigation, and this will be evident when the Report is published. The Inspectors took evidence, either orally or in the form of written statements, from well over one hundred people including nearly all the survivors. It is true that they did not interview personally many of the surviving passengers: this was because they had copies of their statements made to the Police. It was clear from those statements that most of the passengers, as one would expect, were quite unaware of the circumstances leading to the accident; and in the Inspectors’ opinion, requiring them yet again to re-live the events of the night would have added to their distress without any gain to the Inquiry. This view was reinforced by the fact that of those passengers who the Inspectors did approach, most either declined their invitation to interview or failed to reply, and only one wished to make any addition to his statement to the Police.

The first trial of Captain Henderson ended with the jury failing to agree on a verdict in

April. He was retried in July, but the second trial also ended in disagreement, whereafter the prosecution offered no evidence and he was formally acquitted.

7.41 In the meantime, as Annex C shows, further efforts were made to secure an FI and Mr Ivor Glogg began a private prosecution against the owners of the BOWBELLE and some of their directors. Consideration was also given by the MAIB and the Department as to what might be said in public when the MAIB Report was finally published. On 11<sup>th</sup> July Captain Marriott sent the Department a draft note for Ministers giving reasons why no public inquiry into the collision should be ordered. In his note he expressed the view that to order an FI would question the credibility of both the MAIB and the AAIB, upon which the MAIB was broadly modelled.

7.42 On 12<sup>th</sup> July the Department made submissions to the Secretary of State, as set out in detail in Annex C, giving reasons why an FI should not be ordered. Those submissions, which were in the form of a detailed note from a Deputy Secretary, included the following paragraph:

I do not believe that giving the relatives another platform is sufficient reason to justify the expense of a Formal Investigation. There is also the question of the position of the MAIB. The Branch was established in 1989 as an independent authority to ensure that marine accidents are investigated thoroughly, quickly and independently. These aims were achieved in the Marchioness case. It was of course recognised in debate on the Merchant Shipping Act 1988, which set up the MAIB, that an accident of major proportions might still need to be the subject of a formal investigation, despite the existence of the Branch. The decision to use the MAIB in this case perhaps owed something to the plethora of public inquiries into various disasters over the preceding year or two, and the Marchioness could easily have been added to the list. But to order a Formal Investigation at this late stage without evidence of a significant deficiency in the MAIB investigation would call into question the credibility of the whole accident investigation system, including, by extension, that of the AAIB.

I do not accept that to order an FI would call into question the credibility of the whole accident investigation system, including, by extension, that of the AAIB. In my opinion there are some cases which call for a public inquiry, as shown in paragraph 17(ii) of the Lord Chancellor's paper dated 16<sup>th</sup> May, which is referred to as a Note in Annex C and is reproduced in Annex D.

7.43 The Secretary of State accepted the recommendation that calls for a public inquiry should be resisted. To that end, on 16<sup>th</sup> July a meeting took place between representatives of the Department and of the MAIB at which answers to a number of anticipated questions were agreed. They included the following:

Q: Why hasn't there been a public inquiry (Formal investigation) when the relatives of those lost clearly want one?

A: Public inquiries are set up to establish the cause of disasters, and to recommend measures needed to prevent a repetition. When an expert inquiry – such as MAIB's – has been conducted, then a further inquiry would only be justified in the unlikely event of evidence being produced which had not been considered by MAIB and which seemed likely to have a bearing on the findings and might help prevent a future tragedy.

In short the agreed line was that MAIB investigations essentially take the place of FIs.

7.44 There was then a delay until 15<sup>th</sup> August in publishing the report while consideration was given to the pending private prosecution. This delay caused considerable concern, both in the Department and at the MAIB. Indeed correspondence on the subject was exchanged directly between the Secretary of State and the Attorney General. In support of early publication, Captain Marriott commented in a memorandum to the Department that, while

publication of my report would not absolutely rule out a subsequent FI ... it is to be hoped that by demonstrating the extent of our inquiry, it would lead to pressure for further investigation abating.

7.45 In the meantime, on 1<sup>st</sup> and 9<sup>th</sup> August respectively Mr Napier and Mr Prescott wrote to The Times making the case for a public inquiry. Mr Prescott was at that time the Shadow Secretary of State for Transport. He concluded his letter by saying that his party was committed to securing a better legal framework for the aftermath of disasters and that, if he were soon to become Secretary of State, he would immediately grant an inquiry into the case of the MARCHIONESS to prevent any “fancy legal dancing”, unless Mr Rifkind announced one first, which he should. It was perhaps longer before Mr Prescott became Secretary of State than he hoped at that time.

7.46 The MAIB Report was finally published on 15<sup>th</sup> August. The accompanying press notice had annexed to it an “addendum” to the report which gave further information on three matters “which have been the subject of concern to correspondents”. The first of these matters was an explanation as to why not all of the survivors had been interviewed by the inspectors. A copy of the press notice and the addendum are Annex E to this report. On 11<sup>th</sup> September a meeting was held with the Secretary of State to consider where the Department stood following the publication of the report and to consider what response to give to calls for an FI. No final decision appears to have been made at that meeting, although a later minute recorded that the Secretary of State had it in mind at the meeting to commission a review of the way in which the Surveyor General’s Organisation had adjusted its approach to ship safety.

7.47 The Secretary of State also wrote to the Attorney General in September. In his letter he noted that the Department’s plan had been to rely upon a full investigation by the MAIB, with the public interest being looked after by the published report and by the inquest, but that this strategy had been derailed by the decision to prosecute Captain Henderson, which had led to the adjournment of the inquest and the delay in publication of the MAIB Report. He observed that the adjournment of the inquest and the delay in publication of the report had left relatives and survivors feeling justifiably aggrieved that there had been so little public information available about what happened and that this had fuelled demands for a public inquiry to be set up.

7.48 On 22<sup>nd</sup> October a meeting was held between the MAG and the Secretary of State (attended by Captain de Coverly and others) at which the Secretary of State was urged to order an FI. The representations made by the MAG were considered at a meeting on 11<sup>th</sup> November with the Secretary of State which was attended by Captain Marriott and Captain de Coverly, among others. The purpose of the meeting was to decide whether the Secretary of State should order an FI (or some other form of inquiry). In advance of the meeting, various briefing notes were prepared for the Secretary of State, including one by Captain Marriott dated 4<sup>th</sup> November which dealt with the circumstances in which FIs had been ordered in the past and identified their limitations.

- 7.49 It was at this meeting that the decision appears to have been made to hold a more general inquiry into matters raised by the MAIB Report along the lines of the inquiry mooted by the Secretary of State at the meeting of 11<sup>th</sup> September. It was this that led to the setting up of the Hayes Inquiry on 19<sup>th</sup> December. Although an FI was not entirely ruled out, a Departmental minute to the Secretary of State dated 3<sup>rd</sup> December, reiterated the point that it was necessary to take into account the effect of an FI on the MAIB, “which was set up to avoid the need for such inquiries and would be seen to have failed at the first hurdle”, if an FI was ordered.

### 1992 and 1993

- 7.50 The Hayes Inquiry considered safety on the Thames generally, but did not inquire into the causes of the collision because it was not part of its terms of reference to do so. It produced many valuable recommendations (to which I have referred in my interim report), but perhaps the only relevant part of it for present purposes is Mr Hayes’ consideration of a number of earlier incidents on the Thames which were not referred to in the MAIB Report. The Hayes Report was published in July 1992.
- 7.51 In the meantime, as again appears in Annex C, both the used and unused material with regard to the private prosecution were sent to the CPS and to the MAIB. The CPS and the MAIB both decided that the new material did not affect their earlier conclusions. The MAIB did not alter its report in any way and the CPS did not change its decision not to prosecute for manslaughter. The committal proceedings in the private prosecution went ahead, but on 25<sup>th</sup> June the Chief Stipendiary Magistrate dismissed them on the ground that no jury could be sure that any of the acts or omissions alleged against any of the defendants had caused the casualty.
- 7.52 The MAG and others pressed throughout for a public inquiry, relying on a number of different matters including a critique of the MAIB Report which they had obtained from Dr Brian Toft. There was an adjournment debate in the House of Commons on 9<sup>th</sup> July 1992, when Mr Spearing and Mrs Joan Ruddock argued the case for a public inquiry. It was, however, rejected by Mr Steven Norris, the Minister for Transport for London, on the same grounds as before, namely that a thorough inquiry had been carried out by the MAIB and that there were no grounds for a public inquiry. In advance of a proposed meeting between the MAG and the Minister for Shipping, a briefing note was prepared by the Department for the Minister and reviewed by Captain de Coverly, although the note did not contain any recommendations. I am not sure whether the meeting went ahead.
- 7.53 The relatives of those who died also turned their attention back to seeking an inquest, but on 22<sup>nd</sup> July 1992 Dr Knapman refused to re-open the inquests. On 7<sup>th</sup> July 1993 the Divisional Court refused leave to move for judicial review of that decision but Neill LJ expressed the view about a public inquiry which I quoted above. In the meantime pressure for an FI continued but the Department maintained the same line as before. For example, on 13<sup>th</sup> April 1993 Lord Caithness, the Minister for Aviation and Shipping, wrote to Mr Perks, who had written a detailed letter to him, setting out the Government’s position on a number of matters. He said that Annex 1C to the MAIB Report depicted how the inspectors considered the accident had developed and concluded in this way:

In conclusion, I am sorry that you feel that the accident has not been treated fairly. I cannot agree. A very thorough and comprehensive investigation was carried out by the Marine Accident Investigation Branch. The Report of the Chief Inspector of Marine

Accidents has been published, placing the full facts in the public domain. I cannot see that the holding of a Formal Investigation (the term for a public investigation or inquiry under the Merchant Shipping Acts) would be likely to add to the Inspectors' findings or to the recommendations made.

- 7.54 On 8<sup>th</sup> December the Channel Four programme *Dispatches* was screened suggesting that there was further evidence available. There followed a debate in the House of Commons on 14<sup>th</sup> December, in which Mr Spearing, Mr Simon Hughes and Mr Frank Dobson each played a prominent part. Mr Robert Key responded in place of Mr Norris. He rejected the suggestion that the programme introduced new material. He said that the terms of reference of an FI were the same as the terms of reference of an MAIB investigation and that since there had been a thorough investigation by the MAIB, a public inquiry would not achieve anything which had not been achieved by the MAIB.
- 7.55 In a letter dated 30<sup>th</sup> December the Secretary of State, Mr John MacGregor, wrote to Mrs Margaret Lockwood Croft. The letter included the following:

But I can find nothing in the programme to give me cause to think that the Inquiry carried out by the Marine Accident Investigation Branch was less than thorough or that a further Inquiry would add to the account and findings published in the Chief Inspector's Report.

The shortcomings of both *MARCHIONESS* and *BOWBELLE* in so far as they related to the accident were fully covered in the Report and the position it gives for the accident – the only matter in which the programme is significantly at variance with the Report's findings – is strongly supported by the great weight of evidence. Contrary to the impression given by the programme, most witnesses from the *HURLINGHAM* who were able to give an opinion said that it took place between Southwark and Cannon Street Bridges; so did witnesses ashore; and so, most importantly, did the Mate of the *MARCHIONESS* who was on deck at the time just outside the wheelhouse. Further, the wreck of the *MARCHIONESS* lay well to the East of Southwark Bridge and there was a strong tide flowing Westwards towards the Bridge. The evidence of survivors and the nature of the damage is entirely consistent with the Report's findings on the probable cause of events; the expert who appeared on the programme is certainly right in saying that the major damage amidships took place after the boat had been rolled over by the *BOWBELLE* but this supports rather than otherwise the probability that *MARCHIONESS* was heading slightly across *BOWBELLE*'s bow at the time of the initial impact.

## 1994

- 7.56 On 7<sup>th</sup> January 1994 Lord Caithness wrote to Mr Spearing setting out in some detail the reasons why he had concluded that the materials in the *Dispatches* programme did not alter the position as set out in the MAIB Report. It is clear from the following passage that the letter was written after obtaining the opinion of the MAIB:

In fact, the programme covered no ground not examined by the Inspectors. Their Inquiry had been comprehensive with evidence gathered from interviews, police statements, correspondence, documents and records and examination of the vessels; passages on the river were made including a re-enactment so far as was possible in the same conditions as those of the accident; and two research projects were commissioned.

The principal findings were that the immediate cause of the collision was failure of either vessel to see the other and major contributing factors were the construction of the vessels – so that in both of them the view from the conning position was severely limited – and slack practice in some aspects of river navigation which had grown up over many years. The television programme did not dispute these findings; it differed significantly from the MAIB Report only as to the position of the collision and the heading of MARCHIONESS at the time. On the former, MAIB found the collision to have occurred between Southwark and Cannon Street Bridges while the programme suggests it was at or just above Southwark Bridge. Evidence for the MAIB position was so overwhelming that the Inspectors had no doubt and the programme contains nothing to change that view. Evidence on heading is less positive and the MAIB Report admits a degree of uncertainty, but there is little doubt that the two vessels were at least slightly converging rather than on identical headings as the programme suggests; moreover as MAIB said the precise mechanics of the collision were less important than the circumstances leading to it.

- 7.57 On 11<sup>th</sup> January Mr Norris gave detailed written answers to detailed questions asked in the House by Mr Spearing. They were along the same lines as the letter which I have just quoted, but I note that, in answer to the question whether he would deposit the Inspectors' Report in the library of the House of Commons, he said that the only copy of it was sent by the inspectors to the Chief Inspector in accordance with the 1989 Regulations and that it continued to be held by him. He thus in effect refused to deposit it in the library. On 12<sup>th</sup> January Captain Marriott wrote to Mrs Lockwood Croft saying that he could not add to what Mr MacGregor had written in the letter of 30<sup>th</sup> December 1993 quoted above. It is thus clear that all the replies given by Ministers were written after obtaining the views of the MAIB.
- 7.58 Attempts to obtain a public inquiry continued throughout 1994, but the responses were always in similar terms. Some of the requests and replies are referred to in Annex C. These included a long and detailed letter from Michael Grade, the Chief Executive of Channel Four Television, to Lord Mackay of Ardbrecknish (at the Department) on 16<sup>th</sup> June 1994 urging a "full and open inquiry". His letter did not, however, have the desired effect because on 11<sup>th</sup> July Lord Mackay replied saying that he did not agree that the case for a public inquiry was overwhelming, that the MAIB inquiry was thorough and that there was nothing in the letter to cast doubt on "the essential causes of the accident as clearly set out in the MAIB Report". He added in effect that in the light of the previous inquiries, including the Hayes Inquiry, there was no reason to think a further inquiry would add to safety in the future. In the meantime on 10<sup>th</sup> June the Court of Appeal had allowed an appeal from the decision of the Divisional Court and ordered new inquests. Dr John Burton was subsequently appointed to conduct them.

## 1995

- 7.59 The resumed inquest (or strictly inquests) took place between 13<sup>th</sup> March and 7<sup>th</sup> April: see further section 9 below. Before the inquest, the families persuaded the Government to provide funds for them to be represented. The jury returned a verdict of unlawful killing. Although they were not permitted to say at whom it was directed, it could not properly have been directed at any act or omission by Captain Henderson or the owners of the BOWBELLE because the coroner directed the jury that they could not return a verdict inconsistent with the results of the prosecutions, in which he included the failure of the committal proceedings against the owners of the BOWBELLE. The jury also made a number

of recommendations, some of which I discussed in my interim report. I refer to the remainder in section 12 below.

- 7.60 Representatives from the MAIB and the MSA attended the entire inquest. In a Departmental memorandum to the Secretary of State dated 10<sup>th</sup> April 1995, reference was made to various issues which had arisen at the inquest. It was pointed out that although, following the jury's verdict, a number of statements had been made pressing for a public inquiry, it could be said that the safety lessons had now been fully considered and appropriate recommendations made and (save for the jury's recommendations) implemented, and that there appeared to be no justification for an FI. It was also pointed out that, in the context of public inquiries generally, they had not necessarily been the most effective or appropriate means of learning the safety lessons following an aircraft or shipping accident, and that it was for this reason that the AAIB/MAIB approach had been adopted and much Ministerial effort had been expended to explain and defend it. The submission accordingly recommended that Ministers should resist calls for a public inquiry into the disaster.
- 7.61 After the inquest the families returned to their efforts to persuade the Secretary of State to order an FI. They failed for essentially the same reasons as before. The details are set out in Annex C. On 10<sup>th</sup> May Lord Goschen wrote to Ms Louise Christian of Christian Fisher, in response to a letter from her, saying that the Chief Inspector must re-open an investigation if "in his opinion new and important evidence has been discovered", that he was considering the matter in the light of the evidence given at the inquest and that he would write to her when he had done so. Accordingly on 19<sup>th</sup> May Captain Marriott wrote a letter to Christian Fisher that included the following:

... I am required to re-open a completed investigation if in my opinion new and important evidence has been discovered. Although some of the information put to the Inquest is undoubtedly "new" evidence it is not "important" evidence to the extent that had it been known at the time by the Inspectors who carried out the investigation it would have materially altered their findings as to the cause of the accident. It is not therefore my intention to re-open the MAIB investigation on the basis of the information put to the Inquest.

Christian Fisher replied on 22<sup>nd</sup> May and on 7<sup>th</sup> June Captain Marriott responded, saying that for evidence to be regarded as "new and important" it must be germane to causation of the accident and tend to disprove the findings of the Inspectors' Inquiry or have a reasonable chance of so doing.

- 7.62 It is clear from those exchanges that Captain Marriott was applying the express provisions of the 1989 Regulations, as it was his duty to do. It is equally clear from what followed, and indeed from the whole approach of Ministers throughout this period, that they approached the question of whether there should be an FI in the same way. They also replied to a number of different points made on behalf of the families by the MAG. As appears in Annex C, they wrote rejecting an inquiry under section 52 of the 1970 Act. An example of such a letter was that written to the MAG by Lord Goschen on 8<sup>th</sup> September. In that letter he also rejected a suggestion that had been made that the MAIB Report was not full or honest. He pointed to the fact that the jury at the inquest had accepted the findings of the report, which was presumably a reference to their acceptance of the place of the collision, and added that, as to the question of alcohol consumption, he understood from the Chief Inspector

that this was taken into account by his Inspectors, who relied upon the results of blood and urine samples provided to the police, and on the fact that a search of the BOWBELLE by the police revealed no sign of any drinking on board.

I shall return to the question of alcohol below because, as will be seen, it seems clear that, for whatever reason, the MAIB did not have all the information which was available to the police. I should, however, make it clear that there can be no proper suggestion that the inspectors did not address their task both honestly and conscientiously in order to discover the true facts as best they could.

- 7.63 During 1995, as touched on in Annex C, there was some publicity alleging that there was potential significance in the fact, if it was the fact, that Ready Mixed Concrete (“RMC”), the parent company of the owners of the BOWBELLE, had paid for the refurbishment of a private office for Mr Thatcher when he and Mrs Thatcher left Downing Street in November 1990. I must, however, stress that I have seen no evidence that any action by RMC at any stage influenced the decisions of either Mrs Thatcher when Prime Minister or of any other member of the Government in connection with any of the matters which I am considering. I only mention them at all because they are referred to from time to time. I have disregarded them altogether in arriving at my conclusions.

#### 1996

- 7.64 Throughout 1996 the families continued to press for a public inquiry and also (as they had in 1995) for the DPP to take action in the light of the verdict of the jury at the inquest. On 26<sup>th</sup> July the CPS wrote to the MAG saying that, after a review of the evidence in the light of the verdict of the jury at the inquest, there was insufficient evidence to enable a successful prosecution to be undertaken. In Annex C I have summarised Christian Fisher’s response to that decision in a letter dated 29<sup>th</sup> July. Mr Spearing, who (with Mr Hughes) was continuing to take an active interest in the whole matter (as indeed they have done during this Inquiry), wrote to the DPP questioning the decision on 27<sup>th</sup> July and 31<sup>st</sup> August. Mrs Barbara Mills QC, the DPP, replied in some detail by letter dated 20<sup>th</sup> September to Mr Spearing. Thereafter the MAG continued to press for a public inquiry. In particular, as appears from Annex C, they did so by approaching Ms Glenda Jackson MP, who on 25<sup>th</sup> November confirmed continuing Labour support for a public inquiry.

#### 1997

- 7.65 The Home Office Report of the Disasters and Inquests Working Group, part of which is quoted below, was published in March. A survivor was awarded damages for post traumatic stress disorder (“PTSD”). The claims based on PTSD were adjudicated upon by the court or settled, in accordance with the scheme laid down on 8<sup>th</sup> May 1990. In these circumstances I do not think that it is necessary for me to set out the problems of stress in detail, except to say that I recognise that the stress likely to be sustained after an accident of this kind is considerable.
- 7.66 There was of course a change of Government on 2<sup>nd</sup> May 1997, which, perhaps naturally (in the light of all that had gone before), encouraged the MAG to redouble its efforts to persuade Ministers to order a public inquiry. On 25<sup>th</sup> August a meeting was held between the

MAG and others and Ms Jackson, who was now Minister for Transport. As appears from Annex C, a number of people wrote to the Minister, including Christian Fisher, who set out their case in detail in a letter dated 22<sup>nd</sup> September. They also enclosed with that letter a number of statements which had been used in the private prosecution. There followed correspondence in which the Department sought further statements from the MAG and from Christian Fisher, but it appears that witnesses were reluctant to give further statements except in the context of a public inquiry.

- 7.67 Internal Departmental documents at this time show that there was considerable consultation between officials within the Department and the MAIB. The view of officials in both camps (as it were) essentially retained the same view as they had held throughout the whole history of the matter, namely that there should be no re-opening of the MAIB investigation and no FI unless there was significant new information available, which in their view there was not. That view was reflected in the letter of 2<sup>nd</sup> December from Ms Jackson to Christian Fisher, in which she said that in considering whether to order a public inquiry into the MARCHIONESS disaster the Secretary of State “will need to know whether there is any new and important evidence that has not been heard previously”. That approach seems to me to be in line both with the views of officials in the Department and the MAIB and with the views of Ministers in the previous Government.

### **1998 and 1999**

- 7.68 The events of 1998 (or some of them) are set out in Annex C. Both officials and Ministers essentially maintained the line just described and the Department prepared a memorandum recommending that no further inquiry should be held. It consulted both the police and the MAIB, who took the same view. The final detailed memorandum was delivered to Ministers on 11<sup>th</sup> February 1999. It essentially repeated the same points that had been made many times over the years. The matter was, however, subsequently reconsidered, with the result that this Inquiry was announced on 18<sup>th</sup> August and I have been engaged in conducting it since 20<sup>th</sup> September, as explained in my interim report.

### **Postscript**

- 7.69 In setting out the facts, both in Annex C and in the above paragraphs, I have drawn on materials from a number of sources. If I have left any material fact out (which is almost certain given the amount of material sent to me), I apologise. The materials have included not only those provided by the many correspondents, but also Department files for both this Government and the last. I should, however, note that a considerable number of files from the last Government, especially during the time when Mr Major was Prime Minister, arrived after the substance of Annex C had been prepared. Assisted by Diana Weir, I have done my best to include relevant material from those years in Annex C, but there may be more omissions from that period than from others. I have not, however, delayed my report to remedy those omissions because the reasons why no public inquiry was ordered emerge clearly from the materials which I have seen. In these circumstances I have reached the firm conclusion that the public interest would not be served by further delay, but that I should finalise my report now.

## Conclusion

- 7.70 The reason why an FI was not ordered at the outset was that it was decided to wait until the MAIB Report was complete, when the matter could be reviewed. The fact that the MAIB had recently been set up and that it should be given a chance to do what it had been set up to do was a factor in the matter being approached in that way. I have no doubt that, if the MAIB had not been set up, but the old system had still been in operation, an FI would have been ordered at an early stage, although the irony is that, as Captain de Coverly pointed out in the passage quoted above, the Inspector's Inquiry was itself regarded as no different from the old preliminary inquiry.
- 7.71 After the MAIB Report had been published, although many calls for a public inquiry were made, Ministers resisted those calls on the advice of the Department and the MAIB. The MAIB was consulted at every stage in the process. The documents show that there has throughout been very close contact between the Department and the MAIB and that for the most part an approach was agreed between them before it was put to Ministers. I shall return to this point below. The Department and the MAIB have maintained their stance throughout, although it is fair to say that the Department has itself made no submission to me on the topic. I recognise that, given that this Inquiry has been set up by the Secretary of State, it would have been difficult for it to do so.
- 7.72 A number of factors made up the advice given to and accepted by Ministers, of which these seem to me to be the main ones. A full and thorough investigation had been carried out by the MAIB. Although some evidence produced after the MAIB Report was made could be said to be new evidence, it was not important evidence because it did not alter the basis of the conclusions reached by the inspectors and set out in the MAIB Report. It followed that nothing further could be gained by a public inquiry, especially since all relevant lessons had been learned as a result of the various investigations, including the Hayes Inquiry.
- 7.73 There was an additional consideration which ran through the thinking of the MAIB, the Department and Ministers throughout. It was that the MAIB had recently been set up along the lines of the AAIB, that AAIB investigations had almost entirely avoided the necessity for public inquiries and that, if an FI were to be ordered after the publication of the MAIB Report the newly formed MAIB would lack support or credibility.

## 8 Should a Public Inquiry Have Been Ordered?

- 8.1 It does not seem to me to be profitable to consider this question as at every moment since the casualty. The initial decision to hold an MAIB Inspector's Inquiry was of course a matter for the Chief Inspector under regulation 6(2) and (3) of the 1989 Regulations. It was a matter for the Secretary of State whether to order an FI. He could have ordered some other form of public inquiry, but no-one suggested at the time that he should and there can, I think, be no doubt that, if it had been thought appropriate to order a public inquiry, the obvious course would have been to order an FI under section 56 of the 1970 Act (as amended) because that section was enacted precisely in order to permit a public inquiry in the form of an FI in this kind of case.

- 8.2 I can certainly understand the initial decision of the Prime Minister, and indeed the Secretary of State, not to order an FI until the outcome of the Inspector's Inquiry was known. While FIs had been ordered immediately after serious casualties in the past, as in the case of the HERALD OF FREE ENTERPRISE, there were examples of such inquiries being ordered only after the preliminary inquiry, which was the forerunner of the Inspector's Inquiry, had taken place. The question is I think whether an FI should have been ordered after the Inspectors' Report was completed or, at the latest, at about the time that the MAIB Report was published. I have reached the clear conclusion that it should.
- 8.3 I have already expressed my view that this was a suitable case for an FI and, indeed, that if ever there was a case for ordering an FI after the MAIB was set up, this was it. As I see it, the principal reason why an FI should have been ordered was that this was an exceptional case in which the facts should have been exposed to public scrutiny. It is submitted that the matter was sufficiently investigated by the MAIB and in any event that the facts have been sufficiently exposed to public scrutiny as a result of the various prosecutions and of the second inquest which took place between 13<sup>th</sup> March and 7<sup>th</sup> April 1995. It is further submitted that no useful purpose would have been or would now be achieved by a public inquiry, which would be likely to cause distress and, in particular, would be unfair to Captain Henderson after all that he has gone through since the disaster. I shall consider those submissions in the remainder of this section and in section 9.

### The MAIB Report

- 8.4 It is to my mind important to focus upon what the MAIB Report is and what it is not. It is a report made by a body which had technical expertise, but it is not a report after any kind of judicial inquiry. The distinction between the two was put in this way in paragraphs 13 and 14 of the 1997 Home Office Report of the Disasters and Inquests Working Group, which had been set up as long before as November 1990:

13. ... there are various types of inquiry that may be held into a disaster. When considering the overlap between inquests and inquiries the working group concluded that a distinction could be drawn between, on the one hand, the large scale public inquiry, chaired by a judge (or a senior Queen's Counsel) often sitting with expert assessors; and, on the other hand, the technical inquiry undertaken by an appropriate inspectorate. Examples of the latter are the Marine Accident Investigation Branch (under the Merchant Shipping Acts), the Air Accidents Investigation Branch (under the Civil Aviation Act 1982) and HM Railway Inspectorate, which is now part of the Health & Safety Executive (under the Regulation of Railways Act 1871). In addition, the Health and Safety at Work etc Act 1974 empowers the Health and Safety Commission to direct the Health and Safety Executive (or any other person) to carry out an investigation in respect of incidents which the Commission thinks should be investigated.

14. These technical inquiries are often held in private, although their reports are usually made public. The aim of such inquiries is to ascertain the cause of the disaster and to make recommendations to avoid a future recurrence whereas the inquest investigates the circumstances leading to individual deaths. In such cases, the coroner usually adjourns the inquest until the conclusion of the technical inquiry and then resumes. ... In practice, the experience of both the Department of Transport and the Health & Safety Executive is that there need be no great overlap between the technical inquiry and the inquest, provided that the inquest is not resumed until after the inquiry has

been completed. It was therefore decided to exclude those technical inquiries from consideration. It has been suggested, however, that in the Manchester Airport Disaster of 1985, a degree of overlap and consequential confusion did occur.

A footnote to paragraph 13 notes that, in the case of air accidents, EC Council Directive 94/56 establishes the fundamental principles governing their investigation.

- 8.5 In the case of the MAIB, the essential thrust of paragraph 14, which I have just quoted, is to be found in regulation 4 of the 1989 Regulations, which is in these terms:

The fundamental purpose of investigating an accident under these Regulations is to determine its circumstances and the causes with the aim of improving safety of life at sea and the avoidance of accidents in the future. It is not the purpose to apportion liability, nor, except so far as it is necessary to achieve the fundamental purpose, to apportion blame.

The importance of that regulation is to emphasise the fact that the main aim of an MAIB investigation is to improve safety of life at sea and to avoid accidents in the future. In many cases it will be sufficient to leave maritime casualties to be dealt with by a technical investigation by the MAIB and perhaps, in an appropriate case, by an inquest. That will not, however, always be the case.

- 8.6 An essential difference between an MAIB investigation and an FI is that one is in private and the other is in public. Thus there is no opportunity for those interested to test the evidence in any way before the MAIB report is published. The MAIB has now had a considerable amount of experience of investigating casualties and writing reports on them. In August 1989 it had not. As indicated above, Captain de Coverly did not draw any distinction between the Inspector's Inquiry that he was carrying out and the preliminary inquiries of which he had much experience at the Department. That experience was not of course that of a judge but of a surveyor. It may be that it is for that reason that the Inspectors' Report does not contain a detailed analysis of the evidence that was considered by the MAIB. It does not, for example, identify conflicts of evidence and express a view as to which evidence was accepted and which rejected and why. Nor does it contain a discussion of whether the evidence of particular witnesses can be accepted as truthful.
- 8.7 It does, however, contain conclusions with regard to each aspect of the case. Moreover, it is important to draw a distinction between the Inspectors' Report, which they delivered to the Chief Inspector, and the Chief Inspector's Report. Throughout the Inspectors' Report they referred in the margin to the material upon which each conclusion was based. In addition to the annexes, they then appended to their report 14 appendices. The list of those appendices was set out as an annex to the Inspectors' Report and is Annex F to this report. As far as I can see, the appendices contain all or almost all of the material which was available to the MAIB at the time. In particular they contain the declarations taken by the inspectors, the police statements, the VHF channel 14 transcript, various experts' reports and other documents emanating from the owners of the BOWBELLE and others.
- 8.8 The Chief Inspector's Report, which is the MAIB Report and appears in Annex 2, is an amended version of the Inspectors' Report. The principal differences between them which are relevant for present purposes are that many of the names have been deleted and that all the marginal references to the appendices and thus to the evidence have also been deleted. Moreover there are no appendices (as opposed to annexes) so that, whereas all the evidence was appended to the Inspectors' Report, none of it is appended to the Chief Inspector's

Report. It may be noted in this connection that (as stated in section 7 above) on 11<sup>th</sup> January 1994, in a written answer to a question posed by Mr Spearing, the Minister of Transport for London in effect refused to deposit the Inspectors' Report in the library of the House of Commons, which would of course have put it in the public domain.

- 8.9 It follows that the reader of the MAIB Report is in a very different position from the reader of the Inspectors' Report because, except in general terms, he cannot identify the evidence upon which it is based. He does not even know what evidence the MAIB had available to it. He is not therefore in a position to submit the report to critical scrutiny. I do not criticise the inspectors or the MAIB for this because it seems to me to follow largely from the nature of the exercise which the MAIB must undertake under the 1989 Regulations. The fact remains that (as the Home Office Working Party pointed out in the passage quoted above) the MAIB investigation is private and not public.
- 8.10 The result in this case was that the evidence in the report and the reliability of the conclusions could not readily be exposed to public scrutiny. Yet for the reasons I have given, this seems to me to be the kind of case in which the facts should have been exposed to such scrutiny. I noted earlier, in the passage from the recent letter which I quoted, that Captain de Coverly expressed his personal view (no doubt based upon his considerable experience) that "an investigation into any major accident should be open to some form of public scrutiny – though not necessarily a public inquiry of [FI] type". He said that it was for that reason that he welcomed the opportunity to give evidence at the second inquest.
- 8.11 At the time the Secretary of State received either the Inspectors' Report or the MAIB Report, it was by no means certain that there would be a second inquest and (as we saw in section 7 above) it was not because the matter was to be scrutinised at an inquest that an FI was not ordered at that time. In any event the possibility (or even the probability) that an inquest would be held, would not in my opinion have been a satisfactory reason not to hold an FI. An inquest is a very different kind of process from an FI. It is not to my mind a suitable forum for a detailed examination of the causes, including the underlying causes, of a casualty of this kind. A very important difference between the two types of inquiry is that an FI leads to a reasoned report by the wreck commissioner based upon the evidence put before the FI. There is no such reasoned decision after an inquest.
- 8.12 If the view expressed above is correct, what was required here was public scrutiny of the evidence. As I see it, such scrutiny was not possible without the relevant evidence being made publicly available, as would occur at an FI. Yet here, as I have tried to explain, it was not even possible for the public to tell what evidence was in fact considered by the MAIB. In these circumstances only a public inquiry such as an FI could have achieved such scrutiny. It is my view that, for this simple reason, a public inquiry should have been ordered when the MAIB Report was published or shortly thereafter. As I said earlier, there can I think be no doubt that, if the Secretary of State had ordered a public inquiry, it would have been an FI. There can also be no doubt that it would not have covered the many further topics which some correspondents now want. I shall return to this point below.
- 8.13 It will be recalled from section 7 that one of the reasons why it was decided not to order an FI was that the view was taken that, under regulation 9(1) of the 1989 Regulations, the MAIB Report could not be published if an FI was ordered, and it was desirable that the report should be published as soon as possible. Assuming (as may well be the case) that that was the correct construction of regulation 9(1), it was or could have been mitigated in two ways. The first is that (as stated above) under regulation 9(7) the Chief Inspector had power, notwithstanding regulation 9(1), at any time during the course of an investigation to release

information and recommendations if in his opinion it was necessary or desirable to do so in the interests of safety. The importance of regulation 9(7) is that it ensured that information relevant to future safety could be made public at once.

- 8.14 The second way in which any problem could be mitigated is that an FI could presumably have been ordered after the report was published. In these circumstances, while relevant, I do not think that that was a sufficient consideration to lead to the conclusion that an FI should not be ordered, if the other relevant considerations led to the conclusions that an FI should be ordered, as in my opinion they did.
- 8.15 It will be apparent from the above that I do not accept the approach of successive Secretaries of State which I have tried to set out in Annex C and in section 7 above. For example I do not accept the point which is made throughout the correspondence and in answers to parliamentary questions that the terms of reference of the MAIB investigation are or would be the same as those of an FI, or that, because the MAIB investigation was thorough, it follows that no FI should be ordered in the absence of compelling evidence not considered by the MAIB. If Parliament had intended that approach to be adopted when it enacted section 33 of the 1988 Act, it could have done so, but it did not. It left the power to order an FI intact and without qualification. The approach adopted by the MAIB, the Department and successive Secretaries of State seems to me to ignore two important features, to which I have already referred.
- 8.16 The first is that the MAIB investigation is private, whereas an FI is public. The second follows from the first. It is that the evidence considered by the inspectors has never been publicly scrutinised. Not only does the public not know what the evidence was because all reference to it was removed from the Inspectors' Report before the MAIB Report was published, but also none of it was tested. I do not mean to say that evidence can only be tested by cross-examination in an adversarial process, although that is one approach and is the traditional approach historically adopted in an FI, but here there was no testing at all. Thus, for example, there may be those who would wish to argue that the evidence of the two men on the forecastle of the BOWBELLE was unreliable as being either deliberately untruthful or mistaken. I stress that I have not formed any such view because I have not considered what evidence should be accepted and what rejected. My point is simply that no-one has yet had an opportunity to advance an argument along those lines by reference to all the material available, because no-one has had the relevant material.
- 8.17 One of the features of an MAIB investigation under the 1989 Regulations (which is still the case under the 1999 Regulations) is that, although anyone who is to be criticised in the MAIB report must be notified of that fact and given 28 days in which to make appropriate representations, no-one else is given an opportunity to make such representations, either with regard to the primary facts set out in the report or with regard to any of the proposed criticisms. While I do not take the view that such an opportunity should be offered in every case and, indeed, in the vast majority of cases, the public interest will not require a process of public scrutiny, there are some exceptional cases in which the public will properly demand such scrutiny. I have already expressed my view that this was such a case.
- 8.18 In these circumstances I should stress that my conclusion that a public inquiry should have been ordered does not depend upon any new evidence becoming available after the MAIB Report was made. It is based upon the exceptional nature of the case. In this regard I was particularly struck by submissions made at the oral hearing on 8<sup>th</sup> November by Mrs Barbara Davis, whose son was on the MARCHIONESS and survived, and by Mr Iain Philpott, who was on the MARCHIONESS himself and whose girlfriend died on that night. Mrs Davis said

that in her view the existence or otherwise of new evidence, that is evidence not considered by the MAIB, is something of a red herring because what is required is a consideration of all the evidence by one tribunal at one time. Mr Philpott said much the same. Those are compelling reasons why a public inquiry should have been ordered after the MAIB Report was published and, as appears below, it is my view that they remain valid today.

- 8.19 Although my conclusion does not depend upon the existence of new evidence or upon a detailed analysis of the material considered by the MAIB, there are a number of features of the case which underline it. They relate principally to the primary facts, to the issue of alcohol and to the position of the owners of the BOWBELLE.
- 8.20 I shall briefly address these topics, but I should stress that in doing so I do not do so with a view to criticising the MAIB inspectors or the Inspectors' Report, or, indeed, the MAIB Report itself. I do not see it as part of my role to do so. My role is essentially to form a view as to whether a public inquiry should be ordered now. If an inquiry is ordered, that inquiry will consider in detail all the available evidence as to what caused the collision and the loss of life. In these circumstances, given that I have reached the clear conclusion that such an inquiry should be ordered, it is important for me to take care not to prejudge any of the issues which may arise at the inquiry, if one is ordered. I have therefore tried not to form conclusions on any of the topics to which I now turn. Instead I have tried to focus on some of the principal questions which it seems to me would have arisen had a public inquiry been held. There may be many others.
- 8.21 I should also add that there are certain materials that I have not considered, given that they are (or are at least arguably) subject to legal restrictions on their disclosure. These include materials provided to the police in confidence which are subject to the principles in *Woolgar v Chief Constable of the Sussex Police* [1999] 3 All ER 604. It is likely, however, that such materials would have been considered at any public inquiry, had one taken place (and would be considered at any future inquiry), although I should stress that that is no more than a preliminary view. In the event of a public inquiry, any issue on this or any other similar question would of course only be resolved after hearing argument from those interested. For present purposes I have only considered those statements which I am satisfied are in the public domain.
- 8.22 The same is true of the declarations. I have not considered any declarations which are not in the public domain or in respect of which the declarant's consent was not given. Some potential witnesses have died and some witnesses, including Mr Alan Smith of South Coast Shipping, to whom I refer further below, have objected to my considering their declarations. Declarations not in the public domain may be subject to some restriction upon the use to which they may be put. A number of the declarations are in the public domain because they were read out or put in evidence during criminal proceedings or the inquest. I have not heard argument as to the true legal position and have decided that the public interest does not require me to look at declarations not in the public domain. I have, however, looked at declarations in respect of which consent was given. I do not think that there is any possibility that I would have reached a different conclusion as to what recommendations to make if I had looked at other declarations or other police statements.

### Primary Facts

- 8.23 In order to ascertain the primary facts it was of course necessary for the MAIB to consider a number of different types of evidence. They included the statements of eye witnesses, contemporary documents, evidence of subsequent inspections of the vessels (and perhaps other property) and expert evidence. Since this was a case in which a police investigation was proceeding at the same time as that of the MAIB, it was obviously sensible for there to be close co-operation between them. The police naturally took a considerable number of statements. They sent many of them to the MAIB, where they were considered by the inspectors. They would also no doubt have considered transcripts of the answers given by any relevant witness who was interviewed by the police under caution, if they had received them.
- 8.24 It emerged at an early stage that there were two different accounts of what had occurred. The first was that the BOWBELLE would have overtaken the MARCHIONESS without hitting her but for an alteration of heading to port by the MARCHIONESS. The second was that there was no or no significant alteration of heading to port by the MARCHIONESS before she was struck by the BOWBELLE and that it was only after that first impact that her head came round to port. The conflict was identified by the police in a report dated 21<sup>st</sup> August 1989 and said to be up to date as at 0900 on that day. It was subsequently sent to the MAIB. In that report the police described the conflict thus:

Two conflicting accounts of the collision between these vessels appear to be emerging. The first account alleges that the BOWBELLE travelling at the faster speed ran straight over the stern of the MARCHIONESS, without any horns being sounded and without any mandatory crew member at the bow of the BOWBELLE. The BOWBELLE apparently carried on and also collided with Cannon Street Railway Bridge. This account has been given by some witnesses and Mr McGOWAN, the Mate on the MARCHIONESS.

The second account which is given by two independent witnesses who were outside the Anchor public house on the Southwark side of the river varies by suggesting that the BOWBELLE sounded its horns, was travelling straight and collided with the MARCHIONESS when the MARCHIONESS veered across its path.

- 8.25 The conflict was significant or potentially significant because it would or might affect responsibility for the collision. On any view the BOWBELLE was overtaking the MARCHIONESS so that, quite apart from any other duties which she may have had, it was her duty to keep out of the way of the MARCHIONESS under rule 13 of the Collision Regulations. Her responsibility and that of the MARCHIONESS would, however, be likely to be viewed very differently if the vessels would have passed clear but for a deliberate alteration of heading to port by the MARCHIONESS.
- 8.26 In the inspectors' interim report referred to above which was made on or before 29<sup>th</sup> August they said:

It is probable, but not certain, that MARCHIONESS precipitated the collision by altering course into the path of BOWBELLE.

In the MAIB Report (which is Annex 2 at volume 2 page 7) it is not put in quite that way. The relevant parts of the report are at paragraphs 3.6 to 3.9, 6.3 to 6.6 and 16.1 to 16.7. I regret that paragraphs 3.6 to 3.9 were inadvertently omitted from volume 2 when the annexes to my interim report were printed, although they are included in a document

entitled “Errata” which was published with the original report. The remaining paragraphs are at volume 2 pages 19 and 20 and pages 35 and 36 respectively.

- 8.27 Although the conclusions in the MAIB Report are expressed cautiously, they nevertheless show the two vessels converging before any impact. Paragraph 16.6 is in these terms:

The tracks followed by the two vessels after they had passed Southwark Bridge, as they have been deduced, are shown at Annex 1C. It is stressed that they are at best no more than approximation: in particular, and especially since the Skipper cannot speak for himself, the track of MARCHIONESS represents no more than the hypothesis which best seems to fit the evidence.

Annex 1C to the MAIB Report, which is at volume 2 page 64, depicts the MARCHIONESS proceeding on a track across the head of the BOWBELLE. Various possible reasons are given for the initial alteration of heading to port, namely a deliberate alteration of course to port or a yaw to port caused by the first effects of hydrodynamic interaction (“interaction”) or by tidal eddies, and it is then assumed that she steadied on that course, apparently deliberately.

- 8.28 It appears that the starting points on Annex1C, namely positions A<sub>1</sub> and A<sub>2</sub> are based on the evidence of the two seamen on the forecastle of the BOWBELLE and, perhaps also, of at least one witness ashore. There is a reference in the MAIB Report to some of the evidence available to the inspectors, but there is no clear statement of what evidence was considered. I have tried to explain the reason for that, namely that both the references to the evidence in the Inspectors’ Report and the appendices, which contained the evidence, were removed from the final report, which was of course the only report made available to the public until this Inquiry.
- 8.29 It is thus not clear from the MAIB Report what evidence was available to the MAIB, or whose eye witness evidence was accepted and whose rejected and why. In addition, no consideration was given in the report to the question whether the inspectors accepted that all the witnesses were telling the truth. In these circumstances, as already stated, public scrutiny of the subject matter of the report was not possible when it was published. Such scrutiny would not of course have guaranteed a definitive or correct answer to the various questions raised by the collision (including the question of which of the two accounts of the collision identified by the police in their report of 21<sup>st</sup> August 1989 was correct). It would, however, have meant that the public could be reasonably confident that the central questions had been fully considered having regard to all of the available evidence.
- 8.30 Clearly any public inquiry would have considered in detail the accounts given of circumstances leading up to the collision by the crew of the BOWBELLE. I therefore turn first to that aspect of the case. In that regard the MAIB was at a considerable disadvantage because, with one exception<sup>2</sup>, it did not have the statements made to the police by the crew (or indeed by the owners of the BOWBELLE – see below). The differences may be significant, as appears from a comparison between the statement which Mr Terence Blayney gave to the police and the declaration he made to the MAIB. His first statement to the police (dated 20<sup>th</sup> August 1989) was 13 pages long and contained a detailed account of the

<sup>2</sup> The statement of Edward Quantrill (one of the two seamen on the forecastle). It is not clear why his statement (alone amongst the crew statements) was passed to the MAIB.

<sup>3</sup> In his first statement he reversed the names of the bridges. This error was corrected in his second statement.

voyage, of the circumstances of the collision and of the means of communication between the forecastle and the bridge of the BOWBELLE. This is to be contrasted with the account he gave to the MAIB on 22<sup>nd</sup> August, which was less than 2 pages long.

8.31 I am not in any way criticising either the police or the MAIB for the fact that the MAIB was not provided with all of the police statements. It does not appear that the MAIB had any entitlement to see those statements and the police had no obligation to provide them. Nevertheless, the fact is that the MAIB must have been at a disadvantage in investigating the primary facts in circumstances where it did not have access to the statements made by the crew of the BOWBELLE to the police. Had there been a public inquiry, it is likely that all of the relevant materials would have been available for public scrutiny. This was particularly important in relation to the accounts given by the two seamen on the forecastle of the BOWBELLE. Their evidence was very important because they both said that the MARCHIONESS had apparently altered course to port so as to bring her into the path of the BOWBELLE. In his statements to the police (which, as I have said, the MAIB did not have), Mr Blayney described how, when the BOWBELLE first emerged from Southwark Bridge<sup>3</sup> and he first became aware of the MARCHIONESS, she was “a safe distance ahead of us and to the starboard side” but that, before the BOWBELLE reached Cannon Street Bridge, the MARCHIONESS seemed to alter course to port and within “just a matter of seconds” the collision occurred. In his expert evidence at the prosecution of Captain Henderson, Captain John Third of Brookes Bell (who were instructed on behalf of Captain Henderson) said that he had “difficulty” reconciling these observations. I do not know whether that observation is well founded. However, given the importance of their evidence, it would undoubtedly have been preferable for it to have been tested in public.

8.32 The second issue is the effect of interaction on the MARCHIONESS and whether it was a cause of the collision. In a report dated 17<sup>th</sup> April 1990 Captain Eric Beetham wrote this at page 75:

Interaction does occur between the hulls of two vessels in close proximity. With the relatively large underwater volume of the BOWBELLE and the very fine lines and shallow draught of the MARCHIONESS I think it very unlikely that the effects of interaction would have been felt until the distance between the two craft was no more than 5 metres. It would seem unlikely that interaction played a significant part in the actual cause of the collision – the collision being inevitabl[e] by the time any effect of interaction became relevant.

8.33 That is to be contrasted with the view expressed by the MAIB at paragraphs 6.5 and 6.6 of its report as follows:

The essential point, so far as the present accident is concerned, is that a positive pressure field exists near both the bow and the stern and therefore when, as here, a relatively large ship is overtaking a smaller one the latter will tend to sheer across the bow of the former. Where the two vessels are very close the effect can be so great that the small vessels loses all control. It seems highly likely that this effect was a cause, probably the major cause of MARCHIONESS sheering across the bow of BOWBELLE ... Interaction may also have been partly responsible for the initial, relatively slight, convergence of the vessels’ tracks rather than (or as well as) tidal eddy.... Advice from a leading authority on the subject is that with vessels of the size of BOWBELLE and MARCHIONESS, at their speeds through the water at the time of the accident, there would be some effect on the smaller vessel when they were 40 to 50 metres apart.

- 8.34 The “leading authority” to whom the MAIB referred was Dr Ian Dand, who visited the MAIB on 7<sup>th</sup> November 1989 to discuss the likelihood of interaction having been a factor in the loss of the MARCHIONESS. It thus appears that this section of the MAIB Report was primarily based upon the views expressed to the MAIB by Dr Dand. There is a manuscript file note amongst the MAIB’s papers which records Dr Dand’s views on the subject. Dr Dand was not, however, asked to prepare a report at that time; so one cannot be sure how he arrived at the figure of 40 to 50 metres or indeed at what distance Dr Dand thought that interaction would become such as to cause the MARCHIONESS to lose control. He subsequently prepared a report for use in the private prosecution which is dated September 1991, after the MAIB Report was published. It contains a detailed analysis of the forces of interaction based on model tests (albeit of different vessels) and appears to conclude that, when the MARCHIONESS was still 30 metres ahead of the BOWBELLE and with 5 metres between the track of the starboard side of the BOWBELLE and the track of the port side of the MARCHIONESS, virtually no interaction would have occurred, but that thereafter, if neither vessel applied helm, the vessels could have collided by reason of the forces of interaction causing the head of the MARCHIONESS to come round to port.
- 8.35 It is not clear to me whether the views expressed in Dr Dand’s report of September 1991 are significantly different from those which he expressed to the inspectors. Nor is it clear to me what, if any, difference there is between the view expressed in the report and that of Captain Beetham. However, given the potential value of expert evidence of interaction in helping to resolve the central issue between the witnesses as to how the collision occurred, which was identified by the police at the outset, it seems to me that the whole topic of interaction and what (if any) role it played in the collision is one which would have merited (and benefited from) scrutiny at a public inquiry.
- 8.36 Thirdly there is the question of where the collision took place. Quite apart from the inherent desirability of being able to locate where the collision occurred, its location also has a bearing upon which of the two accounts identified by the police is likely to have been correct. If the collision occurred as the MARCHIONESS was approaching Southwark Bridge (rather than when it was between Southwark and Cannon Street Bridges) this makes it much less likely that the collision was precipitated by a deliberate alteration of course by the MARCHIONESS to port<sup>4</sup> because there is no obvious reason why the MARCHIONESS would have done so in the vicinity of Southwark Bridge. This issue is not addressed by the MAIB in its report. It was, however, suggested in the Dispatches television programme made in 1993 that the evidence of those on board the HURLINGHAM was “in flat contradiction to the official scenario”. That suggestion has been repeated in submissions to this Inquiry.
- 8.37 There is certainly some evidence to place the collision at Southwark Bridge. Mr George Williams, the skipper of the HURLINGHAM, told the MAIB in his declaration that the collision happened at Southwark Bridge rather than between Southwark and Cannon Street bridges. Other eye witnesses, including some of those who were on board the HURLINGHAM and some of the MARCHIONESS survivors, have, at various times, also described the collision as having taken place at Southwark Bridge. In a letter of 27<sup>th</sup> July 1994 to Dr. Burton, Christian Fisher referred to substantial new evidence obtained by the Dispatches programme as placing the collision at a different location from that identified by the MAIB and also referred to the evidence of Mr Simon Hook, Mr Dino Pereira, Mr Digenis Stephanou, Mr Glen Tobin, Mr Nick Stephanou and Ms Annette Russell. On 1<sup>st</sup> December

<sup>4</sup> The converse does not of course follow. If the collision took place between the bridges, the question of whether it was precipitated by an alteration of course by the MARCHIONESS would remain an open one.

1994 in a further letter to Dr Burton, Mr Christian Fisher identified Mr Philpott, Mr Hook, Mr Pereira, Mr Rod Lay, Ms Russell and Mr John James as having evidence to give about the location of the disaster or the nature of the collision. Christian Fisher also wrote on 22<sup>nd</sup> September 1997 to Ms Jackson, who was of course by then a Minister at the Department, stating that Mr Anthony Phillips, a witness from the HURLINGHAM, had evidence to give as to the location of the collision.

- 8.38 I do not propose to analyse this evidence in any detail. Such matters would undoubtedly have to be examined at any public inquiry in the future. I should perhaps say that, with the exception of the statement of Mr Nick Stephanou, the MAIB appears to have had statements taken by the police from all the individuals referred to above. However, it only took a declaration from Mr Philpott and thus did not interview or question any of the others. Nor, of course, did it have the benefit of the additional evidence given by those of the witnesses to whom I have just referred who gave evidence at the resumed inquest. It would, in those circumstances, be more accurate to say not that there is “new” evidence as to the primary facts of the collision but rather that the existing evidence has never been fully tested or considered in public. In this connection it should also be noted that one of the two seamen<sup>5</sup> on the forecastle of the BOWBELLE, in his evidence to the MAIB, appeared to place the collision at Southwark Bridge.
- 8.39 It is important to make it clear that I have formed no view on this question. There is a substantial quantity of witness evidence to the opposite effect (namely that the collision occurred at the location favoured by the MAIB). Indeed in his evidence at the second inquest Captain de Coverly observed that the location of the wreck of the MARCHIONESS made it unlikely that the collision had occurred at Southwark Bridge. It may be that any public inquiry would have done no more than confirm the correctness of the account given by the MAIB. We do not know because no such inquiry was held.
- 8.40 The fourth issue which would have been considered at any public inquiry is the question of what (if any) conclusions could be drawn from the nature of the damage to the MARCHIONESS and the BOWBELLE. Examination of the nature of the damage to vessels which have collided with each other will sometimes enable conclusions to be drawn as to the point of first contact, the angle of collision and the relative speed of the two vessels. Thus it is usual for a speed and angle of blow report to be produced by the parties in proceedings in the Admiralty Court where two (or more) ships have collided. The purpose of a speed and angle of blow report is to consider the damage to the two vessels and to draw conclusions from the nature of that damage as to the relative speed of the two vessels and the mechanics of the collision, including (where possible) the relative headings of the vessels. Very often it is not possible to draw any firm conclusions from the nature of the damage. It is, however, almost inevitable that if there had been a public inquiry, expert evidence on this question would have been adduced and tested.
- 8.41 There is in fact some evidence on this question. Mr John Edon and Captain Beetham, then of Edon Liddiard Vince (a firm of marine consultants), inspected the MARCHIONESS on 29<sup>th</sup> August on the instructions of solicitors for relatives of the deceased or survivors. A surveyor representing hull underwriters of the MARCHIONESS was also present. A preliminary inspection of the damage, in particular of the contact area, was made at that time. A subsequent visit was made on 7<sup>th</sup> September, following recovery of the aft

<sup>5</sup> Edward Quantrill, although in this respect his evidence to the MAIB differed from the account he subsequently gave at the first trial of Captain Henderson.

superstructure and certain life saving equipment. The BOWBELLE had also been inspected by that time. Edon Liddiard produced a preliminary report on 22<sup>nd</sup> September 1989. It appears to have been written by Mr Edon, but may have been contributed to by Captain Beetham and may in any event represent his views at the time. Then in September 1991 Captain Beetham made a statement that was used at the committal proceedings of South Coast Shipping in which he considered, amongst other things, the mechanics of the collision having regard to the damage sustained by the two vessels. Finally, Captain Beetham produced a further report dated 3<sup>rd</sup> December 1999 to this Inquiry. It is fair to say that in certain material respects there is a difference between the views expressed by Edon Liddiard Vince in their report of 22<sup>nd</sup> September 1989 and the views expressed by Captain Beetham in his statement in September 1991 and his report of 3<sup>rd</sup> December 1999. This may go to show that it is not easy to draw firm conclusions about such matters or it may show that Captain Beetham changed his mind. In any event these are matters that would undoubtedly have been considered in detail at a public inquiry, had one been held.

- 8.42 These considerations all suggest to me that there remain a number of questions to be conclusively answered under this heading. They include the following. Where did the collision happen? What part of the MARCHIONESS was first struck? What was the angle of blow? What was the heading of each vessel at that time? Did the MARCHIONESS deliberately alter course to port? What effect upon her heading did the forces of interaction have? What was the distance of the BOWBELLE from her at that time? Did anyone on the BOWBELLE see the MARCHIONESS before the collision? If so, when? How long before the collision? Was the situation thought to be safe at that time? Was it in fact safe? If so, what turned a safe situation into one of danger? If neither vessel had altered course at that time would the vessels have passed safely? If so, at what distance? Which of the two versions of the way in which the vessels approached each other is to be preferred and why? Can any sensible conclusion on any of these questions be arrived at on the balance of probabilities? These are just some of the questions which spring to mind. There may be others. None has yet been examined in a public forum.

#### Alcohol

- 8.43 I have already adverted to the fact that the crew statements to the police were not (with the exception of one statement – that of Mr Quantrill who was on the forecastle) provided to the MAIB. This is highly significant when one comes to consider the question of alcohol consumption by members of the crew of the BOWBELLE before the ship sailed. As far as the MAIB was aware, the position was simply that the crew had been tested for alcohol and the results were negative. Accordingly it did not take the matter any further. It is now clear that matters were not quite so simple.
- 8.44 Firstly, there is no doubt that both Captain Henderson and Mr Blayney had been drinking on 19<sup>th</sup> August. This is clear from the statement which each of them made to the police. Captain Henderson's statement to the police (which was read out at the resumed inquest) was that in the period up to 6 pm on 19<sup>th</sup> August he had visited five public houses and drunk about six pints of beer. The evidence of Mr Blayney is even more striking. According to his statement, he recalled that between 3 and 4 pm he drank a couple of cans of Abbot Ale. Between 4.30 pm and 7.30 pm he drank a further two cans of beer. Between 9 pm and 11 pm he then drank about four pints of Foster's lager before returning to the BOWBELLE, which sailed some two hours later. The MAIB was unaware of any of this because it did not have a copy of either Mr Blayney's or Captain Henderson's police statement when it interviewed and obtained declarations from them.

- 8.45 Nor was the MAIB aware of the circumstances in which the police obtained negative blood alcohol readings. In fact the position was that the sample from Captain Henderson was taken at 11.30 am on 20<sup>th</sup> August and that from Mr Blayney was taken at 4.25 pm on the same day. In the light of the delays in taking the samples, it is perhaps not surprising that, in the view of Dr Andrew Clatworthy (the police surgeon who took and tested the samples), it was not possible to exclude the possibility that alcohol may have been present in the blood at the time of the accident. Indeed in his evidence at the resumed inquest, Dr Clatworthy said this in relation to the blood samples taken by the police:

I was supplied with samples of blood from some of the members of the crew and the urine from another member of the crew which had been taken many hours after the accident and I am unable to use those figures to help me at all.

- 8.46 It now seems clear that, if this information had been available to the MAIB, it would have approached the whole question of alcohol in a very different way. In 1994, following an interview which Captain de Coverly gave to a television journalist, he wrote this in a letter:

There is manifestly no doubt that if we had had evidence of significant alcohol consumption during the day before the accident, we would have gone into the matter and at the very least referred to it in our Report – even if, like the coroner, we had felt able to rule it out as a causative factor.

He said much the same in a letter dated 9<sup>th</sup> October 1998 to the MAIB and in an annex to a recent letter to the Inquiry he said that, if they had had evidence of Captain Henderson's drinking during the afternoon, they would, as he put it, "very definitely have followed it up in our investigation". It is fair to Captain Henderson to add that Captain de Coverly also pointed out that Dr Burton considered that alcohol did not play any part in the accident and that in his declaration Captain Henderson expressly said that he and the crew were fully rested and sober.

- 8.47 Again, I make no criticism of either the police or the MAIB for the fact that this information was not known to the MAIB when it made its report. Furthermore, it is possible that its conclusions would have been unaffected. The statements of Captain Henderson and others that they were all fit and sober are plainly an important part of the evidence. On the other hand, in the light of the evidence of drinking on 19<sup>th</sup> August, the possibility that alcohol may have played a part in the disaster is a matter that warranted the fullest possible public scrutiny. It raised a number of questions. They include the following. How much had Captain Henderson and Mr Blayney in fact had to drink? It would perhaps be natural to minimise the amount after a serious accident. Did either of them do so? Was each fit to perform his duties? If not, what difference did it or might it have made?
- 8.48 I should perhaps note that Mr Jonathan Davis (who was a passenger on the MARCHIONESS) wrote to Mr Hayes on 13<sup>th</sup> January 1992 saying that he saw the crew of the MARCHIONESS consuming alcohol before the accident. The MAIB could not of course have had that particular piece of evidence because it was not available at the time it made its report. It seems to me both to have merited and to merit further investigation.

#### The Role of the Owners and Managers of the BOWBELLE

- 8.49 Had there been a public inquiry, the role of the owners and managers of BOWBELLE and MARCHIONESS would of course have been considered in detail. In particular,

consideration would have been given to what steps had been taken by the owners and managers of the respective vessels to ensure that they could operate safely, particularly having regard to the question of lookout forward and aft respectively.

- 8.50 For present purposes I shall concentrate on the BOWBELLE. This is not because the position of the owners of the MARCHIONESS is irrelevant but because it is inevitable that any public inquiry would have focused in particular upon the BOWBELLE and its management. The management of the BOWBELLE was considered by the MAIB in various places in its report. It was touched on in paragraphs 5.1, 15.7, 15.10 and 15.14 and considered in more detail in paragraphs 17.5 to 17.7. Annex 11 of the MAIB Report referred to two incidents involving BOW vessels in 1981 and 1983.
- 8.51 The BOWBELLE was originally built in 1964 for British Dredging. According to the MAIB Report, British Dredging was subsequently acquired by RMC which established East Coast Aggregates (“ECA”) to own and run the British Dredging fleet. It is not clear from the MAIB Report when this was done, although it appears to have been some time in the 1980s.<sup>6</sup> Subsequently, in June 1988, control of the former British Dredging fleet (including the BOWBELLE) passed from ECA to South Coast Shipping (“SCS”), another company in the RMC Group, although ownership remained with ECA. The position was thus that the BOWBELLE fleet had been owned and managed by ECA until June 1988 and thereafter it was managed by SCS.
- 8.52 The management structure of ECA and SCS is not clear from the MAIB Report although it is stated that British Dredging and ECA had employed a “shipping manager” who became the “operations manager” when control of the BOW fleet passed to SCS in June 1988. There are also references in paragraph 17.7 of the MAIB Report to a general manager, a senior superintendent and a marine manager, although none of these individuals was identified by name in the report.<sup>7</sup> It would appear that the shipping manager gave evidence to the MAIB (see paragraph 15.10 of the report). From the evidence before the Inquiry, it appears that the operations manager to whom the MAIB Report referred was Captain Peter Butcher, who made a declaration to the MAIB on 13<sup>th</sup> December 1989. He has unfortunately died since then. I am not sure of the precise date of his death, but, as I understand it, it was in November 1992. The MAIB also obtained a declaration from Mr Alan Smith who, it appears, was the senior superintendent to whom the MAIB referred in its report. Finally, it also obtained a declaration from Captain Andrew Burley who was the alternate master for the BOWBELLE. No declarations were taken from the general manager or the marine manager.
- 8.53 Some of the essential findings of the MAIB in relation to the management of the BOWBELLE were these. During the 1980s Captain Butcher (who, as stated, had been the shipping manager at ECA) had arranged for the BOW vessels to be provided with portable VHF sets intended principally for communications between the forecabin and the wheelhouse. He had also issued an amendment to the company’s (i.e. ECA’s) standing orders specifically relating to lookout and watchkeeping on the Thames. The “director” of ECA (by whom the MAIB may have meant the managing director), had, however, apparently decided

<sup>6</sup> See paragraphs 17.5 and 17.6 of the MAIB Report. In the committal proceedings in the private prosecution, counsel for the prosecution stated that the vessel was still owned by British Dredging in 1982.

<sup>7</sup> At the committal proceedings in the private prosecution, the general manager was identified as a Mr Robert Henry Samuel and the marine manager was identified as a Mr Frederick Brian Darwell. Both were defendants in the private prosecution.

that the amendment should not be included in a set of revised standing orders which were issued in 1987.

- 8.54 Separately from these developments, another step taken “on the initiative of the masters of the three BOW dredgers trading up the river” (it is not clear when) was to post an officer forward with the lookout for the passage through the bridges. However, this practice was dropped on the BOWBELLE (although not apparently on the other two ships) “after a few years”. This was apparently in order to give one of the officers an increased period of rest (see paragraph 15.14 of the MAIB Report).
- 8.55 The police did not apparently take any statements from any managers or senior personnel at SCS or ECA, but they did have certain internal documents from SCS. These included reports from management meetings, masters’ meetings and chief engineers’ meetings, general managers’ reports, BOWBELLE monthly reports and damage reports, minutes from the BOWBELLE’s “safety committee” and a small quantity of internal memoranda. The documents related almost entirely to the period from mid-1988 onwards, when the management of the BOWBELLE passed to SCS. It does not appear that the police had equivalent documents for the period prior to mid-1988. A list of those materials (although not the materials themselves) was provided to me by the police by letter of 7<sup>th</sup> December. Because those documents were provided to the police in the course of a criminal investigation I did not ask the police to provide the documents to me. It is, however, likely (subject of course to argument on the point) that they would have been available to be considered at any FI.
- 8.56 The documents held by the MAIB were similar to those held by the police except that the MAIB, unlike the police, does not appear to have had a full set of the various reports and minutes for the period from mid-1988 up to the date of the collision. It too does not appear to have had any equivalent documents for the period prior to mid-1988.
- 8.57 This clearly made the MAIB’s task more difficult. An example of this is the reference in paragraph 15.10 of the MAIB’s Report to the amendment to the standing orders relating to lookout and watchkeeping on the Thames that was said to have been made at the behest of the shipping manager of ECA (Captain Butcher) some time prior to 1987. This was obviously a key document but the MAIB did not have a copy of it because, although the MAIB was provided with copies of SCS’s standing orders going back to 1981, Captain Butcher had not kept a copy of the document in question. Nor did the MAIB have any documents relating to the revision of the standing orders in 1987 (other than the revised orders themselves) or the reasons why the 1987 revision removed any reference to lookout or watchkeeping on the Thames. Indeed, apparently it did not even have any documents relating to the policy of posting an officer forward or as to the circumstances in which the policy had ceased to operate. These are undoubtedly matters that would have been investigated at any public inquiry because it was obviously of some importance to know what the position had been and why it had changed.
- 8.58 Furthermore, the MAIB did not apparently have any internal documentation from SCS or ECA (or indeed British Dredging) arising out of the two collisions referred to in annex 11 of the MAIB Report. The first of these was between the BOWTRADER and the HURLINGHAM in the early morning of 18<sup>th</sup> October 1981. The second incident was that involving the BOWBELLE and the PRIDE OF GREENWICH on 8<sup>th</sup> June 1983. These incidents are of importance because they were both collisions which took place at night whilst overtaking passenger vessels. In both cases, poor bridge visibility appears to have been

a factor. As regards the BOWTRADER incident, Captain de Coverly had had some involvement in the investigation. On 11<sup>th</sup> November 1981 he wrote this:

[BOWTRADER] is broadly of “flat-iron” type ... with a low wheelhouse so that when trimmed by the stern, as she was at the time of the casualty there must be a considerable “blind” arc ahead of the bow. (According to a manuscript note, the Master estimated that he cannot see a “small launch” within about 300 yards.) .... Nominally two men were keeping a lookout from the fo’c’sle ... but they were also engaged in preparing to raise the hinged foremast and do not appear to have seen the launch in time to give a useful warning ....

As to further action, the circumstances of this casualty ... could easily have been very serious indeed ... it seems to me that real and important lessons are to be learned from the casualty.

8.59 The Department of Transport had said this in relation to the BOWBELLE / PRIDE OF GREENWICH collision:

The principal cause of the casualty was found to be the inadequate visibility from the wheelhouse of both vessels, ahead from BOWBELLE because of her trim and the obstruction caused by her dredging equipment and aft from PRIDE OF GREENWICH because of the passenger accommodation.

8.60 The matter was put in rather stronger terms by the London Marine Office’s Senior Nautical Surveyor:

The cause of this incident can only be put down to grossly inadequate visibility from the respective steering positions, that of the “Bowbelle” ahead and that of “Pride of Greenwich” astern. If adequate visibility from these positions had been achieved the incident would not have occurred ... Until such time [as] a requirement for excellent all round visibility is made and enforced for all vessels using these, or similar, waterways accidents of this nature will continue to occur – possibly with fatal results.

8.61 I would have expected both of these incidents to have been the subject of internal memoranda and indeed to have been considered at senior management level (although it may be that any such documents had been destroyed by 1989). In any event, if a public inquiry had been held, the question of what steps had been taken by the management and owners of the BOWBELLE, in the light of these incidents, to reduce the risks posed by the lack of adequate visibility from the bridge of the BOWBELLE (and other BOW vessels), would undoubtedly have been considered.

8.62 The BOWBELLE had also been involved in five collisions with other vessels on the Thames between 1965 and 1971 as well as making contact with scaffolding under the arches of Cannon Street Bridge in 1982 (although this does not appear to have been the result of poor bridge visibility). There had also been a collision between the BOWTRADER and a Finnish vessel in 1985 and between the BOWBELLE and the BOWSPRITE in 1987 near Tower Bridge. The MAIB was aware of the Cannon Street Bridge incident involving the BOWBELLE in 1982 and of the BOWBELLE/BOWSPRITE collision in 1987 and indeed had in its possession reports made by the crew of both vessels relating to the latter incident. As regards the latter incident, although the Department’s surveyor attributed most of the blame for it to the BOWSPRITE, it is notable that one of his conclusions was that the BOWBELLE should have stationed a lookout on the forecastle head. It is also of interest that

the second mate of the BOWBELLE (who was steering the BOWBELLE at the time of the incident) reported that most of his concentration was on steering the ship and said "I was not fully aware of what was around us". This suggests that poor bridge visibility may have played a part in that collision as well.

- 8.63 Again, one would have expected those incidents to have generated internal documentation at management level, although one would not necessarily expect any records of the incidents prior to the 1980s to have survived. In addition to these incidents, research by Outsider Television Productions for Channel Four in 1993 disclosed 22 incidents involving BOW vessels between May 1988 and June 1989. Most of these involved contact with stationary objects (pontoons, docks, buoys etc). Four of them involved the BOWBELLE. Amongst these 22 incidents was also the loss of the BOWSPRITE off Belgium in December 1988, with the loss of four lives. It may be that none of these incidents had any relevance to the circumstances involving the collision between the BOWBELLE and the MARCHIONESS. They are nevertheless matters which I think a public inquiry would have wished to consider, if only briefly, in order to be satisfied that they had no bearing upon the collision.
- 8.64 I have already referred to correspondence from Christian Fisher suggesting the existence of "new" evidence. One class of such evidence was said to have comprised statements from ex-employees of SCS and its predecessors. Christian Fisher's letter to Ms Jackson on 22<sup>nd</sup> September 1997 enclosed statements from, amongst others, four ex-employees of the owners/managers of the BOWBELLE whose evidence, it was said, had never been heard in public and whose evidence was said not to be "in" the MAIB Report. The individuals in question were Captain George House, Mr William Girvin, Mr George Grinlaw and Mr Roy Clarke.
- 8.65 The crewmen in question had all worked on the BOWBELLE in various capacities in the 1980s. Captain House had worked as master and pilot for 17 years until about 1983. Mr Girvin was a former seaman who had worked on the BOWBELLE and other vessels in the BOW fleet from February until June 1989. Mr Grinlaw was the chief engineer on the BOWBELLE between 1983 and 1988 and Mr Clarke was a former deckhand who had worked on the BOWBELLE for almost a year until May 1989. It would appear that Captain House and Mr Girvin gave statements to the police in the aftermath of the collision, but that these statements were amongst those which were not passed on to the MAIB, although I note that, according to the files of the MAIB, they were contacted by Mr Girvin the day after the collision. It is not possible to tell from the files whether any attempt was subsequently made by the MAIB to obtain a declaration from Mr Girvin.
- 8.66 It is not correct to say that the evidence of these four potential witnesses has never been heard in public since they all gave evidence at the private prosecution of SCS and others, having made statements under section 9 of the Criminal Justice Act 1967. Nevertheless, I regard these materials as of some significance because each of those witnesses was in a position to provide potentially relevant information relating to the system of lookout on the BOWBELLE, the methods of communication between those on the forecastle and those in the wheelhouse and the attitude towards ballasting and visibility of the owners and managers. Furthermore, it is clear that the MAIB did not have any such materials when it prepared its report.
- 8.67 In the light of these matters, it seems to me that, had a public inquiry been held, a number of questions would have arisen which would have warranted detailed consideration of internal materials in the possession of the present or former owners or managers of BOWBELLE. I consider those (and related) questions in section 9 below. Such questions would, however,

have included what consideration had been given to the system of lookout on the BOWBELLE, when and by whom, what steps were taken to ensure that the system (if any) was properly operated and whether there were any events or incidents which should have caused the system to be reconsidered. Full consideration of these questions would have involved taking into account relevant correspondence, notes and memoranda at all levels from the crew up to the board of directors. If a public inquiry had been held, it would almost certainly have considered such materials to the extent that they still existed. It would probably also have entailed hearing evidence from former crew of the BOWBELLE as well as from both junior and senior management at SCS and its predecessors.

## Conclusion

- 8.68 For the reasons which I have tried to give in this section, it is my view that a public inquiry in the form of an FI should have been ordered, if not at the outset, then at the latest at about the time the MAIB Report was published in August 1991. The inquiry could then have been held after the conclusion of the private prosecution, say in early 1993. I have referred above to some of the questions which would have been asked at such an inquiry. I set out more such questions in paragraph 9.11 below in the context of the differences between an FI and an inquest. Of course any such inquiry would have considered the Department's role in connection with a number of matters, including its investigation of earlier incidents and its approach to alterations to the MARCHIONESS.

## 9 Should An Inquiry Be Held Now?

- 9.1 The first question for consideration under this head is what criteria should be applied in order to answer it. Hill Taylor Dickinson submit on behalf of the owners of the BOWBELLE that ultimately the decision whether to hold a public inquiry depends upon whether such an inquiry would be in the public interest. I accept that submission. They further submit that the following questions should be addressed: whether adequate inquiries have already been carried out, whether new evidence has come to light which might materially alter the conclusions reached in earlier inquiries, whether an inquiry is practically possible after ten years, whether an inquiry would assist in a material way in improving the safety of life on the river or at sea and the avoidance of accidents in the future or serve some other useful purpose, and whether the possible benefits of such an inquiry would justify the time and emotional cost involved.
- 9.2 I shall consider those topics in turn and shall also take account of particular submissions made both by Pattinson & Brewer on behalf of Mrs Deborah Faldo, who is of course the widow of Mr Stephen Faldo, who was the skipper of the MARCHIONESS, and on behalf of Mr Andrew McGowan, the mate, and by Kingsley Napley on behalf of Captain Henderson, the master of the BOWBELLE.

### Previous Inquiries

- 9.3 The only previous inquiry that has been carried out into the casualty is the Inspectors' Inquiry leading to the MAIB Report. The problems with that investigation and report have been identified above. It was made after a private investigation, the evidence upon which it was based has never been made public until now and its conclusions were not therefore open

to public scrutiny. I have already given my reasons for my conclusion that this is an exceptional case which has called for public scrutiny of what happened from the outset. The only public scrutiny of the evidence that has taken place has been in the prosecutions and at the second inquest. I should note in this context that, as I said earlier, the Hayes Inquiry was not an investigation into the causes of the casualty.

### Prosecutions

- 9.4 As appears in Annex C and section 7, there were three prosecutions. There were two of Captain Henderson for failing to ensure that a proper lookout was kept, at which the jury failed to agree, and there was one private prosecution of the owners of the BOWBELLE, at which the magistrate held that they had no case to answer. In a well argued submission on behalf of the Centre for Corporate Accountability (“CCA”), its director, Mr David Bergman, submits that no prosecution replicates in any way the purpose or process of examination that takes place at a public inquiry. I agree. By its nature a prosecution has a very limited purpose. Not surprisingly, therefore, none of the prosecution hearings can fairly be regarded as an adequate substitute for a public inquiry at which all the evidence would be considered by one tribunal which would provide a reasoned report on the basis of it.

### Inquest

- 9.5 As also appears in Annex C and section 7, the resumed inquest took place between 13<sup>th</sup> March and 7<sup>th</sup> April 1995. A large number of witnesses were called. Unfortunately, however, none of those representing the survivors or the relatives of those who died had available to them all the police statements and all the declarations. It follows that, as in the case of the prosecutions, no-one had all the material available and it was not the function of the coroner or the jury to produce properly reasoned conclusions as to the primary facts. It also follows, as it seems to me that, although the inquest lasted a considerable time, (in part at least because of the nature of an inquest) it did not produce the public scrutiny which the case required from the outset and it did not produce a reasoned conclusion. Indeed, the particular verdicts of unlawful killing in this case to my mind highlight one of the least satisfactory features of an inquest. The jury must be sure that a person or entity is guilty of unlawful killing before bringing in such a verdict, but it is not permitted to say whom it has found to be guilty. The public is therefore left in the dark.
- 9.6 However that may be, the events of this case in my opinion highlight the unsatisfactory features of the relationship between inquests and inquiries. It seems to me that in cases where an FI (or its equivalent) takes place, the same ground should not be traversed again in an inquest, which should have a much narrower ambit. However, whether or not that is a sound general principle, I am firmly of the view that in this case there should have been an FI and not an inquest, save a formal inquest to identify in each case the medical cause of death. On the facts here the inquest was no substitute for a public inquiry, which would have yielded a reasoned report after an analysis of all the relevant evidence.
- 9.7 I take a few examples of events at the inquest which seem to me to bear out that conclusion. Rule 36(1) of the Coroners Rules 1984 provides, so far as relevant, as follows:

The proceedings and evidence at an inquest shall be directed solely to ascertaining the following matters, namely –

- (a) who the deceased was;
- (b) how, when and where the deceased came by his death;
- (c) ...

- 9.8 Problems have arisen in the past as to the permissible scope of the investigation into the question how the deceased came by his death. There have been a number of cases in which the courts have tried to grapple with what Simon Brown LJ described in *R v Inner West London Coroner ex p Dallaglio* [1994] 4 All ER 139 at p 155 as the tension between sections 8(3) and 11(5)(b) of the Coroners Act 1988 and rule 36(1) of the Coroners Rules. The cases include *R v East Kent Coroner ex p Spooner* (1988) 152 JP 115, *R v East Sussex Coroner ex p Homberg* (1994) 158 JP 357, *R v North Humberside Coroner ex p Jamieson* [1995] QB 1 and *Re Neal*, an unreported decision of the Divisional Court dated 17<sup>th</sup> November 1995. There is a useful discussion of the cases in the fourth supplement to the 11<sup>th</sup> edition of Jervis on Coroners at paragraph 12-101, which supports the proposition that the inquiry at an inquest is confined to matters which are directly causative of death and does not extend to inquiring into the underlying responsibility for every circumstance which might have contributed to the death. The cases are not entirely consistent, but it is not necessary for me to try to resolve any differences between them.
- 9.9 In *ex p Dallaglio* Simon Brown LJ emphasised (at p 155) that the scope of the issues to be investigated was essentially a matter for the coroner. Sir Thomas Bingham MR said much the same at p 164. He said:

It is for the coroner conducting an inquest to decide, on the facts of a given case, at what point the chain of causation becomes too remote to form a proper part of his investigation. That question, potentially a very difficult question, is for him.

Not surprisingly, that question arose at the inquest before Dr Burton. He heard submissions on what evidence he should adduce and what he should not and made a number of rulings in this regard. Those rulings seem to me to emphasise one of the differences or potential differences between a public inquiry and an inquest.

- 9.10 One of the questions considered by the MAIB was whether the BOWBELLE and other similar vessels owned or operated by the owners of the BOWBELLE had had collisions on the Thames before: see chapter 15 of the MAIB Report. I have already referred to this issue in section 8 above in connection with the question whether there should have been a public inquiry. In chapter 4 of the Hayes Report there are a number of paragraphs, namely 4.8 to 4.19, setting out the history of incidents on the Thames in the 1970s and a number of further paragraphs giving details of three incidents in the 1980s, two of which involved the BOWBELLE and the BOWTRADER. It appears to me that Mr Hayes' investigations in this respect went further than those of the MAIB, but, however that might be, paragraphs 17.5 to 17.7 of the MAIB Report contained a discussion of the responsibility of the owners and operators of the BOWBELLE in the light of the consideration given by the MAIB to the events of the 1980s. It is plain that these were relevant matters for an inquiry to investigate if it was to determine the cause of the collision and, in particular if it was to reach satisfactory conclusions as to the reasons why the BOWBELLE was not keeping a proper lookout forward before the collision.
- 9.11 An FI would consider in detail what were the underlying causes for the failure to keep a proper lookout. Again, this is a matter which I have touched on in section 8 above. The matters which an FI would have considered would have included these (no doubt among other) questions. What were the duties of the lookout? What instructions had he been given and by whom? What instructions had the master given to the lookout? What instructions had he been given and by whom to overcome, given the problems of keeping a good lookout forward caused by the design of the BOWBELLE? Were those instructions written or oral? What, if any, steps

were taken to monitor whether the master was complying with such instructions? If the instructions were given by a superintendent, what were his duties? Were they laid down orally or in writing? What, if any, steps were taken by the superintendent's superiors to monitor his performance? What consideration had the board of the relevant company given to safe navigation in the Thames? What (if any) instructions had it given to whom? What steps did it take to ensure that those instructions were carried out? What system was there for reporting incidents through the company? What system was there for ensuring that lessons were learned from casualties? What was the role of the superintendents, their superiors and the board in this regard? Did the system work in the light of the experiences in the 1970s and the 1980s? If not, why not? Where did the responsibility lie for any failures? Was it with one or more of the following: the lookout, the master, anyone else on board, the superintendents, their superiors or the board of directors? Similar (but not of course identical) questions would arise in the case of the MARCHIONESS.

- 9.12 In identifying those questions I do not mean to suggest any answers, but they highlight the differences between an FI and an inquest, including this inquest. If I have understood his rulings correctly, the coroner took the view that he should focus on what actually happened, and not investigate corporate responsibility. It was I think on that basis that he refused to call the managing director of the owners or operators of the BOWBELLE. Indeed, as I understand it, no management witnesses were called at all and no oral or documentary evidence was put before the jury as to the incidents in the 1980s. It was on the same basis that he refused to call Mr Girvin, who was a former member of the crew of the BOWBELLE and who on the face of it had relevant evidence to give as to the system of forward lookout on the BOWBELLE, including evidence about the availability or otherwise of walkie-talkies. In refusing to call him, the coroner said that he had left the vessel three weeks earlier and that "he wasn't there so he is not a witness".
- 9.13 The coroner also refused to call Captain Beetham, who inspected the MARCHIONESS in her damaged condition, and whom the relatives of some of the deceased wanted the coroner to call in order to express his opinion as to the point of impact. The point of collision on the MARCHIONESS was said (with some force) to be relevant to the effect of the impact upon the heading of the MARCHIONESS, to her likely heading at collision and therefore to the issue whether she had altered to port (for whatever reason) before collision. It is true that (as stated above) there is a difference between the views expressed in the Edon Liddiard Vince report of 22<sup>nd</sup> September 1989 and those expressed by Captain Beetham in his statement in September 1991 and in his report of 3<sup>rd</sup> December 1999, but I have little doubt that an FI would wish to hear from him on the subject. That is so, whether or not he personally was the author of the report of 22<sup>nd</sup> September 1989. As indicated in paragraph 8.40 above, it seems to me that the reason why an FI would wish to consider evidence as to what, if anything, can be inferred from the damage to the vessels (and in particular to the MARCHIONESS) is that it may shed light on the heading of the MARCHIONESS at impact, which may in turn help to decide whether the heading of the MARCHIONESS had altered to port before impact and why. To that end I feel sure that an FI would wish to hear not only from Captain Beetham and anyone else who inspected the damage, such as one or more of the inspectors, but perhaps also from others.
- 9.14 I do not criticise the coroner for the decisions which he made, but there can I think be no doubt that much, if not all, of the evidence to which I have just referred would have been put before an FI, which shows the considerable differences between an inquest and an FI. A further difference is evidenced by the fact that, as I understand it, those who were taking part did not have available to them before the inquest began a complete set of the statements of

the witnesses who were to be called or of the relevant documents. This is no doubt not unusual because, as Brooke LJ pointed out (at paragraph 40), when giving the judgment of the Divisional Court in *R v HM Coroner for Lincolnshire ex p Annette Hay* on 19<sup>th</sup> February 1999:

There is no provision in the Act or the Rules for pre-inquest disclosure of witness statements, or indeed of any other documents. There is no statutory obligation on anyone to volunteer any information to the coroner or to co-operate with him in advance of the hearing. Indeed there is no power for the coroner to require any person to give a statement or to deliver up any document in advance of the hearing.

9.15 Again I do not criticise the coroner, but the fact that all the documents and statements were not available to all at the outset to my mind highlights the differences between the two types of process. So do the different ways in which the two processes deal with conflicting evidence. The evidence at the inquest revealed contradictions both between different witnesses and between different statements of the same witnesses. Allegations have been made as to why that is the case. I do not know whether those allegations are valid or not. I do not know where the truth lies, but it is not possible to ascertain the true facts from the verdict of the jury at the inquest, or indeed from the results of the prosecutions.

9.16 All these considerations support the conclusion that the fact that there was an inquest which lasted some time was not and is not a sufficient reason not to order an FI. As Simon Brown LJ said in *ex p Dallaglio* at p 155,

no-one could pretend that [an inquest] would be a satisfactory alternative to the public inquiry so long denied these applicants.

I entirely agree. An inquest in this case was very far from a satisfactory alternative to a public inquiry.

9.17 In these circumstances my answer to the first of the questions posed by Hill Taylor Dickinson is that adequate inquiries have not been carried out to date. I reach that conclusion for the reason already stated, namely that there has been no public investigation. I reach it for essentially the same reason as I concluded in section 8 that a public inquiry should have been ordered earlier. Moreover I do so without consideration of what is said to be new evidence, although concerns remain in the context of the particular topics discussed in section 8, namely the primary facts, the issue of alcohol and the position of the owners of the BOWBELLE. I shall not repeat here what I said there.

### **New Evidence**

9.18 I have considered this point already. My conclusion does not depend upon the existence of new evidence, but, as just stated, I have set out in section 8 above some of my concerns. It seems to me that the evidence at present available (whether or not it was available at the time of the original MAIB investigation) leaves a number of questions unanswered. They have not been answered to date and a public inquiry, at which for the first time all relevant material can be considered by one tribunal, is in my view required to answer them. That tribunal will then be required to give reasons for its conclusions.

- 9.19 I should stress in this regard that I do not accept the submission that an inquiry should only be ordered if it can be shown that no reasonable Chief Inspector could have reached the conclusions in the MAIB Report or if the test for reopening the MAIB investigation under the 1989 Regulations can be satisfied. As I have tried to explain above, the power to order an FI in section 56 of the 1970 Act, as amended by section 33 of the 1988 Act, has never been restricted in any way, whether before or after the publication of the MAIB Report. I have tried to reach my conclusion by considering all the circumstances of the case.

### **Is a Useful Public Inquiry Possible?**

- 9.20 It is submitted on behalf of the master and owners of the BOWBELLE and on behalf of Mrs Faldo and the mate of the MARCHIONESS that it is now too late to hold a useful public inquiry. Some witnesses have died and memories will inevitably have faded, so that it is too late to expect, say, a wreck commissioner, to reach sensible conclusions as to what happened.
- 9.21 In this regard I entirely recognise that, if a public inquiry is to be held after a casualty like this, it should be held as soon as possible, as was done in the HERALD OF FREE ENTERPRISE, where the FI began less than two months after the accident. In the future every effort should be made to that end, provided that an inquiry is not delayed by criminal proceedings.
- 9.22 It does not, however, follow that a useful public inquiry is not possible now. It is true that important witnesses are dead. Thus, for example, Mr Butcher of South Coast Shipping and Mr Kenneth Noble, who was at the wheel of the BOWBELLE, have died since the collision. An inquiry without their oral evidence will not be entirely satisfactory, although Mr Noble died before an FI would have been held, even if it had been ordered at the outset. Moreover, it can be said that an inquiry is not entirely satisfactory without the evidence of those who died as a result of the collision and its aftermath, yet no-one could sensibly suggest that an inquiry should not be held because some of those who would have been important witnesses died in the casualty. In all the circumstances I do not think that it can fairly be concluded that it is no longer possible for a useful inquiry to be held because two of those who would have given evidence are known to have died since the collision.
- 9.23 Equally, I do not think that it can fairly be concluded that a useful inquiry cannot now be held because the passage of time since the casualty will have affected witnesses' memories. It will undoubtedly be less easy for witnesses to remember the details of what happened and that is plainly something which the inquiry will have to have well in mind. It is, however, unfortunately not uncommon for both criminal and civil trials to take place many years after the relevant events and experience suggests that a fair trial can still take place in such cases. All depends on the circumstances. If (as I think should happen) an inquiry takes the form of an FI, the wreck commissioner and his assessors will in my opinion be able to conduct a fair and worthwhile inquiry and give coherent reasons for their conclusions. In doing so they will have well in mind the dangers inherent in evidence given by witnesses long after the event.
- 9.24 One of the central points made by Mr Bergman on behalf of the CCA is that the police statements were unsatisfactory in a number of respects. The allegations are that the police imposed their view on a number of witnesses before they gave their statements to the police, that the police statements were the result of the lack of rigorous questioning and that some of the statements were inaccurate for other reasons. Paragraphs 51 to 76 of the CCA submission are taken up with those points. Those seem to me to be matters which, so far as appropriate, can be considered in the context of the evidence of each of the witnesses to

whom Mr Bergman refers, both before their evidence is considered at an FI and at the inquiry itself. I do not think that the passage of time will prevent a fair conclusion being reached on all questions which are relevant to the central issues, namely what were the causes of the casualty and the loss of life.

- 9.25 Finally in this connection, I should mention a point referred to by Hill Taylor Dickinson. It relates to the possibility of witnesses refusing to answer questions because the answers might tend to incriminate them. Captain Henderson claimed the privilege against self-incrimination at the inquest and refused to answer certain questions at the inquest on this ground. Hill Taylor Dickinson point out that, at the oral hearing or meeting on 8<sup>th</sup> November, counsel for the CPS did not rule out the possibility of a prosecution, even at this late stage. They add that, in these circumstances, there is still a risk of prosecution, however remote, and that it is likely that several witnesses would seek to exercise the privilege as a ground for refusing to answer questions.
- 9.26 I naturally hope that if there is an inquiry, that will not happen, since the inquiry will wish to have the maximum possible assistance from those who can give relevant evidence, but it does not seem to me to be a sufficient reason (either on its own or in conjunction with other factors) not to order a public inquiry now. If the privilege were asserted at any inquiry, it would be necessary to examine the claim with care in order to see whether there was any risk of the particular witness being prosecuted (since it is as I understand it at present the privilege of the witness which is relevant) and, if so, whether he was entitled to refuse to answer the particular question put. I cannot and would not wish to prejudge the validity of any such claim now. It is a matter which would have to be decided at the time, in the light of all the circumstances, including any relevant immunity offered by the DPP, after the tribunal had heard submissions from those interested.

### **Lessons Already Learned**

- 9.27 It is submitted that a crucial purpose of a public inquiry is to learn lessons from a casualty in order to promote safety at sea, and of course on rivers, in the future and that, in the light of the several inquiries to date, those lessons have now been learned. It is submitted that it follows that the public interest does not now require a public inquiry with all its attendant distress.
- 9.28 I entirely accept the submission that an important purpose of an FI is to learn lessons for the future. I have already set out at length in sections 5 and 6 both what I regard as purposes of a public inquiry, and indeed of an FI, and my reasons for concluding that this was in principle a suitable case for an FI. As appears in those sections, although I regard the learning of lessons for the future as a very important function of an FI, it is not the only purpose. Apart from its disciplinary role, a central purpose of an FI in an exceptional case of this kind is to find the facts after public scrutiny, so that the public in general and both the survivors and the families of those who lost their lives in particular may, so far as possible, learn the truth of what happened.
- 9.29 It is for the purpose of ascertaining the true facts in a public forum that, in my opinion, an FI should be held even now. I recognise that the chances of an FI now enabling lessons to be learned for the future which have not been learned in the last ten years are small. Although, as I indicated in my interim report, representations on safety topics can no doubt be made to an FI (if one is ordered), they are unlikely to take matters further than representations to the Secretary of State can do and without the considerable time and cost inevitably involved in an FI. Thus, as explained in detail in my interim report, safety on the Thames has now been

considered many times since the casualty. That consideration has included that given by the MAIB, by the Hayes Inquiry, by the inquest jury and by Part One of this Inquiry. In addition, as I tried to explain in my interim report, both the Department and the PLA have introduced many improvements over the last ten years.

- 9.30 In these circumstances, I would not recommend a public inquiry, whether by way of FI or otherwise, in order to learn lessons for the future. If an inquiry is to be ordered, it can only be to ensure, if at all possible, that the true facts are known.

### **Is an Inquiry Just?**

- 9.31 The question under this head is whether it is just to order an inquiry now after everything that has happened in the past. Is it just to Captain Henderson or to the memory of Mr Faldo? Does it merit the time and emotional strain which will undoubtedly be involved? Should people not be allowed to continue to rebuild their lives without being exposed to everything that an FI will involve?
- 9.32 I recognise that many people, including Mrs Faldo, the widow of the skipper of the MARCHIONESS, have been trying to put the whole affair behind them. I am sure that that is true of many others. I also recognise that Captain Henderson, who co-operated with the investigations from the outset, has had to endure a great deal over the years, including two prosecutions and the inquest. Moreover, it is right to say that some witnesses have given evidence more than once and that very many statements were taken at the outset both by the MAIB and by the police. Other considerations have been drawn to my attention as reasons for not holding an inquiry after so long. It is submitted on behalf of a number of correspondents that witnesses should not now be exposed to the stress of giving evidence and reliving the events of 20<sup>th</sup> August 1989. For example it has been pointed out on behalf of the Metropolitan Police that many officers would be traumatised and distressed, and in some cases further traumatised and distressed, by an inquiry into the events of that night.
- 9.33 These are powerful factors against ordering a public inquiry now, especially when put in the balance with the problems faced by an inquiry after so long, and given that some witnesses have died since the casualty. As so often, however, it is a question of balancing the different considerations, which do not all point in the same direction, in order to assess their relative weight.

### **Conclusion**

- 9.34 Having done my best to carry out that balancing exercise, I have reached the conclusion that there should be a public inquiry because the public interest requires that the facts be properly proved and analysed in the public domain. I recognise that more than one view is possible on this topic, as evidenced by the different view of the previous Government, but I have been asked to express my view. In doing so I do not intend to criticise either the present or the previous Government, but merely to say that it is my firm view that a public inquiry should now be held into the causes of the collision and the subsequent loss of life. I shall consider further below the form that the inquiry should take and what it should cover, but the steps which have led me to this conclusion may be summarised as follows.
- 9.35 This was an exceptional casualty, which was suitable for a public inquiry from the outset. If it was not ordered at the outset, a public inquiry should have been ordered after the MAIB

Report was delivered to the Secretary of State, either before or after the report was published and at the latest when the report was in fact published in August 1991. It could and should have taken place instead of an inquest (or in addition to a formal inquest) after the conclusion of the private prosecution at the end of June 1992. Indeed, if it had been ordered earlier, it might well have taken place before that because Mr Glogg might not in that event have proceeded with the private prosecution. Counsel for the applicant told Nolan J that the application was not being made in a vindictive spirit, but because Mr Langlands-Pearse and the other relatives feared that, unless wider charges were brought, the full circumstances of the tragedy would never be publicly explored.

- 9.36 However that may be, it is my view that a public inquiry should have been held at the latest soon after the private prosecution ended, that is soon after the end of June 1992, perhaps in early 1993. Even at that stage there would have been some difficulties because, for example, Mr Noble had already died, but I do not think that it could seriously have been suggested at that time that an FI could not be fairly and properly conducted. I recognise that the passage of time since then will have created some difficulties, but they can be overcome without injustice, provided that the issues are handled fairly and sensitively.
- 9.37 In that connection I hope that, if an inquiry is ordered, the representatives of the parties will co-operate in such a way as to ensure that no-one (including of course both survivors and police witnesses) needs to give evidence on any matter which may cause distress unless it is absolutely necessary. I shall return to the conduct of such an inquiry below, but on balance I do not think that any of the considerations against an inquiry outweighs the public interest in holding one, which has to my mind existed since the beginning.
- 9.38 It will be clear from the above that I do not share the view of Mr Parkinson, as reported on the Dispatches programme, that a public inquiry is not the way to find out what really happened and to learn lessons. He added:

I think a dispassionate inquiry by experts who have no duty other than to understand what really happened is a far better way of getting – dealing with these matters than the emotion and hysteria of public inquiries.

I agree with him that emotion and hysteria should, as far as possible, be avoided in a public inquiry because the purpose of such an inquiry is to carry out a dispassionate and fair analysis of the relevant facts in the public domain, but I do not agree that in every case it is appropriate to leave the matter to be investigated by the MAIB. There may be very many such cases. Indeed a public inquiry should only be held in an exceptional case, but this was and remains such a case.

## 10 What Should the Inquiry Investigate and What Form Should It Take?

- 10.1 These two questions should I think be considered together because they are related. I shall consider first the question of what types of inquiry are available because the answer has a bearing on both of the principal questions posed in this section.

## Types of Inquiry

- 10.2 Subject to section 49 of the Police Act 1996, and possibly to section 14 of the Health and Safety at Work etc Act 1974 (HSWA), to each of which I shall briefly return below, as far as I am aware there are only three types of inquiry which could be held. Two are statutory and one is non-statutory, although I can see no reason in principle why it should not be possible to hold a statutory and a non-statutory inquiry at the same time. The statutory inquiries are an inquiry under the Tribunals of Inquiry (Evidence) Act 1921 (“the 1921 Act”) and an FI. I shall briefly consider each in turn.

### The 1921 Act

- 10.3 Section 1(1) of the 1921 Act provides, so far as relevant:

Where it has been resolved ... by both Houses of Parliament that it is expedient that a tribunal be established for inquiring into a definite matter described in the Resolution as of urgent public importance, ....

There follow detailed provisions as to the powers of such a tribunal, which are essentially those of the High Court.

- 10.4 It is clear from the express terms of the section that the resolution must identify the matter to be inquired into as being of urgent public importance. Although I recognise of course that Parliament is sovereign and could presumably pass a measure ordering an inquiry into whatever it thought appropriate, neither House could properly pass a resolution under the 1921 Act in this (or any) case unless it concluded that the matter was of urgent public importance.
- 10.5 The circumstances in which it would be appropriate for the inquisitorial machinery of the 1921 Act to be deployed were considered in 1966 by the Royal Commission on the working of the Act under the chairmanship of Salmon LJ. In paragraph 27 of its report, the Commission said that use of the Act should be “confined to matters of vital public importance concerning which there is something in the nature of a nation-wide crisis of confidence”. In paragraph 71 the Commission said that “unless a matter is really of great public importance – as it should be before it is inquired into by a Tribunal under the Act – it is unlikely that Parliamentary time will be spared”. The collision between the MARCHIONESS and the BOWBELLE took place ten years ago. Whilst not in any way wishing to downplay the undoubted public interest in establishing the cause of the collision, I do not think it could sensibly be said that this is a matter about which there is a nation-wide crisis of confidence or that the matter is of “great” or “vital” public importance such as to justify the passing of a resolution by both Houses of Parliament to set up an inquiry under the 1921 Act.
- 10.6 In short, none of the matters which might be investigated now could fairly be described as of “urgent public importance” within the meaning of the Act. Moreover, I would reach that conclusion on the ordinary meaning of the section, construed in its context, even without the assistance of the Salmon Commission. In all the circumstances I have reached the firm conclusion that, unless there is some statutory provision of which I am unaware, subject

possibly to the Police Act 1996 and to section 14 of the HSWA<sup>8</sup>, the only statute under which an inquiry could be held is the 1995 Act. For the reasons set out below, it is my view that section 268 of that Act is entirely appropriate for that purpose.

### Formal Investigation

- 10.7 I tried to describe the legal position as at 1989 and 1990 in section 7. Since then there have been some changes. The 1995 Act is a codifying statute. Section 267 re-enacts section 33 of the 1988 Act and thus makes provision for the investigation of defined classes of accident of which this was one. Section 268 re-enacts sections 56 and 60 of the 1970 Act as amended. Section 268(1) gives the Secretary of State the same untrammelled power to order an FI into a relevant accident as section 56(1) of the 1970 Act (as amended by the 1988 Act) did. The 1995 Act also provides by section 268(2) that a wreck commissioner appointed to hold an FI shall do so under rules made under section 270(1) of the Act. By sections 268(5) and 61(1) the wreck commissioner has the same powers to suspend or cancel the certificate of a certificated officer as a wreck commissioner had, if appointed under section 56(1) of the 1970 Act as amended, which I have described above.
- 10.8 In short, the effect of sections 267 and 268 of the 1995 Act is simply to repeal the earlier statute and to re-enact it, so that the position remains the same as before. It follows that the Secretary of State has the same power to order an FI as he has had since the collision. It also seems to me to follow that the purposes of an FI ordered under section 268 will be the same as those of an FI ordered under the 1970 Act. They are the three purposes identified by Steyn J discussed above, namely establishing the cause or causes of the casualty, learning lessons for the future and disciplining certificated officers.
- 10.9 Section 269 provides for rehearings of FIs which have already taken place. I should note in passing that rehearings have been ordered into the loss of the GAUL and the DERBYSHIRE, but no FI has yet been ordered under section 268. The DERBYSHIRE was, as I understand it, held under section 55 of the 1970 Act, the order for the FI having been made in June 1987, and thus before the repeal of section 55 by the 1988 Act. No rules have been made under section 270 of the 1995 Act, but the effect of section 17(2)(b) of the Interpretation Act 1978 is that the 1985 FI Rules and the 1990 Amendment Rules have effect as if they had been made under section 270(1) of the 1995 Act. It follows that any FI now ordered, including any FI ordered into the collision between the MARCHIONESS and the BOWBELLE, will (unless new rules are introduced in the near future) be conducted under the 1985 FI Rules and the 1990 Amendment Rules.
- 10.10 The 1989 Regulations, which (it will be recalled) set out the procedure for an MAIB investigation, were replaced by the Merchant Shipping (Accident Reporting and Investigation) Regulations 1994, which have in turn recently been replaced by the 1999 Regulations, which came into force on 12<sup>th</sup> October 1999. They contain a new definition of accident and abolish the concept of the Inspector's Inquiry. I am not at present concerned with those aspects of the regulations, but regulation 6(3) provides:

<sup>8</sup> It is arguable that an inquiry into a marine casualty could also be ordered under this section, which is in very broad terms. However, no-one suggested it, and given the availability of the FI procedure, it is difficult to imagine that there would in practice be any need to use it.

Where the Secretary of State causes a formal investigation into an accident to be held pursuant to section 268 of the Act, any investigation conducted under these Regulations relating to the accident shall be discontinued except for the purpose of rendering assistance to the Court and to the Attorney General or the Secretary of State.

That regulation would not strictly apply here because the MAIB investigation in this case was not of course conducted under the 1999 Regulations, although it does underline the fact that one of the duties of the Chief Inspector of the MAIB is to render such assistance to the wreck commissioner and the Attorney General as is in his power, as provided by rule 4A of the 1985 FI Rules, which was inserted into those rules by the 1990 Amendment Rules.

10.11 It follows that, if an FI is ordered, it will be the duty of the Chief Inspector to render such assistance as is in his power to the wreck commissioner and to the Attorney General, who will be responsible for preparing the case for the FI. That assistance would include using or appointing inspectors to take declarations and to exercise any of the other powers of an inspector under section 259 of the 1995 Act, which are very extensive. Those powers are in my opinion sufficient to enable an effective FI to take place.

10.12 The jurisdiction of a wreck commissioner is limited because section 268(1) provides as follows:

Where an accident has occurred the Secretary of State may (whether or not an investigation has been carried out under section 267) cause a formal investigation into the accident to be held –

... by a wreck commissioner

and in this section “accident” means any accident to which regulations under that section apply or any incident or situation to which such regulations apply by virtue of subsection (5) of that section.

The 1999 Regulations were made under section 267 of the 1995 Act.

10.13 Regulation 2(1) provides, so far as relevant:

For the purposes of these regulations and of section 267 of the Act, “accident” means any contingency caused by an event on board a ship or involving a ship whereby:

- (a) there is loss of life or major injury to any person on board, or any person is lost or falls overboard from, a ship or a ship’s boat; [or]
- (b) a ship –
  - (i) causes any loss of life, major injury or material damage;
  - (ii) is lost or is presumed to be lost;
  - (iii) ...
  - (vi) is in a collision; ....

The defining words are “any contingency caused by an event on board a ship or involving a ship” leading to one of the consequences then listed. Regulation 6(1) provides that “any accident may be investigated” and regulation 8(2) provides:

An investigation may extend to cover all events and circumstances preceding the accident which in the opinion of the Inspector may have been relevant to its cause or outcome, and also to cover the consequences of the accident and the Inspector’s powers shall apply accordingly.

Finally, regulation 4(1) of the 1985 FI Rules (as amended by the 1990 Rules) provides:

Where it appears to the Secretary of State that a formal investigation should be held into the circumstances or causes of, or into any particular matter relating to an accident, he may direct that a formal investigation be held and conducted in accordance with these Rules by a wreck commissioner.

When the 1990 Rules were introduced, “accident” meant any accident to which section 56 of the 1970 Act (as amended by the 1988 Act) applied. It now means any accident to which section 268 of the 1995 Act applies.

- 10.14 The effect of those provisions as applied to the facts of this case can be summarised as follows. The Secretary of State has power to order an FI into the collision between the MARCHIONESS and the BOWBELLE, the loss of the MARCHIONESS, the loss of life and the injuries suffered by those who survived. Such an FI would naturally consider the causes of the collision and the loss of the MARCHIONESS and the causes of the loss of life and personal injuries. In doing so, part of its remit would include the search and rescue operation. That would I think be so even if the Secretary of State did not give an express direction to that effect under regulation 4(1) quoted above, although it seems to me that, if the Secretary of State decides to order an FI, and if it is his view that it should cover the SAR operation, it is desirable that he should make that clear by giving an appropriate direction to that effect under regulation 4(1).
- 10.15 There have been calls for a much wider inquiry than that. For example, the MARCHIONESS Contact Group (“MCG”) and the CCA want an inquiry into the conduct of the police, the MAIB, the CPS and the DPP in connection with the various investigations into the casualty. In addition there are calls for an inquiry into the way in which the bodies of those who died were dealt with. Moreover, there are many who would like to see an inquiry into the relationship between the various investigations and inquiries (including inquests), which will often take place after a serious casualty and the MAG wants an inquiry into a number of aspects of the law, including the law of damages, limitation of liability and corporate manslaughter. As appears below, this is not an exhaustive list.
- 10.16 In my view none of those matters is or could be within the jurisdiction of an FI ordered under section 268 of the 1995 Act. That Act must of course be construed in accordance with its legislative purpose, which is to facilitate the investigation of shipping casualties. None of the topics which I have just mentioned is encompassed within that purpose and I do not think that section 268 or the 1985 FI Rules or the 1999 Regulations is wide enough to permit the Secretary of State to order an FI for the purpose of investigating any of those questions.

#### Police Act 1996

- 10.17 Section 49(1) of the Police Act 1996 gives power to the relevant Secretary of State (who would presumably be the Home Secretary) to set up a public inquiry into any matter connected with the policing of any area. I mention it because of the suggestion that there should be an inquiry into the police investigation. I return to that suggestion below. It is sufficient to note here that no-one has referred to the possibility of an inquiry under this section or sought one.

## Non-Statutory Inquiries

- 10.18 This Inquiry has been non-statutory. There have been a number of examples of such inquiries in recent years. One prominent example is the BSE Inquiry. Non-statutory inquiries can be effective because it is rarely necessary to invest those conducting the inquiry with statutory powers, at least where the subject matter of the inquiry is within the sphere of Government or any official agency. In practice civil servants and retired civil servants will almost always co-operate with the inquiry. If my experience in this Inquiry is anything to go by, the same is true of others, although I recognise that that might not always be the case, especially if a particular person or entity perceived it to be in their best interests not to co-operate.
- 10.19 There are, however, some matters which are more suitable for a non-statutory inquiry than others. In the present context, it seems to me to be preferable to order an FI into the matters identified in paragraph 10.14 above. The FI is a creature of statute established for exactly this purpose. It has certain specified powers, including disciplinary powers, although it may be argued that it is too late to consider exercising those powers on the facts of this case. Any further investigation which may be necessary before the FI begins to hear evidence can be conducted by inspectors with wide powers to obtain both oral and documentary evidence. The whole case can then be presented to the wreck commissioner and the assessors by or on behalf of the Attorney General as, in effect, counsel for the tribunal.
- 10.20 The 1985 FI Rules contain detailed rules of both evidence and procedure and, although (as appears below) there seems to me to be an argument for changing those rules in some respects, there is no good reason why they should not apply in this case, which is the very type of case for which they were intended. Section 269(4) of the 1995 Act provides for a right of appeal in some, albeit arguably limited, circumstances. Accordingly, if the matters specified in paragraph 10.14 are to be investigated at a public inquiry, it should be at an FI, which would be much more suitable for the purpose than a non-statutory inquiry.
- 10.21 On the other hand, if there any other matters which the Secretary of State would wish to have considered by a public judicial inquiry, I can see no reason why he should not ask the wreck commissioner at the same time to conduct a non-statutory inquiry into them. I turn to consider the various submissions as to the topics which should be included in a public inquiry. It is convenient to do so in two separate sections.

## 11 What Topics Should be Included?

- 11.1 The topics which it has been variously suggested should be included in a public inquiry, in addition to those which fall within the jurisdiction of a wreck commissioner appointed (with assessors) under section 268 of the 1995 Act, are these: why a public inquiry was refused, the investigations and prosecutions, the way the bodies of the deceased were dealt with, post-disaster procedures and law reform. In the MAG submissions prepared by Mr Napier he identified five purposes of an inquiry, A to E, which encompass most of the topics to which I have just referred.

**Purpose A. To examine all facts and issues not adequately covered by the various hearings to date and to make recommendations.**

- 11.2 This purpose will, as I see it, be accomplished by an FI. As already stated, it will be possible for inspectors to be appointed to carry out any necessary further enquiries and to obtain any relevant documents which have not been obtained to date. The purpose of the FI will not, however, be to consider previous inquiries but to consider what the true facts are and thus what the true causes of the collision and loss of life were, which is what the families have properly been seeking to ascertain. As already stated, this will include findings as to the SAR operation. It will, however, be irrelevant to the questions to be decided at an FI, whether earlier inquiries were satisfactory or not.
- 11.3 As to recommendations, I have already expressed my view that there are unlikely to be any significant recommendations from an FI which relate to safety on the Thames beyond those in earlier reports and in my interim report. It will, however, remain the function of the FI to consider the future safety of the Thames, so if any particular point emerges which may assist safety in the future, it can of course be considered, although I do not see an FI as a re-run of Part One of this Inquiry.

**Purpose B. To examine why a public inquiry was refused by consecutive Secretaries of State.**

- 11.4 I do not think that there is anything to be gained by further inquiry into this question. I have expressed my own view on it in section 7 above and in my opinion the public interest does not require any further consideration of it.

**Purpose C. To examine the current inadequate arrangements for post-disaster inquiries and to make recommendations.**

- 11.5 I shall consider this topic separately below.

**Purpose D. To examine the need for implementation of current proposals for disaster related law reform**

- 11.6 The MAG submits that a public inquiry should consider law reform in the areas of corporate killing, damages for psychiatric injury, damages for pain and suffering and loss of amenity, damages for wrongful death and the limitation of liability in respect of damages payable to passengers on ships.
- 11.7 In short, it is submitted that the inquiry should consider a large area of potential law reform. In my opinion a public inquiry is a most unsuitable vehicle for consideration of such questions. In some of the areas, notably involuntary manslaughter by companies, or corporate killing (Report 237), liability for psychiatric injury (Report 249), damages for personal injury in respect of non-pecuniary loss (Report 257) and claims for wrongful death (Report 263), the Law Commission has already considered the topic in considerable detail. In other areas, it may well be appropriate for it to do so, and it is of course open to anyone to make representations to Government and to interested bodies as to how the law should be changed.

- 11.8 It is not, in my opinion, the role of a public inquiry to consider questions of law reform on this scale and, for my part, I do not recommend it. It is the role of the Law Commission and not of a public inquiry. It would add hugely to the time and cost of a public inquiry to include such issues of law reform and the public interest does not require it.

**Purpose E. To acknowledge the traumatic consequences caused to disaster victims by the inadequacies of post-disaster procedures and to make recommendations.**

- 11.9 I recognise that there are indeed traumatic consequences caused to disaster victims by the way in which they and their families may be treated after a casualty. There has, however, been a considerable amount of academic work on this topic and it does not seem to me to be a matter which can best be advanced by some form of judicial public inquiry. By way of example, I should certainly not regard myself as qualified to express a view on these questions. I shall, however, return below to the rather different question whether the legal procedures and processes after a serious casualty should be improved, which seems to me to be potentially more appropriate for some kind of judicial input.
- 11.10 I would also like to add this. It is clear from some of the representations that have been made to the Inquiry that it is very important that survivors and the families of those who lose their lives in disasters of this kind are treated sensitively in the aftermath of the casualty. I shall return below to the particular problems associated with the way the bodies of the deceased were treated, but it does seem to me to be important that those who take statements from survivors who may be traumatised as a result of the casualty or the SAR operation should take great care not to exacerbate the stress of the witnesses in any way. To this end it seems to me that, where possible, only those who are suitably trained should take statements of this kind. I do not suggest that this is not the case at present, but I would simply like to underline its importance.

**Remaining Topics**

- 11.11 I now turn to the topics of investigations and prosecutions and of legal processes which I shall discuss in this section before addressing the problems associated with the way the bodies of the deceased were dealt with, which I shall do in section 12.

**Investigations and Prosecutions**

- 11.12 The MCG and the CCA seek an inquiry into the conduct of the police, the MAIB, the CPS and the DPP in connection with the various investigations into the casualty. A similar submission was made by the Edge Hill Centre for Studies in Crime and Social Science, which called for an examination of the adequacy and appropriateness of the investigative and inquisitorial procedures as applied to the disaster. Dr Anne Eyre, Senior Lecturer in Disaster Studies and Management at Coventry University, suggests that what is required is an explanation and evaluation of the decisions by the CPS not to bring criminal charges against the owners of the BOWBELLE.

11.13 The CCA submission includes the following:

2. A public inquiry should be held since:
  - (i) a public inquiry should have been announced immediately after the disaster;
  - (ii) the inquiries that did take place – the MAIB and the coroner’s Inquest – failed (either separately or in combination) to come close to achieving the goals and purposes of a public inquiry; and
  - (iii) subsequent to the disaster (as in the case of the death of Stephen Lawrence) the government failed to conduct a proper criminal investigation and ensure that the correct prosecution decisions were taken.

The focus of this submission concerns (iii) above.

3. It is our contention that failures on the part of:
  - (i) the police,
  - (ii) the MAIB (whose findings were taken into account in the decisions by the Crown Prosecution Service), and
  - (iii) the Crown Prosecution Service

may well have led to a very serious miscarriage of justice involving the deaths of 51 people. Prima Facie evidence for this assertion exists, and it is necessary for a public inquiry to examine it in detail.

11.14 I have already expressed my view at length that there should be a public inquiry in the form of an FI into the casualty and the SAR operation. In doing so, I have accepted the submission that neither the MAIB investigation nor the inquest achieved the purposes of a public inquiry. The point made in (iii) is, however, very different and to my mind far-reaching.

11.15 The CCA states that its submission primarily relates to serious questions about how the authorities dealt with the disaster and that the core of its submission relates to the criminal investigation into the disaster and the prosecution decisions that were made as a result of that investigation. It is submitted that there is evidence that the initial criminal investigation into the possible culpability of any company, company director or senior company officer was inadequate and flawed and that there are strong grounds to believe that, had a proper investigation taken place, manslaughter proceedings could well have been pursued against South Coast Shipping and one or more of its senior officers. The CCA suggests a parallel with the Stephen Lawrence inquiry. It says:

It is our contention that whilst racist bias tainted the Stephen Lawrence investigation, there are clear indications that another form of bias tainted the MARCHIONESS investigation; that is to say “corporate” bias, and that an inquiry to determine whether this is the case is required.

It adds that

just as the criminal justice system cannot be seen to treat Black victims differently from White; so the system cannot be seen as treating corporate criminals differently from ordinary criminals. This, however, is the allegation in this case.

11.16 I am bound to say that I see no parallel between the issues raised in the Stephen Lawrence Inquiry and those potentially raised here. The Stephen Lawrence Inquiry raised questions of fundamental human rights, whereas this aspect of the Inquiry does not.

- 11.17 I recognise that companies can and do make far-reaching decisions and take actions that affect, for good or ill, the well-being of others. Clearly the police, as well as other relevant investigative and regulatory agencies of the state, ought to ensure that they inquire into suspected criminal activity of companies with as much rigour as they do in respect of private individuals. The CCA expresses concern that they do not do so. It has set out in its submission a number of examples which are said to show that that is the case, notably the HERALD OF FREE ENTERPRISE, King's Cross, Piper Alpha and Southall disasters. There is, however, no question of the events after those disasters being investigated as part of a public inquiry into the MARCHIONESS. The only question which I am considering in this context is whether the actions of the police, the CPS, and the MAIB in investigating the sinking of the MARCHIONESS ought now to be the subject of a public inquiry.
- 11.18 The MCG has also pressed for an inquiry into the various investigations. The MAG, on the other hand, while certainly critical of aspects of the investigations and reports, has not called for the investigations themselves to be the subject of a further inquiry. The MCG has focused more upon the police and the MAIB than upon the CPS and has not placed its submission against any background of a general failing by the authorities properly to investigate corporate responsibility for negligent or criminal acts.
- 11.19 If an FI is ordered in accordance with my recommendations, it will consider the relevant facts. In doing so, it will be necessary for it to evaluate the evidence. That evidence will no doubt include evidence of witnesses who have made statements before. As already noted in paragraph 9.24 and elsewhere, there are some witnesses who have given more than one account in the past. A considerable part of the CCA submission is taken up with an analysis of the reasons for that. It criticises the way in which some of the statements were taken. It may well be necessary for some of these issues to be resolved in the course of the FI, or perhaps in the course of the investigations leading up to it. This may entail scrutiny of the way in which particular statements were taken.
- 11.20 It will of course be possible for the reader of the report of the FI (if there is one) to draw conclusions from it and to compare it with the basis of the MAIB Report and indeed with the basis of the prosecutions. I am not, however, persuaded that it would be appropriate to investigate the investigations. It is only in a very exceptional case that that would, to my mind, be appropriate. There is no public interest in such an inquiry now. It would be extremely protracted and expensive and would add unnecessarily to the time and cost inevitably involved in an FI.
- 11.21 I do not regard the public interest as being served by directly investigating the investigators more than ten years after the event, as lessons to be learned from such an exercise are likely to be few. In respect of lessons that might be learned for the MAIB, it should, of course, be borne in mind that the investigation into the sinking of the MARCHIONESS was the first investigation undertaken by the MAIB, which had been in existence only a very short time. It has conducted many investigations since then without, to my knowledge, being the subject of public criticism. There is no reason to think that a public inquiry into the MAIB's first investigation and report will enable it to operate better in the future.
- 11.22 I should perhaps note in this regard that Rear Admiral John Lang has been the Chief Inspector since April 1997 and has introduced a number of changes which are directed, as he put it in a letter to the Inquiry dated 10<sup>th</sup> November 1999, to making the MAIB every bit as good as the AAIB. He added:

I want the organisation to be capable of conducting a thorough investigation that would match, if not surpass what a Public Inquiry would achieve. That such standards are

demonstrably attainable is already evident; the AAIB's reputation stands for itself. That this can be achieved at a fraction of the cost of a Public Inquiry is obviously a sensible use of public money.

That seems to me to be a sensible approach, although, as I have tried to explain above, there appear to me to be some exceptional casualties which should be investigated in public at a public inquiry. However that may be, I do not think that anything is to be gained for the future in carrying out a public investigation of the way in which the MAIB conducted its first investigation ten years ago.

- 11.23 I would, however, make one observation which I hope will assist the MAIB in achieving the high standards which Rear Admiral Lang has set for it. It is this. One of the main reasons why the MAIB was established was because it was felt that there was a need for a body to investigate marine casualties which was independent of the Department. It therefore seems to me that, if the MAIB is to have the full confidence of the public, it must rigorously maintain its independence from the Department.
- 11.24 In the course of the Inquiry I have been provided with files from the Department and the MAIB covering the period from the disaster until recently. It is clear from those files that the MAIB was regularly consulted by the Department in relation to various matters arising out of the publication of the Chief Inspector's Report and the subsequent calls for a public inquiry. I recommend that in the future both the Department and the MAIB take steps to ensure that dealings between them are limited to those matters which necessarily arise in connection with the performance by the MAIB of its proper investigatory functions, including of course reporting to the Secretary of State. Otherwise, there is a danger that the public will perceive, rightly or wrongly, that the MAIB is an arm of the Department rather than an independent investigative body. This would be unfortunate because it would defeat one of the very objects for which the MAIB was set up.
- 11.25 In these circumstances I recommend that clear guidelines be laid down setting out precisely the role of the MAIB on the one hand and the role of the Department on the other. Reading the documents evidencing the decision making process over the years from 1989 to 1999, I was left with a sense of unease at the close relationship between the Department and the MAIB when such questions as to whether an FI should be ordered were being considered by Ministers. Clear guidelines should be laid down and published so that the public may know the demarcation line between the Department and the MAIB and have confidence in the MAIB in the future. These are not, however, matters which should be separately considered at a future public inquiry and I stress that nothing that I say is intended to diminish the role of the MAIB as an independent agency, charged with investigating marine accidents in the same way that the AAIB investigates air accidents.
- 11.26 As for the police, there is, of course, always a public interest in being confident that the police are conducting their investigations thoroughly and competently, no matter the nature of the investigation. There are complaints made that, effectively, the standard of investigation in this case fell below what is expected. However, not every such allegation against the police leads to a public inquiry. Indeed, such public inquiries are rare. They are now set up under section 49 of the Police Act 1996, although (as I have already stated) no-one has so far suggested that an inquiry should be ordered under that section. Complaints about the police are ordinarily made to or through the Police Complaints Authority. Yet I am not aware that in this case there has even been a reference to the Police Complaints Authority. If this was a case which was thought to warrant a public inquiry, I would have expected such a complaint to have been made and, if one was made, I would have expected

it to have been brought to my attention.

- 11.27 As noted above, the police investigation will inevitably be scrutinised to a certain extent by the FI in its search for the true facts, which is likely to include a consideration of the acts and omissions of the owners and managers of the MARCHIONESS and BOWBELLE. The wreck commissioner will have to conduct his own inquiry into those matters, aided by such further investigations as may be conducted by inspectors, as discussed above. The wreck commissioner will have to reach conclusions based on the findings of those investigations and such other evidence as emerges at the hearing. That, in my view, is sufficient, subject perhaps to this.
- 11.28 It is part of the role of an FI to make recommendations for the future. If it appears to the wreck commissioner after hearing all the evidence that lessons could be learned which would help the future investigation of a serious casualty, I see no reason why he should not say so. I have in mind the possibility that he might wish to recommend that the MAIB and the police should lay down a framework for the investigation of accidents of this kind. The framework might include ensuring that investigators with appropriate expertise would be quickly available in order to avoid the risk that appropriate inquiries are not undertaken, appropriate witnesses not questioned, appropriate questions not asked and appropriate documents not obtained and studied. It is for example suggested here that more forensic tests should have been carried out. It is obviously important that all such tests should be carried out, both in the context of an MAIB investigation to find the facts and learn lessons for the future and in the context of a police investigation to consider whether a crime has been committed. It also strikes me that some thought should be given to the question when declarations should be taken and when police statements should be taken and to the circumstances in which the MAIB ought to be provided with evidence (including statements) obtained by the police, perhaps instead of obtaining declarations itself (and vice versa).
- 11.29 The division of responsibility between the police and the MAIB will also be important if the view which I expressed in my interim report, namely that consideration should be given in such cases to prosecution under sections 2 and 3 of the HSWA, leads to the conclusion that those sections should be used more readily in the future. It seems to me that these are matters which can properly be considered in a general way either by the wreck commissioner carrying out an FI or by the same person considering these questions as part of a non-statutory inquiry. I do not, however, think that the public interest requires a public inquiry into the investigations carried out in this case ten years ago by the MAIB or by the police.
- 11.30 Although the CPS is in a different situation, the same is in my opinion true. It would not be within the jurisdiction of an FI to examine its decisions and I regard the decisions of the CPS and DPP as being even less suitable for a public inquiry than the police and MAIB investigations. The proper way of challenging such decisions is by an application for judicial review to the High Court. Such an application was made in respect of the DPP's decision in this case not to prefer charges of manslaughter. As I have already stated, one of the survivors of the tragedy, who was also the husband of a victim, applied to the court for an order of mandamus directed to the DPP compelling him to bring further charges or, alternatively, to give full consideration to the laying of such charges. Nolan J dismissed the application and no attempt to renew it was made to the Court of Appeal.
- 11.31 I can see no sensible basis upon which I could recommend a public inquiry into the decisions of the DPP or the CPS at any stage. Such an inquiry would itself be long and expensive. It would involve an analysis of the investigations, of the decision to prosecute Captain Henderson on limited charges and not for manslaughter (which was the very decision

scrutinised by Nolan J), of the decision not to prosecute the owners or managers of the BOWBELLE and of the decision not to prosecute anyone after the inquest. It could not sensibly be undertaken without a detailed analysis of all the advice given to the CPS and the DPP over that period. Such an investigation would in my opinion only be justified in a most exceptional case such as that of Stephen Lawrence. It is not justified here.

- 11.32 The public interest will be properly and sufficiently served by an FI along the lines that I have indicated, at any rate if it is open to it, either as part of the FI or as part of an additional non-statutory inquiry, to consider making recommendations on the topics touched on in paragraphs 11.28 and 11.29 above.

### Legal Processes

- 11.33 Mr Napier's Purpose C is in these terms: to examine the current inadequate arrangements for post-disaster inquiries and to make recommendations. The question under this heading is whether a public inquiry chaired by a judge or senior QC should be asked to review the whole system governing the relationship between inquiries, inquests and criminal and civil proceedings.

- 11.34 There is an undoubted tension between public inquiries, inquests and criminal and other legal proceedings when a transport disaster occurs. This is a topic which the Department is currently considering in the context of its Consultation Document on Transport Safety dated March 1999. The purpose and terms of reference of this review, which I shall call the "Transport Safety Review", are described as follows:

1.01 The safety of those who travel is regulated and enforced in the UK, and accidents investigated, by a range of public bodies, operating under a number of different Acts of Parliament. From time to time it has been suggested that the process of safety regulation could be made more effective and efficient if the arrangements were more streamlined. Most recently, the House of Commons Select Committee on the Environment, Transport and Regional Affairs has recommended a new independent authority for transport safety.

1.02 The Government is determined that transport safety regulation and enforcement should fully conform to the principles it has laid out in its Better Regulation Guide. It underlined the importance of safety for the success of its new transport policy in its 1998 White Paper on the Future of Transport, and recognised that the Committee's recommendations had far-reaching implications for how matters are presently organised. It said it would review the arrangements for transport safety, including accident investigation, and would then produce a substantive response to the Committee's reports. This consultation forms an essential part of that review.

1.03 The review's terms of reference are:

to consider whether a more integrated or unified approach to transport safety across modes would be more effective, produce a safer travelling environment and secure best value for money.

- 11.35 Part three of the review concerns accident inquiries and legal proceedings. I shall quote a relatively long passage from that section of the paper because it seems to me succinctly to encapsulate the problems in this area:

- 3.01 Society's response to a major transport accident is an important determinant of transport safety across all modes. Following an accident there is a desire to establish what went wrong and why, and – unless the accident was clearly unique – to learn how to prevent it happening again. If blame is an issue, there will be a wish to discover where that blame lies, and to impose some form of sanction. There may be questions of compensation.
- 3.02 Establishing what went wrong and how to avoid a recurrence is generally the business of technical investigations. For cases raising serious issues of wider concern, a public inquiry (in Scotland, a fatal accident inquiry) may be appropriate. Where there are signs that a criminal offence may have been committed a criminal investigation may lead to prosecution, and there may be the possibility of a private prosecution. Where death is involved, there will normally be a Coroner's Inquest in England and Wales, or an investigation by the Procurator Fiscal in Scotland. Regulatory authorities may have a role, in considering disciplinary sanctions. Civil liability and questions of compensation will be dealt with in the civil courts.
- 3.03 The interaction between these activities has sometimes lead to tensions since it is impractical, save in exceptional circumstances, to have criminal proceedings and a public inquiry running in parallel. Once a criminal process is under way there is a need to avoid the risk of prejudice to the proceedings as a result of a parallel public investigation of the circumstances of the accident. There may also be a risk from the reporting of conclusions of accident investigations, but in that case there is also an argument for early publication, in the interests of accident prevention. It is particularly important to minimise that risk for serious criminal proceedings where the penalty could involve imprisonment.
- 3.04 This can sometimes lead to the adjournment of a public inquiry, and delays in reports, pending the outcome of criminal proceedings, causing frustration for the relatives of any deceased and for the injured – who may nonetheless be equally anxious to see the legal proceedings go forward quickly. There is potential in all of this for public confidence in the effectiveness of the overall response to major accidents to be undermined.
- 11.36 The principal tension is created when there is the prospect of criminal proceedings arising from the accident. Concern to ensure that the accused receives a fair trial can, and does, lead to public inquiries being adjourned, as for example in the case of the Southall Inquiry. Further, it is not just inquiries that are affected. Technical investigations undertaken by bodies such as the MAIB, AAIB or HSE may be affected in that the publication of their reports might need to be delayed until completion of the criminal proceedings. Coroners' inquests may also need to be adjourned: see rule 26 of the Coroners Rules 1984.
- 11.37 Overlaps between the various procedures potentially give rise to a certain amount of duplication, such as between inquests and inquiries. As already noted, in 1990 the Home Office set up a working group to consider this topic. Its 1997 Report described the overlap as follows:

The overlap between any inquest and a public inquiry arises when the coroner investigates how the deceased died. The coroner's responsibilities are focused more on the death of individuals, compared with a public inquiry which is likely to take a broader look at the causes, with the aim of making recommendations to avoid recurrence. It is a matter for the individual coroner to decide the width of his own inquiries as to how

the death occurred but inevitably, as recent disasters have shown, there can be a considerable overlap, so that the inquest hears much of the same evidence as the earlier public inquiry.

11.38 To overcome the problems created by the overlap, the working group recommended that the role of the coroner be limited, by securing the adjournment of the inquest when a public inquiry is established and limiting the circumstances in which the inquest can be resumed. That recommendation has now been given legislative effect by section 71 of the Access to Justice Act 1999, which inserted section 17A into the Coroners Act 1988. Section 17A provides in effect for the adjournment of an inquest in the event of a judicial inquiry and for the resumption of the inquest at the conclusion of the inquiry only for exceptional reasons.

11.39 Mr Napier, who is not only a partner in the firm of Irwin Mitchell (who are of course the solicitors for the MAG), but has also been president of the Association of Personal Injury Lawyers (“APIL”), gave an address to the First European Conference on Traumatic Stress in Emergency Services Peacekeeping Operations and Humanitarian Aid organisations on 17<sup>th</sup> March 1996. He noted seven different types of “inquiry” which can follow a disaster:

These are a public inquiry, an internal inquiry, a specialist inquiry and report to the Minister by the AAIB (aviation accidents) or MAIB (maritime accidents), a coroner’s Inquest, a criminal investigation (which may or may not lead to prosecution by the DPP or by a private individual), civil proceedings for compensation and the administrative law remedy of judicial review. All of these inquiries can overlap, get in each other’s way and require the same evidence to be given by the same people several times. Insofar as there is any pattern at all it is one of inconsistency that simply adds fuel to the anger and frustration of the victims.

11.40 The case of the MARCHIONESS is, perhaps, a classic example of how many of these problems can arise in one case. There was no internal inquiry and there has not (yet) been a public inquiry, but there were two prosecutions and, in effect, two inquests. There was both a prosecution brought by the DPP, which involved old style committal proceedings and led to two jury trials and the postponement of the publication of the MAIB Report and a private prosecution at which the prosecutor did not have all the evidence available to the police or to the MAIB. The inquest was adjourned because of the criminal proceedings and then resumed before a different coroner following an application for judicial review which went on appeal to the Court of Appeal.

11.41 It is to my mind long past time that the relationship between these various processes should be reviewed. It is fair to say that this is a point which has been recognised by the Department in the terms of reference of the Transport Safety Review which I have quoted above. However, the existence of the Review has not stopped people from making representations to this Inquiry. Indeed, far-reaching recommendations have been made to me. For example APIL has submitted as follows:

APIL believes a single body is needed to co-ordinate the whole process with a full time secretariat. APIL suggests the creation of an Accident and Disaster Investigation Bureau for the purposes of carrying out urgent enquiries into all disasters and accidents causing injury and loss of life to members of the public, and monitoring the implementation of measures to improve public safety. The following illustrate the functions of the Bureau and the powers that should be designated to it:

- To hold a public inquiry into any major accident, to be chaired by a High Court Judge or senior lawyer, to be chosen from a specialist list to be maintained by the Bureau.
- To grant legal aid for the representation of any person or body appearing before an inquiry held by the Bureau.
- To make recommendations as to the prosecution of any witness to an inquiry held by the Bureau.
- To grant immunity from prosecution for any witness to an inquiry held by the Bureau.
- To deal with the formal requirements of an inquest so as to dispense with the need for holding any separate inquest into any death following a public inquiry into a major accident.
- To award damages including punitive or exemplary damages against any person or body.
- To make findings of fact which will be binding on any subsequent hearing as to damages in any civil suit arising from a major accident.
- To maintain a secretariat to monitor the implementation of any requirements imposed by the Bureau for the improvement of public safety – following an inquiry into a major accident.

11.42 The DERBYSHIRE Family Association (“DFA”) has made a slightly different proposal as follows:

The DFA urges the Government to establish a specific body of appropriately qualified persons that would be known as a Disaster Management Team. Such a body would incorporate persons who themselves have suffered bereavement in a disaster and persons who have actually survived disasters. The DFA would argue that such persons could bring an essential light to bear on any investigations, and help it towards fully rounded completion. The views of such persons should be given due weight particularly when deliberating on the need or otherwise for a public inquiry.

11.43 As already noted, the MAG submits that one purpose of a public inquiry (Purpose C) should be “to examine the current inadequate arrangements for post-disaster inquiries and to make recommendations. In support of that submission, it has annexed and referred to a large amount of material. Amongst that material referred to is the 1995 report of the Law Society’s Civil Litigation Committee entitled “Group Actions Made Easier”. Paragraph 4.3 of that report considered Boards of Inquiry, referred to inquiries generally and to particular inquiries into “major one-off disasters” and discussed legal representation and legal aid. It continued:

4.3.2 Moreover, in such circumstances, the Working Party saw some merit in there being a legal presumption, subject to the agreement of the parties, that, in any subsequent civil litigation, findings of fact by a board of inquiry are binding, subject perhaps to the right of a party to give notice in its first pleading that it challenges a particular

finding: in that event, such a finding would be subjected to further evidence and examination by the court. The Working Party did not consider that there should be an absolute requirement for such a presumption; but the parties should be encouraged to give serious consideration to agreeing the presumption before the Inquiry makes its findings: in appropriate cases. The availability of legal representation, and probably Legal Aid, would certainly facilitate such agreement.

In addition, the working party regarded it as desirable, in appropriate cases, for greater use to be made in subsequent litigation of notices to admit facts found by inquiries and inquests.

- 11.44 Reference might also have been made in this context to the concluding part of the judgment of Steyn J in *The Speedlink Vanguard* [1986] 2 Lloyd's Rep 265, where he said (at p 273):

*Recommendation regarding wreck inquiries.*

Finally, I wish to draw attention to a recommendation made by Mr Justice Devlin in *Waddle v Wallsend Shipping Co Ltd* sup ([1953] 2 Lloyd's Rep 105). He said (at p 131):

... I think that the competent authority might consider whether the useful purposes that wreck inquiries serve would not be increased if the report was made available to any Court which had to determine the cause of the loss. It is not necessary that the findings of fact in the report should be treated as binding. The opinion of the Commissioner based on the facts he finds has at least as high a value as that of an expert based on the facts which he assumes to be proved; and it has the advantage of being quite independent of either side....

Thirty-four years later I now respectfully repeat and endorse this recommendation. What is needed is a statutory provision enabling the Judge hearing the collision or limitation action to make such evidential use of the report as a whole as he thinks fit.

It is not perhaps for me to say at this stage, but it seems to me that that is a very sensible suggestion, and that such a provision would certainly be more useful than a notice to admit facts, which in my experience is of very limited value indeed.

- 11.45 Further documents annexed by the MAG echo the Consumers' Association's calls for a National Disaster Court and a Disaster Commission. In a speech given on 23<sup>rd</sup> September 1991 by Mr David Tench, the Association's then Director of Legal Affairs, he referred to six of the procedures later referred to by Mr Napier, which I have noted above, and then outlined how those bodies would operate, as follows. The Disaster Court would assume the role of all the other courts which currently become involved in the present system. Thus any person or company alleged to be guilty of a criminal offence would be prosecuted before the Disaster Court, which would have all the powers of the Crown Court to handle such cases. As I understand the proposal, whether it was a question of manslaughter, or breach of, say, the rules of navigation, the Disaster Court would deal with the matter. Similarly all claims for compensation or damages arising out of the disaster, or at least all such claims made by the victims as ordinary citizens, would be dealt with by the Disaster Court. It would have all the powers and responsibilities of the High Court to handle such cases, and would take on the responsibility of determining them as quickly and effectively as possible.

- 11.46 Those are all suggestions worthy of consideration. I do not doubt that most, if not all, of them will be raised and considered as a part of the Department's Transport Safety Review

referred to above. Indeed, I have seen the responses of a number of people and organisations to the consultation paper which do address those matters, although I have only seen those which consider the problem from the marine angle. They include submissions from Professor Evans, who is Professor of Transport Safety at University College London, NUMAST, British Waterways, the National Union of Rail, Maritime & Transport Workers, Professor Richard Goss, who is Professor Emeritus at Cardiff University, and the International Marine Contractors Association. The submissions I have seen have not, perhaps understandably, attempted a close analysis of the various problems in this area but have, rather, tended to advance a personal or organisational point of view.

- 11.47 The problems presented are a combination of legal principle, legal policy and practical issues. It is perhaps difficult to divorce them entirely from the factual circumstances in which they arise, although there are now a number of practical examples which can be used from different parts of the transport system. In the marine field this is obviously such a case and would provide a possible background against which problems of this kind could be considered. Moreover, it might be said that these are essentially legal problems which merit the consideration of a judge or senior lawyer in the context of a public inquiry and that a public inquiry into the MARCHIONESS disaster would provide a sensible vehicle for their consideration.
- 11.48 There is obvious force in that suggestion. On the other hand, it might be said that these are problems which are not limited to maritime disasters like that of the MARCHIONESS, but arise in connection with disasters in other forms of transport. Moreover, it might also be said that the problems can best be considered not by way of a public inquiry, but by seeking representations both from those who have relevant interests and those who have relevant experience and reaching sensible administrative conclusions in that way. In this context, representations might of course be sought from those who have experience of various types of inquiry, including judges and other senior lawyers who have chaired them.
- 11.49 There is in my opinion much to be said for both points of view. There is I think force in the suggestion that it would be a constructive way forward to ask a judge or senior QC, with experience of public inquiries, to conduct an analysis of the problem as part of a public inquiry. It might be done as an adjunct to an FI into the loss of the MARCHIONESS because many of the problems are highlighted by the experience of events since the casualty. On the other hand, as I have said, the problems are not associated only with maritime casualties, but extend both across transport and across industry generally. Indeed similar problems would arise if there were a major disaster in any walk of life. It would thus widen a MARCHIONESS FI considerably if the wreck commissioner were asked to carry out such an inquiry.
- 11.50 In these circumstances, while it could certainly be done, would be of interest to conduct and might have advantages, it is not obvious that such an inquiry should be carried out as an adjunct to a MARCHIONESS FI, and not, for example, as an adjunct to the Paddington Rail Inquiry. On balance I have reached the conclusion that, subject to two provisos, the consideration of the problem would be best conducted, not by public inquiry, but by widespread consultation in the context of the Transport Safety Review. I have reached that conclusion for two main reasons. The first is that I would certainly not be recommending a separate free-standing public inquiry into these questions in the absence of an FI, because they do not seem to me to be the kind of problems which are best solved by incurring the expense of a public judicial inquiry. The second is this. Ultimately the question of what, if any, steps to take will be a matter first for Government and then for Parliament to decide. There is no reason why representations should not be sought and obtained from all those

interested, including groups such as the MAG, the MCG and the DFA. Once those representations have been made, I can see no reason why the ordinary processes of Government should not then enable sensible decisions to be made for the future.

- 11.51 The two provisos are these. The first is that, as I have already said, it seems to me that it would be sensible to seek representations from or the advice of those who have conducted or taken part in public inquiries in disaster cases in the past, including judges, counsel and solicitors, in order to identify and try to solve the problems. Their advice seems to me to be likely to be a valuable addition to all the other information which will no doubt be available, including advice from coroners, the police, the CPS, the HSE, the MAIB, the AAIB, victims and their families, environmental groups, defendants and owners and operators of transport facilities (including ships and trains) and of industrial plant, together with many others.
- 11.52 The second proviso is that this part of the Transport Safety Review should be carried out in the near future. This is an area in which there has been considerable delay in the past. I have already referred to the fact that the Home Office Working Group, which in any event had only limited terms of reference, was set up in 1990 but did not report until 1997. Moreover, the Lord Chancellor wrote a paper entitled "Disasters and the Law: Deciding the Form of Inquiry" as long ago as 16<sup>th</sup> May 1991, to which I have already referred. I have annexed it to this report as part of Annex D because it contains what seems to me to be a very clear analysis of the problems which exist or potentially exist after a serious casualty and because it shows that these problems were being given active consideration as long ago as May 1991.
- 11.53 The Lord Chancellor's paper should be seen in the light of earlier letters, including a letter dated 30<sup>th</sup> December 1988 from the Legal Secretary to the Attorney General to the DPP setting out the Attorney General's view as to the relationship between public inquiries and prosecutions, which was written in connection with the Clapham rail disaster, and a subsequent memorandum from a Department legal adviser, Mr GH Beetham, dated 17<sup>th</sup> October 1990. Mr Beetham also wrote a further memorandum dated 29<sup>th</sup> August 1991, which commented on the Lord Chancellor's paper. I have included all these documents in Annex D because they seem to me to make a valuable contribution to the debate and should be readily available to anyone who wishes to make representations to the Department as part of the Transport Safety Review.
- 11.54 It is clear from Annex D that problems of the kind discussed above have been the subject of debate in Whitehall for at least ten years. Yet they have not been resolved (at least publicly) and it was only in March 1999 that the Department's consultation paper was issued. One advantage of a public inquiry would be that it would concentrate the minds of all those concerned and might perhaps produce action more quickly than the ordinary processes of Government. In this regard, Part One of this Inquiry might or might not achieve any positive results, but it has certainly had the advantage of concentrating the minds of many people upon safety on the Thames, which was itself beneficial.
- 11.55 It is because of the inordinate delay in solving the questions raised by the Lord Chancellor's paper that I have introduced my second proviso. In conclusion, I would not recommend a public inquiry on the issues raised under this head, provided that the consultation process includes those judges (as for example Lord Cullen, Hidden J, Sir Barry Sheen) and others (as for example Professor John Uff QC) who have conducted public inquiries and provided that the process lasts only, say, nine months and action is then taken.

- 11.56 I would add only three further points. The first is that it seems to me that an application to this case of the principles stated in the Lord Chancellor's paper would have led to the ordering of a public inquiry: see paragraphs 12 and 17(ii). In particular, in paragraph 17(ii) he gave as one example of a case in which a public inquiry chaired by a judicial figure would be justified, a disaster, the scale of which "in terms of loss of life or other impact renders a judicial inquiry inevitable". For the reasons which I have given earlier, it is my view that this was such a case.
- 11.57 The second point is this. I appreciate that this is not the time or place to express firm views as to the most sensible way forward in the future, but I make a few preliminary observations because I would not want it to be thought that, by setting out some of the submissions made to the Inquiry, I have accepted them. In particular, my present view is that the idea put forward by the Consumers' Association that it would be possible to have a Disaster Court, which could find the facts, make recommendations for the future and determine both criminal and civil liability, is unworkable. As I see it at present, the role of an inquiry is and should be entirely separate from the role of either a criminal or a civil court.
- 11.58 As the papers in Annex D make clear, one of the essential problems is how to balance the public interest in an inquiry and the public interest in the possible prosecution of a person or company arising out of the disaster. It would not be appropriate for me to express a view on those difficult questions in this report, save to say this. The question in what circumstances an inquiry should precede a prosecution and in what circumstances a prosecution should precede an inquiry may or may not be issues for political decision, as suggested by Mr Beetham in his paper of 17<sup>th</sup> October 1990, but he was surely right to say:
- What, in my view, we lack is a clearly defined machinery for arriving at the decisions in individual cases as to where the proprieties lie in the public interest.
- The position remains the same today. It seems to me to be desirable that steps should be taken to establish such machinery and that that machinery, or at least appropriate guidelines, should be published so that everyone may know what criteria are being applied.
- 11.59 Finally, it does seem to me that the time has come when it would be desirable to set up a statutory framework for inquiries generally. There is at present no generally applicable statute which covers public inquiries. The 1921 Act has been shown over the years to be much too restricted and cumbersome. In my view a statute should be enacted to give power to the appropriate Secretary of State to order a public inquiry. The statute should also set out the powers of the inquiry, which to my mind should be as flexible as possible. There are at present many types of inquiry with many different rules and many different procedures. I mention only two. The 1985 FI Rules, as amended in 1990, are essentially adversarial in character, no doubt because they owe their origins to the 1923 Rules, which in turn were based upon earlier rules. The Health and Safety Inquiries (Procedure) Regulations 1975, as amended, also have significantly adversarial elements in them<sup>9</sup>.
- 11.60 It would, in my opinion, be desirable to remove the adversarial aspects of the rules of the various inquiries and to give the chairman of every inquiry power to conduct the inquiry as he or she thinks fit, subject of course to an overriding obligation of fairness. The inquiry

<sup>9</sup> Subject to regulation 8.

should have powers, so far as appropriate, to compel witnesses to give evidence and to obtain documents and would be subject to judicial review. Otherwise the procedure should be as flexible as possible in order to give the tribunal power to conduct the inquiry as he or she thinks fit. Such an approach should save both time and money.

## 12 Treatment of the Deceased

### Removal of Hands for the Purpose of Fingerprinting and Identification

- 12.1 Following the sinking of the MARCHIONESS, the identity of 51 deceased had to be established. The condition of those bodies found within the MARCHIONESS was such that their fingerprints could be taken without any difficulty at the mortuary. The taking of fingerprints from those who were found in the river was more difficult because of the changes which had occurred to the bodies by reason of their immersion in water for a period of time. The hands of 25 out of the 27 deceased found in the river were removed for the purposes of obtaining fingerprints, authorisation having been given by the coroner, Dr Knapman. It was not until two years after the event that the families of those who had had their hands removed, found out that this had occurred. Quite understandably, this is a matter which has caused considerable distress, and in some cases anger, to those families and is an issue which I have been asked to consider by a number of them and their representatives.
- 12.2 The MAG submits that any further inquiry should address the families' concerns about identification and post mortem procedures. I have focused on the two particular points which have caused most concern and distress to the families, namely the removal of hands and refusal to allow relatives to view the bodies. I concentrate first upon the removal of the hands because it has caused particular distress. The MCG in its submission referred to "the almost unbelievable suggestion (which took years to verify) that the bodies of many of the victims had been mutilated by having their hands removed". This matter has also been raised by other correspondents who have connections with, are themselves the victims of or are researching into the effect of disasters.
- 12.3 While there has never been a specific inquiry aimed at ascertaining the reasons behind the coroner's authorisation to remove the hands, it is possible to elicit many of the facts from the evidence which has been given in various forms since 1992. Dr Knapman swore an affidavit in January 1993 for the purposes of defending an application for judicial review of decisions which he had made in 1992. The application was not directly concerned with, but touched upon the removal of the hands. In his affidavit he set out certain of the duties of a coroner and a chronology of events from the date of the MARCHIONESS disaster to the commencement of the inquests, including identification of the bodies and the decision to remove the hands. He also explains why the removal of the hands was authorised. Although I recognise that this evidence has not been tested in any way, whether by cross-examination or otherwise, the affidavit usefully sets out the rationale behind the decisions which were made at the time.
- 12.4 It emerges from Dr Knapman's affidavit that he met Dr Dolman (his deputy), a senior police officer and Dr Richard Shepherd (the pathologist) to discuss how to deal with the identification of the bodies. He deposed in paragraphs 25 and 26 of his affidavit to the five criteria to be used and how they were to be applied. Briefly, the methods to be used were as follows: visual identification; clothing; personal items such as jewellery; teeth and

fingerprints. All five criteria would be used where possible. It was decided that, in relation to those bodies found on the vessel (and in which the process of putrefaction had not commenced), three of those criteria would be likely to suffice. In relation to those found elsewhere in the river, it was decided that visual identification would be unreliable, perhaps impossible and would cause distress. In paragraph 26(3)(b) of his affidavit Dr Knapman said this:

In circumstances where it was impossible to take adequate fingerprints from the bodies without removing the hands of those bodies to the Fingerprint Laboratory, those hands should be removed.

With regard to the routine taking of fingerprints from the victims of disasters he stated that it was

perceived to be the best practice in the United Kingdom to obtain fingerprints from the victims of all disasters. Further, it is considered essential to obtain fingerprints immediately in cases where decomposition has begun, since to delay causes deterioration in the quality of those fingerprints, or even their total disappearance.

- 12.5 It is my understanding from Dr Knapman's affidavit that a decision was made at an early stage that fingerprints would be taken from all bodies which arrived at the mortuary and that, where that was not possible on site, the hands would be removed and taken to the fingerprint laboratory. It does not appear that the decision to remove hands was taken individually in the case of each deceased having regard to what other means were available for identification. This is borne out by a letter written by Deputy Assistant Commissioner Meynell ("DAC Meynell") to Dr Knapman on 15<sup>th</sup> May 1992, in which he stated:

In the normal course of events fingerprints of the deceased are taken from a body at the mortuary. In exceptional circumstances including immersion in water . . . it is necessary for special techniques to be used at the Fingerprint Laboratory. The facilities at the Laboratory are not portable and therefore in such cases the Coroner's permission is sought to remove the hands for forwarding to the Laboratory

- 12.6 It is also borne out by evidence given at the resumed inquest in 1995. In *ex p Dallaglio* Sir Thomas Bingham MR said (at pp 164-5):

It is, however, clear, as was accepted by counsel for the applicants in argument, that the treatment of the bodies of the deceased after death could not form part of a properly conducted inquest.

Nevertheless, the coroner, Dr Burton, allowed considerable latitude to counsel for the families in questioning witnesses as to the practices adopted with regard to the fingerprinting of the deceased and the removal of hands.

- 12.7 Superintendent Reece, who was part of the mortuary team set up at Westminster, said that as part of the identification procedure, clothing and personal items were not the main factors that the coroner laid down at the time as those which he would accept for identification. It was his evidence that all decisions as to such matters came through the coroner, who issued instructions that, where visual identification was likely to be suspect because of the state of deterioration of the body, then other methods should be employed. In cross-examination he said that it was his understanding that the coroner gave a blanket instruction that, where it was thought appropriate, the hands could be removed.

- 12.8 Dr Shepherd, one of the pathologists undertaking post mortem examinations, gave evidence at both parts of the inquest. Although his role was essentially to perform post mortems, he said that the decision to remove hands was taken by the coroner on advice from senior fingerprint officers and from him. He gave evidence as follows in March 1995:

Each body . . . the hands were removed at the post mortems or after the post mortems were performed. It wasn't in my recollection a single episode. The decision having been taken that the fingerprints couldn't be successfully taken from those bodies the hands were then removed.

Attempts were made to take fingerprints from those bodies which were unsuccessful which is why the request was made to the coroner for the hands to be removed. If it was hard on the ones that were recovered quickly from the river it would have become increasingly hard on the bodies that had been in the river for a longer and longer period. So I don't think there was a global decision but the decision was made on the early bodies who were least decomposed and would obviously apply more and more as the bodies had been in the river for a longer period.

My advice was sought on if I felt that fingerprints were necessary I said that I thought they were and the coroner then made the decision as the person who was performing the identifications whether or not the hands should be removed. My advice to him was that I thought it should but he had the decision whether or not to pursue it.

That quotation and those that follow are set out exactly as they appear in the record of the inquest which is available. It follows that the quotations include the errors in the transcript, which are considerable, but in each case the gist of the evidence is clear.

- 12.9 The following evidence of Mr Roger Fostersmith, the coroner's officer, whose job it was to assist with the identification of the deceased, lends further support to the conclusion that, once it was decided that fingerprints could not be obtained from a particular body at the mortuary, the hands were removed.

As far as I am aware and as far as I recollect there was a certain point in time when we were told by the experts and finger print experts that they were unable to get reasonable impressions from the hands and my understanding that moment on then hands were removed for the purpose of identification.

That is confirmed by Mr Jeffery Sinnott (the operational police officer in charge of processing bodies through the mortuary), who said that the coroner gave a blanket instruction that, where it was thought appropriate, the hands could be removed without having to refer back in each case. Mr Robert Viner, a civilian identification officer, said that he had been instructed to try and take prints from everybody and that, if this could not be done in the mortuary, it had to be done by other means. He said at the inquest:

I can't remember whether we made any attempt on an individual body but it was obvious from examining, I think there were four bodies, at the time that were showing signs of deterioration and it was obvious to us from our experience that it would be necessary for the hands to be removed to obtain a useful set of fingerprints.

The simple instructions are. If you aren't able to obtain satisfactory set of prints or useful set of prints from the mortuary then you will ask the Coroner's permission to remove the hands.

Mr David Strong, the senior identification officer, said that he was called to the mortuary by Mr Viner because Mr Viner thought it might be necessary to request the removal of hands. He gave evidence as follows:

I viewed four of the bodies, looked at the condition of the hands and they were such that I deemed it necessary for the hands to be removed ... we returned on the 24<sup>th</sup>, at that stage we were also able to view a number of other bodies which were in the same condition, it was at that stage I requested that the hands be removed.

He said that the request would have been made to one of the officers present, but

it was at that stage that I was informed that the coroner had already given his permission for the hands to be removed.

- 12.10 It seems to me that, in the light of this evidence, it is reasonably clear why and how the decision was reached as to the removal of hands. Following the retrieval of the first body from the water, which was in a condition to have fingerprints taken at the mortuary, a number of bodies were brought in which were in a worse condition. The coroner had determined that fingerprints were to be taken from all the deceased. He gave authorisation for hands to be removed from any bodies where it was not possible to take good fingerprints without doing so. Thereafter, identification officers decided whether it was possible to take fingerprints from the deceased without removal of hands. Those decisions were made on a purely technical basis, without addressing the question of whether the deceased could be identified without his or her fingerprints being taken.
- 12.11 To my mind that picture emerges clearly from the evidence given at the inquest. Although the coroner ultimately declined to permit further questioning on this topic, so far as I am aware no-one challenges the primary facts set out above. In these circumstances I do not think that the primary facts would have emerged any differently if further evidence on this topic had been called. In short, the facts are now clear. It should perhaps be emphasised that the reason for that is in large measure due to the fact that Dr Burton permitted questioning at the inquest and counsel for the relatives helped to establish the facts through his cross-examination of the various witnesses to whom I have referred.
- 12.12 A number of relatives understandably continue to seek specific explanations as to why the hands were removed from some of the bodies when they were not in fact identified by means of their fingerprints. A striking example of that is that at the inquest, Mrs Joyce Drew, whose son Christopher Garnham was amongst the deceased, asked why her son's hands had been removed when the belt which he was wearing contained a photograph of him, a blood donor's card and the keys to his flat.
- 12.13 No formal conclusion was reached by the Divisional Court, the Court of Appeal or the coroner as to the necessity or otherwise of removing the hands of certain victims of the disaster or whether the procedures adhered to were rigorous and likely to provide the general public with confidence that such action was or is only taken in appropriate cases. Although the Court of Appeal was not required to decide these questions, Simon Brown LJ did observe in *ex p Dallaglio* (at p 147):

No doubt identification procedures involving the use of amputated hands, as to the need for which there appear to be two schools of thought, should be reviewed.

As appears below, they have in fact been reviewed since the casualty.

## Refusal of Permission to View the Bodies

12.14 A number of people have made repeated complaints that they were refused permission to view the bodies of their close relatives and friends who died in the disaster. In evidence at the second inquest Mrs Lucy Garcia said that she called at the mortuary every day but nobody allowed her to see her daughter. Mrs Lockwood Croft said in evidence that the undertaker told her that he had strict instructions from the coroner that she could not view the body. Other relatives have made submissions to the Inquiry about refusals to allow them to view the body.

12.15 At the first inquest in February 1990 Dr Knapman, in his capacity as coroner (rather than giving evidence) said to counsel:

None of my staff have any authority to deny anybody from seeing a dead body. The fact is of course this may be misrepresented by other people for very good reasons people seek to keep people away etc and when all is said and done, the bodies are released to the families themselves and there is certainly a view that it would have been far better to view the body in a private funeral parlour than in the rather clinical mortuary here.

12.16 In his letter of 15<sup>th</sup> May 1992, to which I have referred above, DAC Meynell wrote to Dr Knapman that it was not the case that relatives were denied the right to view the bodies of the victims. They were advised about the condition of the bodies and discouraged from viewing them and they were free to make arrangements for viewing at the undertakers.

12.17 In paragraph 34 of his affidavit, Dr Knapman stated that it would have been difficult but not impossible for families to view the putrefied bodies of their loved ones in the mortuary if they so wished. After identification they would have been released into the care of the funeral director. He stated that some funeral directors might not have facilities for viewing putrefied bodies and that others might have taken the view that allowing families to see the putrefied body of a loved one would cause unnecessary grief. He also stated that it was not uncommon for a funeral director to say to the relatives that they were unable to see the body because it was a "coroner's case". In paragraph 35 of his affidavit he said this:

... at no stage did I ever indicate to anybody that the relatives could not view the bodies of their loved ones if they so desired. If and insofar as any Police Officer ever indicated this to be the case to any relative, that officer must have muddled my decision that visual identification should not be used in certain cases, or allowed himself to be swayed by a misguided, but well-intentioned reluctance to allow a relative to be upset by viewing a body in a putrefied condition

12.18 In *ex p Dallaglio* Simon Brown LJ said (at p 145):

What almost certainly happened is that the coroner's officer and undertaker, anxious to spare Mrs Lockwood Croft the distress of viewing her son's body in its putrefied state, had lied about their instructions. Their efforts were misguided though well-intentioned.

12.19 At the second inquest in March 1995 Superintendent Reece said:

Nobody was ever told that they could not never see the bodies. It is beyond our power to do that ... but we did strongly recommend that in many cases they were unsuitable for visual identification.

He said that he advised the liaison team working with the families that in certain circumstances it would be inadvisable and would not recommend that they view the body.

Mr Manuel Pereira, the acting manager of the mortuary, said that he did not know if anyone gave instructions that the bodies were not to be seen but it was not his decision as to whether somebody should be able to view a body at the mortuary. Mr Sinnott said that no-one was told that they could not see the bodies but visual identification was not recommended. Dr Shepherd expressed the view in evidence that, however badly decomposed or mutilated a body was, the relatives should be able to view it, although visual identification was not recommended. PC Robert Rumbold, the coroner's officer, said that, so far as he was aware, there were no orders that people could not view the bodies, although it was the policy of Westminster Coroner's Court never to ask relatives visually to identify mutilated or decomposed bodies.

- 12.20 I am not in a position to form any but the most tentative conclusion as to why family members were not permitted to see the bodies. However, so far as I can tell, it was out of a desire to protect them from the horror of seeing the putrefied body of a loved one. The whole episode is highly regrettable and there is no doubt that the anguish caused as a result must have been immeasurable.

### **Should there be a Public Inquiry?**

- 12.21 The question which I have to consider is whether there should be a public inquiry into any of these matters. That seems to me to depend upon whether it would be in the public interest for there to be a public inquiry. Although I recognise the distress which was caused when relatives were not allowed to see the bodies of those who died, I do not think that it could fairly be said that such a refusal or refusals justified a public inquiry. The same is true of the other matters raised in the submissions which the Inquiry has received, with the possible exception of the removal of the hands. When the fact that hands had been removed from 25 bodies became known it undoubtedly caused some public shock. The public would I think naturally expect the reasons for the decision to be properly investigated and, depending on the circumstances, a public inquiry of some kind might be appropriate. I turn, therefore, to the question whether the public interest requires a public inquiry into the removal of the hands.
- 12.22 I recognise that the families of those whose hands were removed continue to seek explanations as to why it happened. I can well understand the strength of their feelings because, on the basis of the material which I have seen, I have formed the view that it was unsatisfactory for hands to be removed for the purpose of fingerprinting without taking into consideration in relation to each individual body all other factors and features which might lead to a positive identification. For example, it would appear that Mrs Drew's particular concern is a legitimate one.
- 12.23 I also recognise that the coroner whose decision it was to authorise the removal of the hands has not been questioned, nor has his evidence been tested. Likewise none of the evidence has been tested before a tribunal tasked with ascertaining the reasons behind the decision.
- 12.24 Nevertheless, it does seem to me that the essential evidence is already in the public domain. It is evidence that has been subjected to public scrutiny in a way that the evidence relating to the facts of the casualty itself has not been scrutinised. The difference between the evidential position in these two respects seems to me to be this. In the case of the casualty all the evidence has not until now been put into the public domain and exposed to public scrutiny, so that an FI is required to perform that function. On the other hand, while it may be that it cannot be said that all the evidence is in the public domain, so far as the decision to remove hands is concerned, the primary facts are sufficiently clear that it is not, as I see

it, necessary for a public inquiry to be set up in order to discover the true facts. The only respect in which there remains any real doubt is in relation to the question of who exactly was responsible for the decision to authorise the removal of hands in each case. Although this does not emerge from the evidence at the inquest, what is clear (as I have said) is that the hands were removed without sufficient regard for the question of whether the bodies could be identified by means other than fingerprinting and I do not think that there would be anything to gain from exploring at a public inquiry the question of which individual was responsible for that.

- 12.25 There is also this consideration. In January 1994 the Metropolitan Police produced a document entitled “The Identification of the Deceased Following Mass Disaster”. This document is annexed in its entirety to this report, as part of Annex G. It predates consideration of these issues by the Court of Appeal and by the coroner at the second inquest. It does not, however, seem to have been brought to the attention of either. Significantly, the document notes that there is now set up an Identification Commission comprising the coroner, the identification officer, the supervising Home Office pathologist, representatives of the post mortem team and of the ante mortem team, an odontologist, the crime scene co-ordinator and a senior fingerprint expert. Any requests for specific forensic procedures in respect of any bodies or parts of bodies, including the taking of samples, organs or limbs, will be made at the daily (or more frequent) meeting of the commission. A decision will then be made by the coroner after receiving advice from all parties.
- 12.26 These procedures are still current and have been reinforced by the Association of Chief Police Officers’ Emergency Procedures Manual 1999. This lengthy document contains, in essence, a set of national guidelines to assist contingency planning for major incidents and disasters involving large numbers of people. I annex, as part of Annex G, sections 6, 14 and 15 of that document dealing with the Major Disaster Advisory Team, the Casualty Bureau and Identification of the Dead respectively. Those documents speak for themselves and, as I see it, represent a substantial advance on the position as it was at the time of the disaster in 1989.
- 12.27 In all the circumstances I have reached the conclusion that I should not on balance recommend a public inquiry. While others may well take a different view, for my part, I do not think it would be in the public interest for the primary facts to be further inquired into at considerable public expense. Nor, on balance, do I think that the public interest requires a public inquiry to be held into the question who made the decision in each case to remove hands and why. In the light of the changes and tightening up of procedures for the identification of deceased persons following a mass disaster, such as the sinking of the MARCHIONESS, I have reached the conclusion that it would not be in the public interest for these particularly distressing matters to be re-examined at great public expense.
- 12.28 Nevertheless, there are certain matters which I think would benefit from further consideration by the relevant Government department (which I understand is the Home Office). Thus I note that section 15 of the Emergency Procedures Manual, which is entitled “Identification of the Dead”, sets out comprehensive guidelines and instructions with regard to the allocation of roles and the recording of ante mortem and post mortem information. However, one of the concerns raised by counsel for a number of the families at the second inquest was that the recording of decisions and the reasons therefor in the context of the removal of hands was woefully inadequate. I share that concern. There does not appear to be any provision in the manual for the recording in writing of any decision to authorise the removal of hands together with the reason for it. I have no hesitation in recommending that there should be such a requirement.

- 12.29 Further, I would also recommend that strong advice be given, both in the manual and in any training course which officers are required to undergo, that requests for the removal of body parts only be made after consideration on a case by case basis, taking into account all other available means of identification. It is hoped that this type of issue should not arise in the same way in the future because I have been informed by the Metropolitan Police that developments in DNA technology since 1989 now enable positive identification to be obtained (in most cases) quickly and simply and without the removal of body parts.
- 12.30 I would also reiterate the recommendations which the inquest jury, although not strictly empowered to do so, made in a letter delivered to Dr Burton with their verdict on 7<sup>th</sup> April 1995:
1. Families of victims must always be informed of their rights to attend or elect medical representatives to attend post mortems. With appropriate counselling, they should be offered the opportunity to view their relative's body. The issue of visual identification must, however, be treated with caution.
  2. Removal of hands for the identification of bodies should be done only when all other methods have been exhausted (especially the matching of dental records) and not as a matter of expediency. In such circumstances, mortuary technicians and pathologists must remember that a procedure which may seem standard to them, is likely to be deeply distressing and offensive to relatives.
  3. We would like to remind all agencies of the importance of keeping detailed and accurate records. Particular attention should be given to the correct documentation of proceedings in the mortuary.

These suggestions and recommendations, which were of course made after the jury had heard several weeks' evidence, seem to me to be eminently sensible.

- 12.31 I should perhaps add two considerations. The first is that, although I have formed the view that the public interest does not justify a public inquiry, I recognise that the appropriate Secretary of State (who would presumably be the Home Secretary) might take a different view and order a public inquiry. I also recognise that he might ask the wreck commissioner appointed to conduct an FI (if one is ordered) to conduct the inquiry, although it must I think be accepted that this is not the kind of question which would ordinarily be considered by a wreck commissioner. Indeed, it has struck me that, if it were decided that a public inquiry should be held into these questions, there might be a case for including it, not with an FI, but with an inquiry such as the Alder Hey Hospital Inquiry.
- 12.32 I might add in this connection that, as I was finalising this part of the report, I received a letter dated 17<sup>th</sup> December from Irwin Mitchell on behalf of the MAG, saying that the issue of the removal of hands as body parts, has been brought into sharper focus following the recent public concern expressed about the removal of organs from babies at the Alder Hey Hospital. They also say that they are concerned that there may have been breaches of the Human Tissue Act, presumably the Human Tissue Act 1961. They do not identify what breaches are or might be alleged, but, as I read it, the Act is concerned with the removal of parts for medical purposes, so that it is difficult to understand what they have in mind. However, I am certainly no expert on issues of this kind, and these considerations perhaps emphasise the point I was making in the last paragraph, namely that if, contrary to my recommendations, a public inquiry were ordered, adding such an inquiry to an FI might not be the best way of proceeding.

- 12.33 The second point is related. Although I do not recommend that a public inquiry be held into these matters, that does not mean to say that I do not think that post mortem procedures should not be kept under review. Those procedures include the removal of body parts generally, the recording of any decisions to remove body parts and the reasons for such decisions, issues of consent with regard to removal of body parts and permission to attend a post mortem and also issues regarding permission to view the deceased at various stages. The distress caused in this case shows the importance of treating these issues with the utmost sensitivity.

## 13 Summary and Conclusions

### Part One

- 13.1 Annex B contains a number of corrections and comments on errata and alleged errata in my interim report. I have set out in section 3 my remaining conclusions relevant to Part One of the Inquiry. I hope that I have done so reasonably succinctly so that it is not necessary to repeat them here.

### Part Two

- 13.2 A public inquiry should only be ordered where it is in the public interest to do so. No private person or entity has a right to a public inquiry. The purpose of a public inquiry (which is discussed in section 5 above) is not to enable private persons or entities to prepare a case for civil litigation or prosecution, but to ascertain the true facts and to learn lessons for the future. Most inquiries will have both purposes, but there may be cases in which the public interest requires the holding of a public inquiry in order to ascertain the true causes of a casualty, even if relevant lessons have already been learned. A public inquiry should thus be ordered where there is a need for full, fair and fearless investigation and for the exposure of relevant facts to public scrutiny. An FI has a further purpose, namely the disciplining of certificated officers.
- 13.3 As I have tried to explain in section 6, this was in principle a suitable case for a public inquiry. The loss of the lives of 51 young people who were at a party on a passenger vessel on the Thames on a clear summer night in the middle of London came as a shock to the public. In my view it cried out for public scrutiny in order to discover how it was that such a terrible event could occur.
- 13.4 I stress that it does not follow from my conclusions in this case that a public inquiry should always be ordered where a marine casualty causes loss of life. In many cases it will be entirely satisfactory for the casualty to be investigated by the MAIB and for an inquest to take place. There are however exceptional cases in which the public interest in principle requires a public inquiry. This was, and is, such a case.
- 13.5 If a public inquiry had been ordered at any time up to now, it would have been an FI. Throughout the last ten years the statutory power of the Secretary of State to order an FI has been entirely unfettered. In section 7 and Annex C, I have tried to give an account of relevant events between 1989 and 1999, from which it can be seen with reasonable clarity why an FI (or any other form of public inquiry) was not ordered.

- 13.6 The reason why an FI was not ordered at the outset was that it was decided to wait until the MAIB Report was complete, when the matter could be reviewed. The fact that the MAIB had recently been set up and that it should be given a chance to do what it had been set up to do were factors in the matter being approached in that way. I have no doubt that, if the MAIB had not been set up but the old system had still been in operation, an FI would have been ordered at an early stage.
- 13.7 After the MAIB Report had been published, although many calls for a public inquiry were made, Ministers resisted those calls on the advice of the Department and the MAIB. The MAIB was consulted at every stage in the process. The documents show that there has throughout been very close contact between the Department and the MAIB and that for the most part an approach was agreed between them before it was put to Ministers.
- 13.8 A number of factors made up the advice given to and accepted by Ministers, of which these seem to me to be the main ones. A full and thorough investigation had been carried out by the MAIB. Although some evidence produced after the MAIB Report was made could be said to be new evidence, it was not important evidence because it did not alter the basis of the conclusions reached by the inspectors and set out in the MAIB Report. It followed that nothing further could be gained by a public inquiry, especially since all relevant lessons had been learned as a result of the various investigations, including the Hayes Inquiry.
- 13.9 There was an additional consideration which ran through the thinking of the MAIB, the Department and Ministers throughout. It was that the MAIB had recently been set up along the lines of the AAIB, that AAIB investigations had almost entirely avoided the necessity for public inquiries and that, if an FI were to be ordered after the MAIB Report was published, the newly formed MAIB would be seen as lacking credibility.
- 13.10 In section 8 I considered in detail the question whether a public inquiry should have been ordered. In my opinion it should. I understand why it was not ordered at the outset, but an FI should in my view have been ordered at the latest when the MAIB Report was published, and perhaps earlier. An FI should have been ordered because this was an exceptional case in which the facts should have been exposed to public scrutiny.
- 13.11 The MAIB Report was no substitute for a public inquiry because it was a private and not a public investigation. As discussed in paragraphs 8.7 to 8.10, although the Inspectors' Report referred to the evidence which the inspectors considered, and indeed appended it, the MAIB Report did not. Ministers declined to publish the Inspectors' Report, with the result that it was not possible to tell what evidence was considered by the inspectors. It was in any event not possible to tell from either report which witnesses were regarded as reliable and which were not. It follows that the reliability of the conclusions reached by the MAIB could not readily be exposed to public scrutiny. In expressing that view, I do not blame the MAIB, because the very nature of an MAIB investigation is that it is private and not public. It follows that it is no substitute for a public inquiry in a case, like this, where the public interest requires one.
- 13.12 My conclusion that an FI should have been held does not depend upon the existence of evidence not considered by the MAIB or indeed upon a detailed analysis of the evidence considered by the inspectors. Consideration of all the evidence will be a matter for the FI, if one is ordered. However, a number of features of the case underline my conclusion. They relate principally to the primary facts, to alcohol and to the position of the owners of the BOWBELLE. Under each of those headings there appear to me to remain a number of unanswered questions. I have touched upon some of the questions which seem to me to be

relevant in paragraphs 8.23 to 8.67 and 9.11. I have not, however, attempted to answer the questions because again that will be a matter for any FI.

13.13 I have considered in section 9 the question of whether a public inquiry should be ordered and held now. In my opinion it should for these main reasons:

1. The facts and evidence have never been exposed to public scrutiny in one forum tasked to consider and analyse all the relevant evidence and to write a reasoned report.
2. In particular, neither of the prosecutions nor the inquest was an adequate substitute for a public inquiry: see paragraphs 9.4 to 9.17.
3. My view does not depend upon the existence of new evidence, in the sense of evidence not considered by the MAIB. However, there remain a significant number of questions to be answered, which would have been answered by a public inquiry in the past and would now be answered if such an inquiry were to be held: see paragraphs 8.23 to 8.67, 9.11 and 13.12.
4. In answering those questions, a public inquiry would of course consider all the evidence now available, which (as explained in section 8) is in some respects more extensive than was available to the MAIB. The inquiry might or might not reach the same conclusions as the MAIB did.
5. Although ten years have passed since the casualty and some witnesses have died and other witnesses' memories are not likely to be as good as they were, I see no reason why it should not be possible for a public inquiry to arrive at reasonable conclusions based on all the available evidence. It would of course be necessary for the inquiry to have regard to the gaps in the evidence and the passage of time when assessing it. See paragraphs 9.20 to 9.27.
6. I recognise that there are factors which weigh in the balance against holding a public inquiry at this stage. In addition to those just mentioned, they include the following. In the light of the inquiries to date, it is unlikely that lessons for the future safety of the Thames would be learned from a public inquiry. An inquiry would be likely to cause stress, both to witnesses (including survivors and police witnesses) and others. Many people have been trying to put the disaster behind them, including the master of the BOWBELLE, Captain Henderson (who has endured two criminal trials), Mrs Faldo, the widow of the skipper of the MARCHIONESS, and Mr McGowan, the mate.
7. Doing my best to balance the competing considerations (of which there are many), while recognising the difficulties, the balance lies in favour of an inquiry, which can in my view be conducted in a way which will be fair to all. See paragraphs 9.31 to 9.38.
8. In short this remains, as it has been from the outset, an exceptional case in which the facts should be considered and determined in a public forum.
9. I stress that an inquiry would require to be sensitively handled and that the co-operation of all interested parties would be required to ensure that only relevant evidence was put before it. See paragraph 9.37.

- 13.14 I also stress that an inquiry would focus on all relevant issues and not just those relating to the BOWBELLE. I am conscious that two of the three particular topics which I identified in section 8 as giving rise to concern relate to the BOWBELLE and that, as a result, many of the particular questions which I have raised also relate to the BOWBELLE. I have set out those questions because they seem to me to underline the conclusion that a public inquiry should be ordered, not because they are the only questions in the case or because an inquiry would not ask other questions. It would ask many other questions, particularly questions relating both to the operation of the MARCHIONESS and to the activities of the Department in the 1980s. Finally in this regard, I repeat that in raising the questions, I do not intend to suggest the answers. It will be for the inquiry to provide the answers, if an inquiry is ordered.
- 13.15 If a public inquiry had been ordered at any time in the years following the collision, as recognised on all sides it would have been an FI. The statutory provisions, which are extensively discussed in paragraphs 7.1 to 7.18 and 10.7 to 10.16, were designed for the public examination of a marine casualty such as occurred here. The relevant provision at present is section 268 of the Merchant Shipping Act 1995. I recommend that an FI be ordered under that section. For the reasons given in paragraphs 10.3 to 10.6, this is not a proper case for an inquiry under the Tribunals of Inquiry (Evidence) Act 1921. It is, however, a case in which it is desirable that the Attorney General should have the assistance of inspectors appointed under the 1995 Act in order to prepare the matter for the inquiry. It is also a case in which it is desirable that the wreck commissioner should have appropriate powers in order to conduct the FI firmly, but fairly. A non-statutory inquiry would not be suitable, whereas an FI would. It would have the additional advantage that the wreck commissioner would be assisted by suitably qualified assessors.
- 13.16 As indicated in paragraph 10.14 above, the effect of the relevant provisions as applied to the facts of this case can be summarised as follows. The Secretary of State has power to order an FI into the collision between the MARCHIONESS and the BOWBELLE, the loss of the MARCHIONESS, the loss of life and the injuries suffered by those who survived. Such an FI would naturally consider the causes of the collision and the loss of the MARCHIONESS and the causes of the loss of life and personal injuries. In doing so, part of its remit would include the search and rescue operation.
- 13.17 The FI would in my view have jurisdiction to consider the SAR operation even if the Secretary of State did not give an express direction to that effect under regulation 4(1) quoted in paragraph 10.13 above. However, it seems to me that if the Secretary of State decides to order an FI, and if it is his view that it should cover the SAR operation (as in my opinion it should), then it is desirable that he should make that clear by giving an appropriate direction to that effect under regulation 4(1). I therefore recommend that he does so.
- 13.18 I would only add two points. The first relates to an inquiry into the SAR operation. It seems to me to be of particular importance that any evidence, particularly oral evidence, given at an FI into the SAR operation should be restricted to that which is absolutely necessary, because it is likely to be distressing and may cause or potentially cause further stress, which should be avoided if at all possible. This applies both to survivors and to the rescue services, including the police. I would naturally expect all those involved to co-operate in this regard.
- 13.19 The second point is this. As extensively discussed in sections 11 and 12, it has been proposed that a number of other topics should be the subject of a public inquiry. Some correspondents say that it would be appropriate to inquire into all the investigations which have taken place over the years. I do not agree, but it is important to note, as I have indicated in paragraphs

9.24, 11.2, 11.19 and 11.27, that the FI is likely to involve a consideration of the reliability of the evidence of particular witnesses, which is likely in turn to involve a consideration of the reliability of their previous statements, which may well in its turn involve an analysis of how they came to be made.

13.20 None of the matters considered during this Inquiry other than those set out in paragraphs 13.16 and 13.17 above is within the jurisdiction of an FI and none of them would satisfy the requirements of the 1921 Act. It follows that, subject perhaps in one respect to section 49(1) of the Police Act 1996, any inquiry into any of them would have to be non-statutory: see paragraphs 10.6 and 10.16 to 10.21. It would, however, be possible to ask the person appointed as wreck commissioner to consider other questions on a non-statutory basis.

13.21 In sections 11 and 12 I have considered a number of topics which it has been suggested should also be the subject of a public inquiry. I have reached the conclusion that the public interest does not require the further considerable expenditure of time and public money which would be involved in such inquiries over and above that which will necessarily be involved in an FI, if one is ordered. My conclusions may be summarised in this way.

#### Refusal of Inquiry in the Past

13.22 This is the MAG's Purpose B, which is referred to in paragraph 11.4. I have expressed my own view on why a public inquiry was refused in section 7. In the light of that discussion and my conclusion that a public inquiry should have been ordered, the public interest does not require an inquiry into the reasons for refusals to order one in the past.

#### Legal Processes

13.23 This is the MAG's Purpose C and is discussed between paragraphs 11.33 and 11.60. I agree with the MAG that the present position is unsatisfactory. The relationship between the many different legal processes should receive urgent consideration. The question is whether the urgent consideration should be by way of a public inquiry chaired by a judge or senior QC or by the ordinary processes of Government. Those processes are already under way in the form of the Transport Safety Review. The problems are difficult and could be included in the terms of reference of a public inquiry, but on balance I have reached the conclusion that the better course is for them to be considered in the usual way, subject to two provisos.

13.24 I have given my reasons in paragraphs 11.46 to 11.55. In short, the problems are not confined to one form of transport. They relate not only to all forms of transport but also to industry generally and they should be soluble by the ordinary processes of Government. There should be no need for a public inquiry, provided that those asked for their views include those with experience of such public inquiries in the past and provided further that the consultation process takes a short time. There has already been very considerable delay: see paragraphs 11.52 to 11.55.

13.25 As at present advised, my own contribution to the debate would include (but not be limited to) the following. The suggestion of a single Disaster Court to find the facts, make recommendations and establish civil and criminal liability would be unworkable, although the report of a public inquiry should be admissible in evidence in civil proceedings: see paragraphs 11.57 and 11.44.

13.26 I do not express a view here upon the difficult problem of balancing the public interest in learning the truth and making recommendations for the future at a public inquiry, on the one hand, and the public interest in bringing prosecutions in an appropriate case, on the

other hand. Clearly defined machinery should, however, be devised for arriving at decisions as to which should precede the other and on what basis. It seems to me to be desirable that steps should be taken to establish such machinery and that that machinery, or at least appropriate guidelines, should be publicised so that everyone may know what criteria are being applied: see paragraph 11.58.

- 13.27 The time has in my opinion come to set up a statutory framework for inquiries generally (including FIs) to replace the various statutes which govern them at present. It would, in my opinion, be desirable to remove the adversarial aspects of the rules of the various inquiries and to give the chairman of every inquiry power to conduct the inquiry as he or she thinks fit, subject of course to an overriding obligation of fairness. The inquiry should have powers, so far as appropriate, to compel witnesses to give evidence and to obtain documents and would be subject to judicial review. Otherwise the procedure should be as flexible as possible. Such an approach should save both time and money. See paragraphs 11.59 and 11.60.

### Inquiries into the Investigations

- 13.28 It is submitted that a public inquiry should be ordered into the various investigations which have taken place, notably by the police, the MAIB and the CPS. Such an inquiry would be far-reaching and expensive. I have discussed the submissions in detail in paragraphs 11.12 to 11.32. My clear conclusion is that the public interest would not be served by directly investigating the investigators more than ten years after the event.
- 13.29 In the case of the MAIB, which I have discussed in paragraphs 11.22 to 11.25, its position is very different now from its position then and a public investigation into the MAIB investigation would serve no useful purpose. As I have already indicated, some parts of its investigation are likely to form part of any FI. However, I do make these observations. If the MAIB is to have the full confidence of the public, it must rigorously maintain its independence from the Department. To this end I recommend that in the future both the Department and the MAIB take steps to ensure that their dealings are limited to those matters which necessarily arise in connection with the performance by the MAIB of its proper investigatory functions, including of course reporting to the Secretary of State. Otherwise, there is a danger that the public will perceive, rightly or wrongly, that the MAIB is an arm of the Department rather than an independent investigative body. This would be unfortunate because it would defeat one of the very objects for which the MAIB was created.
- 13.30 In these circumstances, I recommend that clear guidelines be laid down setting out precisely the role of the MAIB on the one hand and the role of the Department on the other. Such guidelines should be published so that the public may know the demarcation line between the Department and the MAIB and have confidence in the MAIB in the future. These are not, however, matters which should be separately considered at a future public inquiry and I stress that nothing that I say is intended to diminish the role of the MAIB as an independent agency, charged with investigating marine accidents in the same way as the AAIB investigates air accidents.
- 13.31 As to the police and the CPS and the DPP, again I do not think that a public inquiry is called for: see paragraphs 11.26 and 11.27 and paragraphs 11.30 and 11.31. Lessons can, however, be learned for the future. In that context my conclusions are set out in paragraphs 11.28 and 11.29. For convenience, I repeat them here as part of my overall conclusions.
- 13.32 It is part of the role of an FI to make recommendations for the future. If it appears to the wreck commissioner after hearing all the evidence that lessons could be learned which would help

the future investigation of a serious casualty, I see no reason why he should not say so. I have in mind the possibility that he might wish to recommend that the MAIB and the police should lay down a framework for the investigation of accidents of this kind. The framework might include ensuring that investigators with appropriate expertise would be quickly available in order to avoid the risk that appropriate inquiries are not undertaken, appropriate witnesses not questioned, appropriate questions not asked and appropriate documents not obtained and studied. It is for example suggested here that more forensic tests should have been carried out. It is obviously important that all such tests should be carried out, both in the context of an MAIB investigation to find the facts and learn lessons for the future and in the context of a police investigation to consider whether a crime has been committed. It also strikes me that some thought should be given to the question when declarations should be taken and when police statements should be taken and to the circumstances in which the MAIB ought to be provided with evidence (including statements) obtained by the police, perhaps instead of obtaining declarations itself (and vice versa).

- 13.33 The division of responsibility between the police on the one hand and the MAIB on the other will also be important if the view which I expressed in my interim report, namely that consideration should be given in such cases to prosecution under sections 2 and 3 of the Health and Safety at Work etc Act 1974, leads to the conclusion that those sections should be used more readily in the future. It seems to me that these are matters which can properly be considered in a general way either by the wreck commissioner carrying out an FI or by the same person considering these questions as part of a non-statutory inquiry. I do not, however, think that the public interest requires a public inquiry into the investigations carried out in this case ten years ago by the MAIB or by the police.

#### Law Reform

- 13.34 This is the MAG's Purpose D. It is to examine the need for disaster related law reform. For the reasons given shortly in paragraphs 11.6 to 11.8, it is my view that it is not the role of a public inquiry to consider questions of law reform on a large scale, which is what would be involved if the MAG's submission were accepted, especially given that many of the topics have been considered in detail by the Law Commission.

#### Traumatic Consequences of Disaster

- 13.35 This is the MAG's Purpose E, which is to acknowledge the traumatic consequences caused to disaster victims by the inadequacies of post disaster procedures and to make recommendations. As to this, I recognise that there are indeed traumatic consequences caused to disaster victims by the way in which they and their families may be treated after a casualty. There has, however, been a considerable amount of academic work on this topic and it does not seem to me to be a matter which can best be advanced by some form of judicial public inquiry. I should certainly not regard myself as qualified to express a view on these questions. See paragraph 11.9.
- 13.36 It is clear from some of the representations that have been made to the Inquiry that it is very important that survivors and the families of those who lost their lives in a disaster of this kind are treated sensitively in the aftermath of the casualty. It is important that those who take statements from survivors who may be traumatised as a result of the casualty or the SAR operation should take great care not to exacerbate in any way the stress already affecting the witnesses. To this end it seems to me that, where possible, only those who are suitably trained should take statements of this kind. I do not suggest that this is not the case at present, but I would simply like to underline its importance. See paragraph 11.10.

### Treatment of the Deceased

- 13.37 Considerable distress was caused to relatives of those who lost their lives in a number of ways. Most distressing was the fact that the hands of 25 out of the 27 found in the river were removed for the purposes of obtaining fingerprints and it was not until two years later that the families discovered what had happened. I have considered the evidence in some detail in section 12 and have reached these conclusions, which are set out in paragraph 12.10.
- 13.38 It seems to me that, in the light of the available evidence, it is reasonably clear why and how the decision was reached as to the removal of hands. Following the retrieval of the first body from the water, which was in a condition to have fingerprints taken at the mortuary, a number of bodies were brought in which were in a worse condition. The coroner had determined that fingerprints were to be taken from all the deceased. He gave authorisation for hands to be removed from any bodies where it was not possible to take good fingerprints without doing so. Thereafter, identification officers decided whether it was possible to take fingerprints from the deceased without removal of hands. Those decisions were made on a purely technical basis, without addressing the question of whether the deceased could be identified without his or her fingerprints being taken.
- 13.39 In reviewing the evidence I have not considered who was personally responsible for that state of affairs, but, as far as I am aware, no-one challenges the primary facts set out above. In these circumstances I do not think that the primary facts would have emerged any differently if further evidence on this topic had been called. I recognise that the families of those whose hands were removed continue to seek explanations as to why it happened. I can well understand the strength of their feelings because, on the basis of the material which I have seen, I have formed the view that it was unsatisfactory for hands to be removed for the purpose of fingerprinting without taking into consideration in relation to each individual body all other factors and features which might lead to a positive identification.
- 13.40 Given those conclusions, I have on balance reached the conclusion that the public interest does not require a public inquiry into the question which individual or individuals was or were responsible for the decisions to remove the hands in each case. In the light of the changes to and the tightening up of procedures for the identification of deceased persons following a mass disaster, I have reached the conclusion that it would not be in the public interest for these particularly stressful matters to be re-examined in public at great public expense.
- 13.41 Other concerns have been expressed and I have discussed the refusal of permission to view the bodies in paragraphs 12.14 to 12.20. Although I recognise that they have caused distress, I do not think that a public inquiry into them would be justified.
- 13.42 Although I have reached that conclusion, legitimate concerns remain: see paragraphs 12.28 and 12.29. In particular, one of the concerns raised by counsel for a number of the families at the second inquest was that the recording of decisions and the reasons therefore in the context of the removal of hands was woefully inadequate. I share that concern. There does not appear to be any requirement in the Emergency Procedures Manual, referred to in paragraph 12.26, for the recording in writing of any decision to authorise the removal of hands together with the reason for it. I have no hesitation in recommending that there should be such a requirement.

- 13.43 Further, I would also recommend that strong advice be given, both in the manual and in any training course which officers are required to undergo, that requests for the removal of body parts only be made after consideration on a case by case basis, taking into account all other available means of identification. I also reiterate the additional recommendations of the jury at the inquest, as follows:
1. Families of victims must always be informed of their rights to attend or elect medical representatives to attend post mortems. With appropriate counselling, they should be offered the opportunity to view their relative's body. The issue of visual identification must, however, be treated with caution.
  2. Removal of hands for the identification of bodies should be done only when all other methods have been exhausted (especially the matching of dental records) and not as a matter of expediency. In such circumstances, mortuary technicians and pathologists must remember that a procedure which may seem standard to them, is likely to be deeply distressing and offensive to relatives.
  3. We would like to remind all agencies of the importance of keeping detailed and accurate records. Particular attention should be given to the correct documentation of proceedings in the mortuary.
- 13.44 If, contrary to my recommendation, the appropriate Secretary of State orders a public inquiry into any of these matters, I recommend that he consider whether there might be a case for including it, not with an FI, but with an inquiry such as the Alder Hey Hospital Inquiry: see paragraphs 12.31 and 12.32.
- 13.45 In any event, I recommend that post mortem procedures be kept under review. Those procedures include the removal of body parts generally, the recording of any decisions to remove body parts and the reasons for such decisions, issues of consent with regard to removal of body parts and permission to attend a post mortem and also issues regarding permission to view the deceased at various stages.

### **Next Steps**

- 13.46 If the Secretary of State accepts the conclusions which I have reached, he will order an FI. I would like to touch upon two aspects of such a decision, which are closely linked. They relate to my personal position and to the procedure an FI is likely to adopt.
- 13.47 It may seem out of place for me to refer to my own position, but I do so in order that the matter can if necessary be the subject of comment or submission by anyone interested. The point may not arise at all because it will only do so if I am asked to conduct an FI. I mention it only because I recognise the possibility of my being asked to do so, given that I have already considered much of the relevant evidence and am familiar with the background to the case, albeit without trying to reach any conclusion of fact on any point. In the course of considering and writing both parts of the report, as I indicated in my interim report, I have had the great assistance both of Bill Sandal and his team from the Treasury Solicitor's Department and of David Goldstone and Samantha Leek of counsel, assisted by Neil McAteer. That assistance has naturally included considering many different aspects of the case including the facts and evidence. I have had detailed discussions on those and other topics both with counsel and with other members of the Inquiry team.

- 13.48 I have referred in paragraphs 7.11 to 7.14 above to the change of procedure at an FI introduced by the 1985 FI Rules, as subsequently amended by the 1990 Amendment Rules, and how those amendments came about. The effect of the changes is that the preparation and presentation of the case at an FI will now be conducted under the direction of the Attorney General, who will no doubt ordinarily instruct counsel on his behalf. It is my view, as I put it in paragraph 7.13, that the effect of the changes is that the Attorney General, or counsel on his behalf, while no doubt retaining his independence to make such submissions to the FI as he thinks appropriate, is now (as both Mr Phillips and Sheen J put it in the FIs to which I have referred) to be counsel to the tribunal.
- 13.49 Historically, until the HERALD OF FREE ENTERPRISE inquiry, the case was presented by counsel for the Department (or its predecessors), the whole process was almost entirely adversarial and there was no contact between counsel for the Department and the wreck commissioner except in open court. As I recall, at the HERALD OF FREE ENTERPRISE inquiry there was some informal contact between the wreck commissioner and counsel, who acted in essence as counsel to the inquiry. No-one objected to that course because it seemed to be very sensible.
- 13.50 I would expect contact between the wreck commissioner and counsel for the Attorney General, who would act as counsel for the tribunal. I would certainly propose to approach an FI in that way if I were appointed the wreck commissioner, because it seems to me to be the most sensible way in which to conduct an inquiry of this kind. The question would then arise whether any difficulty might arise from the fact that I have already discussed some of the problems with Bill Sandal and his team and with counsel. In considering that question, I have assumed that, although it would plainly be a matter for the Attorney General whether he instructed the same team, he would be likely to do so because any other approach would involve considerable further time and public expense, which would be entirely unnecessary given the work already done both by Bill Sandal and his team and by counsel. I therefore anticipate that the Attorney General would wish to instruct essentially the same team, subject perhaps to instructing leading counsel.
- 13.51 On that assumption, if the correct approach, as a matter of principle, were for an FI to be conducted on a solely adversarial basis, without any contact between the wreck commissioner and counsel for the Attorney General, or the Attorney General himself, it might cause embarrassment if I were to be appointed as wreck commissioner because of my previous discussions with the Treasury Solicitor's team and with counsel during the course of this Inquiry. On the other hand, if the proper course, as in my opinion would be the case, would be for the Attorney General and his counsel to be treated as counsel to the inquiry, as anticipated by Mr Phillips and by Sheen J and as is in my view contemplated by the 1990 Amendment Rules, no problem would arise. I note in passing that, as I understand it, that is the way in which Colman J is approaching the rehearing of the FI into the loss of the DERBYSHIRE.
- 13.52 I mention these points here because it seemed to me to be sensible to mention the potential problems publicly. They may not arise for any one of at least three reasons. Firstly, the Secretary of State may not order an FI. Secondly, if he does, he may appoint someone else to act as wreck commissioner. Thirdly, all parties may accept the approach suggested above. Indeed, I would hope that everyone would agree that counsel for the Attorney General should indeed be regarded as counsel to the tribunal, whoever is appointed as wreck commissioner.

### Summary of Main Conclusion

13.53 As stated in paragraph 4.1, I was asked to advise

whether there is a case for a further investigation or inquiry into the circumstances surrounding the MARCHIONESS disaster and its causes on 20<sup>th</sup> August 1989.

My answer to that question is yes. I make these principal recommendations:

1. The Secretary of State should exercise his power under section 268 of the Merchant Shipping Act 1995 to cause a formal investigation to be held into the collision between the MARCHIONESS and the BOWBELLE, the loss of the MARCHIONESS, the loss of life and the injuries suffered by those who survived.
2. Although I take the view that the remit of a formal investigation would include the search and rescue operation, I recommend that the Secretary of State give an express direction to that effect in accordance with regulation 4(1) of the Merchant Shipping (Formal Investigations) Rules 1985, as amended.

13.54 I do not recommend that a public inquiry be ordered into any other question because the public interest does not require it, especially in the light of the consideration which this Inquiry has been able to give to many of the topics raised. However, the wreck commissioner appointed to hold a formal investigation would naturally consider whether there are any further lessons to be learned for the future arising out of the disaster or the search and rescue operation. In this regard I see no reason why he or she should not include recommendations, both as to safety on the Thames and to matters such as co-operation in the future between those investigating maritime casualties, including the MAIB and the police.



Lord Justice Clarke  
22<sup>nd</sup> December 1999