Desktop Review of Court of Inquiry and other investigations into the RNZAF Iroquois Helicopter Crash ANZAC Day 2010

# FINAL REPORT

# REDACTED FOR LEGAL PRIVILEGE

Michael Heron QC

28 May 2020

# Contents

# Executive Summary

1. In the early morning of Anzac Day 2010 three Iroquois helicopters left Ohakea airbase in formation to participate in flypasts as part of Anzac day services. On route, Iroquois Black 2 (**Black 2**) crashed into hills east of Pukerua Bay. Three of the four crew members lost their lives; the fourth received very serious injuries but survived against all odds. The accident will live in the memory of the New Zealand Defence Force (**NZDF**) and New Zealanders for many years to come.

2. The crew of Black 2 were brave and diligent men. Those who died left behind families, friends and colleagues for whom the loss remains. My deepest condolences go out to all those affected by the tragedy.

3. When an accident of such magnitude occurs, there are many questions that must be asked of all involved. In the more than 10 years since, many have considered, evaluated, and concluded on the causes of the accident, who was responsible or at fault, what were the contributing factors, the lessons to be learned and the changes that needed to be made.

4. I was commissioned to consider the documents provided to me and determine whether they had comprehensively addressed issues of causation, fault and responsibility. If they had not, then I was asked to identify how additional aspects could be addressed and by whom.

5. The Documents supplied to me demonstrate that the authorities involved have by their inquiries and investigations comprehensively addressed the causes of and fault or responsibility for the Anzac day crash and the deaths and injuries that resulted from it.

6. In my view, there are no other additional aspects of the causes of, fault or responsibility that remain to be addressed and could reasonably be addressed.

7. The Court of Inquiry (**COI**) process, the materials provided to it and the recommendations made, were meticulous, thorough, professional and ultimately revealing to NZDF. The Burleigh Evatt report to the State Services Commissioner reviewed progress on the recommendations made by the COI. It was very professional and thorough.

8. The other authorities involved appear to have given the causes, fault and responsibility for the accident and the resulting deaths/injuries full and proper consideration.

9. On the face of the Documents, there could be an appearance of delay in progressing some of the disciplinary investigations. Though that may not have been the case, it is not clear from the Documents whether there was earlier consideration given to potential senior responsibility. That said, the Documents suggest it is unlikely that the conclusions reached would have differed.

10. The tragic accident on Anzac day 2010 has, in my view, been carefully and thoroughly reviewed. The care and attention taken by NZDF through the COI process compares well to comparable civilian processes and accidents.

# Background

11. This desktop inquiry was commissioned by the Minister of Defence pursuant to Terms of Reference (**Terms**) dated 4 December 2019, which are reproduced at **Appendix 1**. The Minister requested that I consider the existing analyses of the Iroquois Black accident of 25 April 2010. He asked me to give advice on whether certain documents (**Documents**) "comprehensively addressed the causes of and fault or responsibility for the Anzac day crash" and the deaths and injuries that resulted from it and, if they did not, the additional aspect of the causes of, fault or responsibility that remain to be addressed, how they should be addressed, and by whom.

12. The Documents to be reviewed were received by me by hand on 19 December 2019. Those Documents were set out in the Terms, having been identified by NZDF as relevant to this review. I understand that NZDF's consideration of what was relevant began by collating the COI record and NZDF's own record of key documents relevant to the accident. NZDF also searched its joint database for materials, and included in the Documents further material that related to the accident in a broader sense. The Documents were provided to me in strictest confidence for the purposes of this review. I will refer to them generally, in the interests of maintaining confidentiality.

13. The Terms required me to review the Documents and advise:
    a) whether the Documents identified have comprehensively addressed the causes of and fault or responsibility for the Anzac Day crash, the deaths of three of the crewmen and the serious harm injury suffered by the fourth;
    b) if not, what additional aspect of the causes of, fault or responsibility for the Anzac Day crash and the deaths or harm to those officers and airmen remains to be addressed and how that additional aspect could be addressed and by whom; and
    c) any other matters I consider relevant.

14. The Terms also identify certain limitations upon the content of my report so as to preserve the anonymity of those not charged in relation to the crash, to preserve legal privilege and to preserve the confidentiality of the record of proceedings of the COI and individuals giving evidence to the same.

15. I was authorised to use the services of barrister Charlotte Agnew-Harington to assist in the review.

# Methodology

16. With assistance, I first reviewed the entirety of the Documents to ascertain that I had received all that were listed as relevant and to identify if any particular document had been omitted. No obviously relevant document had been omitted, although an exhibit of interest was missing from the COI record (discussed further below). One media article suggested I had not been provided with the "[Air Accident Analysis Report]". [1] That media article was incorrect; I was provided with that report as part of the record of the COI.

17. I then familiarised myself with the basic principles behind air accident analysis (and complex accident reviews). These can be found and are discussed in a range of materials but in particular I considered the various expositions of James Reason's approach (the "Reason Model")[2] and the seminal Haddon-Cave Nimrod review as being authoritative guides on the proper approach to causation analysis in complex accidents.[3]

18. I summarised the process and findings of each authority involved in considering the accident and the resulting deaths and injuries. The authorities included:
    a) The COI (concluded 2 December 2011);
    b) Australian Defence Force Directorate of Defence Aviation and Air Force Safety (**DDAAFS**) (15 September 2010);
    c) The Crown Law Office (10 August 2011 and 20 September 2011);
    d) Burleigh Evatt, a professional services firm, reporting to the SSC (6 December 2012);
    e) The SSC and MBIE, considering health and safety roles in a military context (10 December 2012);
    f) NZDF Service Police in three reports (31 August 2011, 30 March 2012, and 11 April 2012);
    g) NZDF internal legal services (31 August 2011, 12 September 2012, 13 September 2012, 13 November 2012, 12 December 2012, 22 April 2013 and internal peer review of 23 April 2013);
    h) The Wellington Crown Solicitor reviewing the NZDF legal advice (12 September 2012);
    i) The Summary Appeal Court (15 December 2011);
    j) An NZDF disciplinary officer (16 April 2013);
    k) Mr Matthew McClelland QC (20 March 2013);
    l) The Coroner (24 August 2016);
    m) Legal submissions and the sentencing decision of Hastings DCJ in the District Court at Wellington (18 July 2014); and
    n) Various other reviewers, including psychological, technical, and engineering experts (amongst others).

19. I considered whether the Documents generated by or on behalf each of those authorities comprehensively addressed the causes of and fault or responsibility for the Anzac Day crash, and the resulting deaths and injuries.

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[1] David Fisher, "Fatal Anzac Day military air crash under fresh review after NZ First promise", New Zealand Herald 18 December 2019. See https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=12294341 accessed 20 April 2020.

[2] I understand that RNZAF uses this model as its default for assessing accidents and incidents. That model is commonly accepted as useful for aviation accidents. See for example Transport Accident Investigation Commission reports such as TAIC Final Report AO-2015-007: ZK-HKU, collision with terrain, Fox Glacier, 21 November 2015 Appendix 4); Panagiota Katsakiori, George Sakellaropoulos, Emmanuel Manatakis "Towards an evaluation of accident investigation methods in terms of their alignment with accident causation models" Safety Science 47 (2009) 1007.

[3] See, for instance: Whitney DeCamp and Kevin Herskovitz "The Theories of Accident Causation Whitney DeChamp and Kevin Herskovitz"; Alexander Cedergren and Kurt Petersen "Prerequisites for learning from accident investigation – A cross-country comparison of national accident investigation boards" Safety Science 49 (2011) 1238; Fu Gui, et al "The development history of accident causation models in the past 100 years: 24model, a more modern accident causation model" Process Safety and Environmental Protection 134 (2020) 47.

20. In particular, I considered the process adopted in each case, who was involved, the evidence reviewed and the findings and recommendations made. In turn, I compared that to the processes which could reasonably have been available following such a tragic accident. Finally, I considered whether any other reasonable avenue of analysis remained to be considered.

21. In doing so I considered by comparison other tragic events such as the Pike River Coal Mine explosion and other serious transport or armed forces accidents where fatalities occurred.[4] Other such aircraft accidents included:
    a) The Bell UH-1H Iroquois ZK-HJH accident that occurred at Taumarunui on 4 June 2001;[5]
    b) The Bell/Garlick UH1B Iroquois helicopter accident that occurred near Mokoreta on 23 April 2004;[6]
    c) The Hot air balloon collision with power lines and in-flight fire near Carterton on 7 January 2012 (noted as New Zealand's third worst aviation disaster, after the Air New Zealand Erebus crash of November 1979 and the National Airways DC3 crash in the Kaimai ranges in July 1963);[7]
    d) The Airbus Helicopter AS350BA, ZK-HKU accident that occurred at Fox Glacier on 21 November 2015;[8] and
    e) The Hughes 369D, ZK-HOJ accident that occurred at Wanaka on 18 October 2018.[9]

22. Ultimately, I examined whether the various authorities involved in this case had fully considered the causes of and fault or responsibility for the crash and its consequences. I searched for whether there were additional aspects of the causes of, fault or responsibility for the Anzac Day accident and the harm resulting which could reasonably be examined and, if so, by whom. I did so by reference to my experience with accidents causing death over my last 25 years of legal practice and by comparison to how other such accidents have been considered in New Zealand and elsewhere.[10]

23. This report summarises my review and my findings and recommendations. Much of the material provided to me is legally privileged, confidential, or sensitive. Much of it is protected by statute. Other aspects relate to and could affect the reputation and interests of individuals. I do not wish to compromise the rights to privacy and reputation of those individuals; nor do I want, unduly, to cause pain to any of those involved, especially given the passage of more than ten years. For these reasons, my report is a summary only.

24. I also include a high-level summary of some of the Documents and source material, including transcripts of witness interviews and a vast array of exhibits. These observations are given on the basis that they are most salient to my findings; discussion of certain aspects and the omission of others should be seen as indicative only of my desire to ensure my report is focussed and helpful. My overall conclusions relate to and have been informed by more than just those matters I refer to expressly.

25. Where any aspect of the COI report or record raised an issue of concern, I have attempted to deal with that aspect cautiously, in an effort to provide sufficient detail as to explain my reasons for raising an issue, without compromising the sanctity of the record or the privacy of the individuals concerned.

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[4] See the international standard and recommended practice for accident investigation – Annex 13 to the Convention on International Civil Aviation, 7 December 1994.
[5] See https://www.taic.org.nz/inquiry/ao-2001-005r, accessed 20 April 2020.
[6] See https://www.taic.org.nz/inquiry/ao-2004-003 accessed 20 April 2020.
[7] See https://www.taic.org.nz/inquiry/ao-2012-001 accessed May 2020.
[8] See https://www.taic.org.nz/inquiry/ao-2015-007 accessed 20 April 2020. This crash has some similarities to the present in terms of pilot experience, poor supervision and the impact of weather conditions.
[9] See https://www.taic.org.nz/inquiry/ao-2018-009 accessed 20 April 2020.
[10] Other accidents referenced included aircraft, marine and other transport accidents where lives have been lost and forensic processes such as inquests, prosecutions and inquiries have followed.

26. It was not my role to give an opinion as to whether I agreed with the conclusions reached by the various authorities involved. I took the approach that where there had been consideration of the causes of and fault or responsibility, I would only comment if in my view that consideration fell short of being adequate by virtue of being irrational or unreasonable in the legal sense.[11] As lawyers will understand, that is a high threshold.

27. I provided a confidential draft report to NZDF for comment on 15 May 2020. I received comments and incorporated those as appropriate in this final report.

[11] In *Peters v Davison* [1999] 2 NZLR 164 Tipping J, stated:
Parliament grants the decision maker the power to decide on the footing that the power is to be exercised lawfully (i.e. correctly in law), fairly (i.e. according to the rules of natural justice, if applicable) and reasonably (i.e. within the bounds of reason – the *Wednesbury* principle). If the decision maker goes wrong in law, acts unfairly or makes an unreasonable decision, the decision is regarded as having been made ultra vires and thereby the decision maker exceeds his or her jurisdiction.

# Findings

28. My findings are as follows:

A. The Documents supplied to me demonstrate that the authorities involved have comprehensively addressed the causes of and fault or responsibility for the Anzac day crash and the deaths and injuries that resulted from it.

B. The lack of a thorough independent health and safety investigation by a competent authority was originally a significant omission which was to some extent addressed by the successful private prosecution proceedings brought by Black 2's surviving crewman and by the recommendations of the SSC review in that respect.

C. There are no other additional aspects of the causes of, fault or responsibility that remain to be addressed or that could reasonably be addressed.

D. The COI process, the materials provided to it and the recommendations made, were meticulous, thorough, professional and ultimately revealing to NZDF. The Burleigh Evatt report to the SSC reviewed progress on the recommendations and would have given comfort to the then Minister. It was very thorough and professional.

E. The other authorities involved (as listed) appear to have given the causes, fault and responsibility for the accident and the resulting deaths or injuries full and proper consideration.

F. Some delay in progressing some of the disciplinary investigations and consideration of disciplinary charges is regrettable, although ultimately it is unlikely that the conclusions reached would have differed.

G. The tragic accident on Anzac day 2010 has, in my view, been carefully and thoroughly reviewed. The care and attention taken by NZDF through the COI process compares well to comparable civilian processes and accidents.

H. The Minister ought to seek advice from NZDF and consider whether the outstanding recommendations arising from the SSC MBIE review (item 18(e) above) have been implemented satisfactorily.

I. NZDF ought to consider and review whether the delay in completion of the disciplinary processes was orthodox and explicable.

# Timeline of Events and Documents

| Date | Event |
|---|---|
| 25 April 2010 | Accident kills three and injures one. |
| 26 April 2010 | COI established. |
| 15 September 2010 | Peer review of the Court of Inquiry process by the Australian Defence Force DDAAFS (this document is dated incorrectly 15 October 2010). |
| 10 August 2011 | Crown Law Office provides advice to the NZDF Director General of Defence Legal Services. |
| 31 August 2011 | Service Police deliver interim report discussing allegations relating to the planning and authorising of the Anzac day flypast and liability of the Authorising Officer given upcoming expiry of limitation periods.<br>Service Police recommend charges against the Authorising Officer for breach of various DFFOs. |
| 31 August 2011 | NZDF receives internal legal advice concerning offences under the AFDA against the Authorising Officer. [redacted] |
| 20 September 2011 | Advice of the Crown Law Office to the then Minister of Defence. |
| 20 September 2011 | Service Police advise that the limitation period of charging the Authorising Officer with AFDA offences expires on this date. |
| 2 December 2011 | COI report delivered. |
| 15 December 2011 | Summary Appeal Court decision quashes conviction of Authorising Officer. |
| 30 March 2012 | Service Police report considers allegations relating to the flight authorisation process, consideration of crew currency and qualifications, and compliance with applicable rules. |
| 1 April 2012 | Service Police report considers command responsibility within the broader command structure. |
| 12 September 2012 | NZDF receives internal legal advice in relation to whether the Formation Leader should be charged with manslaughter. |
| 12 September 2012 | Crown Solicitor delivers a peer review of the internal legal advice relating to the potential to charge the Formation Leader with manslaughter. |
| 13 September 2012 | NZDF receives legal advice (internal) relating to potential offences under the AFDA against the pilots and co-pilots of Iroquois Black. |
| 13 November 2012 | NZDF receives further legal advice (internal) relating to potential offences under the AFDA against the pilots and co-pilots of Iroquois Black. |
| 6 December 2012 | Burleigh Evatt delivers a report entitled "Review of the Implementation of the Court of Inquiry's Recommendations following the 2010 Anzac Day Iroquois Crash", commissioned by the SSC. |
| 10 December 2012 | SSC and MBIE deliver a report entitled "Review of Health and Safety Roles in the Military Context". |
| 12 December 2012 | NZDF again receives further legal advice (internal) relating to potential offences under the AFDA against the pilots and co-pilots of Iroquois Black. |
| 20 March 2013 | Matthew McClelland QC reports on NZDF's treatment of and engagement with families of the victims. |
| 16 April 2013 | Decision of Disciplinary Officer not to charge the Formation Leader with AFDA offences. |
| 22 April 2013 | NZDF receives internal legal advice concerning command responsibility for the accident. |
| 23 April 2013 | NZDF receives internal peer review of the legal advice of 22 April 2013. |
| 25 April 2013 | Default general expiry of limitation period for offences under the AFDA in respect of the 25 April 2010 accident. |

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|---|---|
| 27 June 2013 | Surviving crewman of Black Two seeks the ability to lodge a prosecution of NZDF out of time in relation to the accident. |
| 22 October 2013 | District Court grants Black 2's surviving crewman leave to bring a private prosecution against NZDF, despite delay. |
| 18 July 2014 | District Court sentences NZDF in the matter of the private prosecution brought by the surviving crewman of Black Two. |
| 24 August 2016 | Coroner releases finding as to the causes of the death of the deceased crew of Black Two. |

# The COI report – in summary

29. Following the crash, NZDF promptly established a COI pursuant to section 200A of the Armed Forces Discipline Act (**AFDA**). The report and record of the COI was provided to me for the purposes of this review. Both contain confidential, sensitive and privileged information.

30. The AFDA imposes a multitude of procedural obligations and safeguards, including protection for witnesses and material presented to the COI.[12]

31. COI proceedings sit outside of the ordinary judicial framework; neither the record of proceedings nor any evidence produced can be admitted against any person in other proceedings, judicial or otherwise.[13] Furthermore, the record of proceedings cannot generally be disclosed, subject to exceptions.[14]

32. The report of the COI was released to me by the Chief of Air Force for the purposes of this inquiry in accordance with s 200T AFDA. Strict security and custody measures were put in place to protect the material in my possession.[15]

33. I have considered the COI's report and the full record of proceedings, which includes the transcripts of interviews with witnesses, and exhibits. The report is and remains confidential. The following summary deals in high-level terms with the material and my assessment of it. As outlined above, my focus has been on the process employed and the questions asked.

34. The COI report introduces the crash and sets out the process followed by the COI in accordance with its Terms of Reference. On my reading, the terms were plainly drafted to direct the COI to consider all possible lines of inquiry. Indeed, there is a catch-all provision that allows the COI to investigate all "other" issues that appear relevant to this tragedy.

35. The report records that the COI heard from 34 witnesses. It also considered a vast array of specialist reports from within and outside of NZDF. These included, for instance, the Air Accident Analysis Report, Human Factors Report, and a multitude of technical reports (discussed below).

36. The COI analysis and report are framed by reference to the Reason Model. That model is internationally well-regarded and often cited as an appropriate framework for considering aviation accidents. The COI found failings corresponding to all levels of the Reason Model.

37. The report records that the COI was re-assembled on 1 and 2 December 2011 to receive any evidence from the families of the deceased crewmen of Black 2 in accordance with the requirements of natural justice. Over that period, the COI also received certain pieces of updated evidence, recalled one witness and heard evidence from two more. The COI's report is dated 2 December 2011.

38. The report briefly summarises the events before, during and after the accident (ending with the incident response measures established later that morning), before going on to analyse the circumstances surrounding the accident.

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[12] Ss sections 200 – 201 AFDA.
[13] S 200S AFDA. Exceptions may apply, however, in relation to charges for making a false statement, or perjury. See s 200S(3) AFDA.
[14] S 200T AFDA.
[15] Those measures necessarily altered, but remained in place, during March and April 2020 on account of New Zealand's Covid-19 response and lockdown.

39. The report then proceeds to analyse the compliance with and efficacy of "all orders, instructions and publications". Then comes consideration of the "other issues that may be relevant". After that, it lists the COI's 169 findings.

40. The report steps through each of the COI's Terms of References and summarises its conclusions in respect of each one. It considers the circumstances surrounding the accident by reference to the Reason model. It recounts the extent and cause of injuries suffered by the crew of Black 2, confirms their duty status, and makes conclusions on compliance with and efficacy of orders, instructions and publications. Other issues are considered, and it concludes by making a series of recommendations. Annexed to the Report is a list of Iroquois Black crew, a high-level overview of the Reason Model, the DDAAFS Peer Review, the summary of the currency, qualifications and hours of the crew; and diagrams of the Iroquois Black formation. There also follows a glossary of terms and abbreviations.

41. Factors that were considered by the COI include:
    a. The characterising and use of the Iroquois;
    b. Tasking and authorisation for the flight (when, by whom, whether compliant with all orders and instructions, whether the crew were appropriately qualified and current);
    c. Preparation for the flight (again, training, compliance with orders etc, planning of the flight);
    d. The attitudes of those involved;
    e. The conduct of the flight;
    f. The response (including search and rescue);
    g. Post-crash technical analyses (e.g. of the aircraft, safety equipment);
    h. Possible flight paths explaining how Black Two hit terrain;
    i. Compliance with and efficacy of orders, instructions and guidelines; and
    j. "Other" factors considered relevant to the COI's task.

42. I discuss briefly below the COI's consideration of several important matters going to the causes of and fault or responsibility for the accident.

*Flight preparation and planning*

43. Compliance with orders and consideration of the currency, competency, qualifications and experience of the crew was a key consideration. The COI found there was a lack of monitoring and consideration of the competency and currency of the crew. Further, the full extent of the cumulative risk was not considered and oversight from within 3SQN and OC 485WG missed several opportunities to mitigate risk and ensure compliance with orders.

*Authorisation*

44. Authorisation concerns were a key aspect of the COI's investigation and findings. The COI found there had been compliance failures in respect of certain DFFOs, even though the authorisation process was conducted in good faith and believed to be professional by those involved.

*Analysis of compliance with and efficacy of all orders, instructions and procedures*

45. This section of the COI report relates specifically to the COI's Terms of Reference. It notes that 24 relevant orders, instructions and procedures may not have been complied with in the course of the Iroquois Black tasking. Given its consideration of these matters, I think the COI rightly assessed the broader context and preceding events, as well as the more immediate accident sequence, relating to the accident.

46. The large number of findings of non-compliance was, reasonably, said to show that the orders, instructions and procedures had not been effective at providing permanent governance; thus there were failings of both design and compliance. Persistent issues around the content of rules and rule breaking had been identified earlier but not remedied.

47. The COI reported that "command effectiveness" in respect of 3SQN had been called into question by earlier reports. At the time of the accident, there was no "functional command system" at a senior level located at Ohakea. Subsequent to the accident, I understand (and the COI records) the RNZAF stood up 488WG at Ohakea to provide direct senior oversight at that base, under the command of a Group Captain.

*Other Issues that may be relevant*

48. Many other issues relevant to the accident were identified by the COI. This section of the report discusses four particular issues: the "can do" culture on 3SQN, the lack of operational risk management (**ORM**) systems, the lack of use of the RNZAF Iroquois Simulator, and various issues relating to this accident connected to the wider RNZAF.

*Summary of findings*

49. The COI report sets out 169 findings. Each finding is set out succinctly and assigned to an appropriate category.

*Analysis relating to each term of reference*

50. The COI report is bookended by a summary of the COI's findings and perspectives in respect of each of its Terms of Reference.

# Source Material – Key Documents and Exhibits

51. Alongside the COI record, a separate set of key Documents was also provided to me (as discussed above). The summary below refers to those Documents to give a sense of what was considered when and by whom. I include my observations only where necessary in the context of this report, out of a concern to protect the privilege or confidentiality of the Documents and the interests of the individuals concerned.

52. The summary below takes a thematic approach to those Documents and the other materials. It groups, according to the aspect of the accident under investigation, both the key Documents that cover that aspect and relevant exhibits or pieces of evidence (such as specialist reports).

53. The "themes" I have used to group the material are as follows:
    a. Materials that relate to the COI process itself. These are limited in space and time to materials concerning how the COI process was run.
    b. Materials relating to the broader accident response. By this I mean the materials that deal with non-COI processes for assessing the causes of and response to the accident.
    c. Materials that consider natural persons that might liable for causing or contributing to the accident. This primarily relates to criminal liability and liability under the AFDA.
    d. Materials relating to technical analyses, e.g. of the equipment used.
    e. Materials relating to the organisational liability of NZDF.
    f. Other materials outside of those categories.

## The COI Process

*Transcripts of witness interviews*

54. The COI heard from 34 witnesses and the record shows that there were many hours dedicated to discussing the circumstances (in the broadest sense) surrounding the accident. Transcripts of witness interviews are included in the COI record. The questions that the COI put to witnesses indicate a concern to ascertain:
    a. The events of 25 April 2010;
    b. What happened in the days leading up to the flypast, including the processes, timeframes, and steps taken in relation to tasking, authorisation, crew selection, briefing, and preparation;
    c. The experience, competency, and personal attributes of the Iroquois Black crews, particularly Black 2's crew and the formation pilots;
    d. The culture and operational aspects of 3SQN and the broader RNZAF;
    e. The content and understanding of the orders, rules and guidance that applied to 3SQN;
    f. The relevance of the various orders, whether they were considered useful, whether they were fit for purpose and complied with;
    g. Who authorised and oversaw the flypast, including command involvement;
    h. The categorisation, training and currency of all formation members, as well as general approaches to such matters on 3SQN;
    i. Various approaches to, experience of, and training relating to flying in poor weather conditions, on instruments, using NVG, and inadvertent IMC; and
    j. RNZAF's approaches to health and safety, including earlier incidents and health and safety reporting and management systems.

55. Each witness was informed of their right against self-incrimination and cautioned before giving evidence that could be harmful to them.

56. A summary of the evidence given by each witness would not be helpful and could compromise the protections given by the AFDA. On that basis, I make observations rather than set out what was said by whom. I note:
    a. the surviving crew of Iroquois Black were all interviewed;
    b. so too was the Authorising Officer;
    c. the psychologist who had worked with the pilot of Black 2 gave extensive evidence; and
    d. training officers and other seniors were called and gave evidence before the COI.

*Exhibits*

57. Even more extensive than the witness interviews are the exhibits that the COI considered. As with the transcripts, I have considered carefully how to deal with exhibits for the purposes not only of privilege but also in terms of what will be helpful to readers. The following canvasses those aspects of the exhibits that need necessarily to be addressed to ensure my findings can be considered in context.

58. In general terms, I note that the exhibits include:
    a. maps of the route (intended and actual) taken by the various Iroquois Black formation members on 25 April 2010;
    b. records of the training and qualifications of the formation members;
    c. notes taken by the formation members immediately after the accident, and a record of interviews they had with seniors prior to engaging with the COI;
    d. records of the planning leading up to the Anzac day flypast;
    e. notes made by other members of NZDF that were presented to the COI;
    f. records relating to the pilot of Black 2 and his engagement with RNZAF's psychologists;
    g. temporary 3SQN orders;
    h. extracts of study guides given to 3SQN pilots;
    i. audit reports, including an audit report in respect of 485WG's 2009 review of 3SQN;
    j. engineering and technical reports commissioned as a result of the accident (some of which are discussed further below); and
    k. a medical report relating to the Iroquois Black crew at the time of the accident.

59. The COI, properly, considered a vast range of exhibits and, in my view, was methodical and reasonable in forming its conclusions.

*Peer Review of the Inquiry – Directorate of Defence Aviation and Air Force Safety – Royal Australian Air Force – 15 September 2010*

60. This review was requested by RNZAF Flight Safety. The purpose was to provide a summary of the assessment of the efficacy of the COI process and methodology from a military aviation perspective. I note that the COI report was not yet available to the Peer Reviewers.

61. The peer review found the methodology used by the COI to be thorough, systematic and robust. The Peer Reviewers were confident the COI would identify the primary contributing factors leading to the accident.

*Crown Law review of the Court of Inquiry process – 10 August and 10 September 2011*

62. Upon request from the Minister of Defence and Defence Legal Services, the Crown Law Office reviewed the process of the COI and the same material from the COI now available to me. Crown Law's advice is privileged. Suffice it to say that the Crown Law advice would have given the Minister considerable comfort.

63. Indeed, completion of this review provides significant assurance in terms of process followed and evidential basis for the conclusions reached. The broad Terms of Reference of the COI and the very

extensive findings and recommendations are likely to be well-founded given the care that was taken and the thorough Crown Law review.

## The Broader Accident Response Process

*Burleigh Evatt Review of the Implementation of the COI's Recommendations following the 2010 Anzac Day Iroquois Crash - 6 December 2012*

64. The Minister of Defence sought assurance through the SSC that NZDF had a robust plan to implement the recommendations of the COI. Burleigh Evatt was commissioned to provide independent quality assurance of the implementation plan and actions taken by NZDF in response to the COI's recommendations.

65. Burleigh Evatt concluded that the majority of recommendations (including all substantive recommendations) made by the COI had been implemented. The outstanding recommendations were expected to be concluded by June 2013. Adequate management arrangements were in place and supported the implementation of the recommendations.

66. The Burleigh Evatt report and process provided a very thorough, professional and expert review of NZDF's response to the COI recommendations. It would have served to give the Minister comfort that the broader causes and responsibility for the crash were identified and addressed.

*SSC Review of Agency Health and Safety Roles and Functions in a Military Context – 10 December 2012*

67. The Anzac Day crash revealed the need for clarity as to which government agency is responsible for investigating alleged breaches of the Health and Safety in Employment Act 1992 (**HSE Act**).[16]

68. These issues arose because the Anzac Day accident was not investigated under the HSE Act. Both the Civil Aviation Authority (**CAA**) and the Ministry of Business Innovation and Employment (**MBIE**) considered that the responsibility for doing so lay with the other entity. A Crown Law opinion of 31 August 2012 had advised that the CAA was not responsible for investigating military aviation incidents and therefore responsibility fell to MBIE. This review did not address the causes of or fault or responsibility for the accident itself. It recommended certain changes to resourcing, law, and policy.

*Mathew McClelland QC review of procedures and performance dealing with families of injured or deceased members – 20 March 2013*

69. This document summarises an independent review undertaken by Mr McClelland QC regarding the appropriateness of RNZAF's interaction with the families of Black 2's crew following the crash.[17] The review appears thorough and found, generally, that there had been fair and reasonable treatment, although improvements could be made in specific areas. It had no relevance to causes, fault or responsibility for the accident.

## Issues of liability

*Service Police Interim report – 31 August 2011*

70. This report considered allegations relating to the planning and conduct of the flypast, ultimately recommending charges against the Authorising Officer for authorising the flight by crew who lacked currency in relevant competencies or qualifications, allowing flying operations below applicable

[16] That Act has since been repealed and replaced with the Health and Safety at Work Act 2015, which came into force in April 2016 and was one of the responses to the Pike River Mine explosion.

[17] Mr McClelland QC's report mentions a report by Laura Gillan relating to her review of RNZAF's handling and management of issues arising out of the death of Black 2's second crewman. A copy of that report was provided to me on request. I understand that report was rejected by one of the families involved and Mr McClelland's review was commissioned and completed to replace the review completed by Ms Gillan.

minima, and failing to supervise categorisation and currency schemes. It also canvassed available defences and limitation issues. The report advised that a six-month limitation period applied such that any charge would need to be entered by 20 September 2011.[18]

*Disciplinary Proceedings – Authorising Officer – HQ NZDF – Directorate of Legal Services – Minute 31 Aug 11*

71. This Minute noted the interim Service Police Report above. It considered the suggested charges and set out the applicable legal framework in respect of charging decisions. The Minute concluded there was insufficient evidence to support charges against the Authorising Officer, *except* for alternatives of (1) failing to comply with written orders (authorising a formation display without being an officer of Squadron Commander status); or (2) negligently authorising such a display for the same reasons.

*Summary Appeal Court decision of Judge Dawson in respect of an appeal by the Authorising Officer – 15 December 2011*

72. This decision relates to the Authorising Officer's appeal against the guilty finding made by the Disciplinary Officer at Summary Trial on 2 September 2011. The charge was for failing to comply with written orders contrary to s 39(a) AFDA by authorising the Anzac day flypast without authority.

73. The judgment canvasses those arguments put before the Judge by the Authorising Officer. The Judge allowed the appeal, quashed the conviction and noted that the alternative charge of negligently failing to comply with written orders could not now succeed and should be withdrawn.

*Service Police Interim report 2 – 30 March 2012*

74. The second interim report focused on allegations that flight authorisation proceeded notwithstanding the lack of currency in flight competencies or qualifications. It also discussed the conduct of flying operations below applicable minima.

75. The Service Police discovered that failings in the supervision and management of personnel, flight safety incidents, training and the categorisation and currency scheme dated back to at least 2006. Those responsible for the operation of the aircraft were said to be liable for charges under the AFDA. Charges under the Crimes Act (manslaughter, injuring) were discussed in relation to the Formation Leader.

*Service Police Report 3 – 11 April 2012*

76. The aim of the third report was to formally advise command of the completion of the investigation regarding allegations against commanding officers, OC 485WG and CO 3SQN. It also set out to identify any additional allegations requiring investigation, particularly in relation to offences connected to the accident. It focussed on the ambit and processes relating to roles within the command structure, rather than on individuals.

77. Ultimately, it found there had been systemic organisational failures (categorisation, currency, culture, orders) rather than specific individual failures that could not (the report said) be addressed by a Service Police investigation.

78. The report considered liability, defences and chances of success in relation to OC 485WG and CO 3SQN. Although there was evidence that could support AFDA charges, limitation issues militated against charging.[19] Further, there was difficulty in recommending charges against individuals when the issues were longstanding, systemic, which pre-dated their involvement, and where evidence suggested higher command was aware of the issues.

[18] Pursuant to s 20(5) AFDA the six-month period runs from when the person ceased employment in the Armed Forces.
[19] Ss 18 and 20 AFDA.

*Defence Legal Services Minute – 12 September 2012*

79. This Minute is addressed to the ACC from Defence Legal Services. It discusses allegations of manslaughter in light of the second report of the Service Police.

80. [redacted]

*Defence Legal Services Minute – 13 September 2012*

81. As with the above, this Minute is addressed to the Air Component Commander from Defence Legal Services. It discussed whether the ACC should refer charges against the Pilots of Black 1 and 3 and the co-pilot of Black 1 under the AFDA following the Service Police report covering that topic.

82. The Minute considered allegations of various AFDA breaches. [redacted]

*Defence Legal Services minute – 13 November 2012*

83. This Minute followed the two above and is addressed to the Air Component Commander. Following the above advice, Defence Legal Services personnel consulted with the Director of Military Prosecutions (**DMP**). [redacted]

*Defence Legal Services Minute – 12 December 2012*

84. This Minute reflected revised advice on negligence charges against the Formation Leader following the views of an additional Air Commodore (and RNZAF expert), [redacted]

85. [redacted]

*Charge notice against Formation Leader – negligently failed to abort the transit flight – 16 April 2013*

86. The charge for negligently failing to perform a duty contrary to s 73(1)(c) AFDA was investigated and dismissed, with reasons, by the Formation Leader's Commanding Officer on 16 April 2013. I am satisfied, from a legal perspective, that the conclusions drawn were available and reasonable.

*Defence Legal Services Minute – 22 April 2013*

87. This Minute provided advice as to command responsibility for the accident. The author revisited the Service Police investigation into allegations as to supervision and administration of the categorisation and currency schemes for 3SQN by superior command.

88. The Minute records that the original investigation was conducted by the Service Police and the report was provided to ACC on 30 April 2012. It was not provided to DLS at that point, however I am advised

[20] This document was also provided to me as one of the key documents. [redacted]

that the ACC took legal advice and made decisions relating to liability at an earlier stage. DLS requested the report from the ACC on 12 September 2012, with a view to assessing whether there might be command responsibility in relation to the accident.

89. [redacted] Liability of other more senior officers was also considered, [redacted]

90. [redacted] It is unclear, then, whether the Minute was primarily concerned about issues of evidence or limitation. Ultimately, however, the Minute agreed with the conclusions of the original investigation team. [redacted]

91. The Documents could give rise to the perception that there was a lack of enthusiasm for pursuing AFDA charges against senior officers and could invite speculation that limitation issues were used to preclude action (when an earlier review might not have had those issues). The ACC involved informed me that was not the case and NZDF advised the limitation issues were already apparent (as noted in the Service Police report). Issues of evidential sufficiency were also live. I am not, therefore, suggesting the result would have differed had this matter been considered sooner, other than to the extent that limitation issues might have been less relevant.

*Defence Legal Services minute – 23 April 2013*

92. This Minute is addressed to the ACC and is a peer review of the conclusions reached by DLS in the above Minute. [redacted]

93. [redacted]

## Technical Reports

*Human Factors Report into Crash for COI – RNZAF psychologist – 20 July/3 August 2010*

94. The Human Factors Report (**HFR**) is a piece of evidence referred to often in the COI report and those reviews and reports that came later. The HFR considers pre-dispositional, precipitating and incident human factors that contributed to the accident.

95. The HFR is thorough and considered. To give a high-level summary:
    a. A number of significant latent and organisational factors were influential. Those included: the training, experience, attitude and subsequent mental models; risk perception and decision making by the pilots concerned, in particular the "can do" attitude of 3SQN; the limits of the Iroquois helicopter leading to avoidance of instrument flying (and restricted

[21] s 20 AFDA.

training); inadequate IIMC and NVG SOPs; the normalisation of routine violations; and the failure of the RNZAF safety audit system to identify the presence of these latent failures.

b. These organisational factors did not prepare the pilots of Black 2 sufficiently to handle the circumstances they encountered.
c. The Formation Leader was influenced by the same latent factors, but in a different way. That influence probably contributed to an underestimation of the weather risk and the decision to operate outside of safe operating practice.

*Exhibit FQ – Report of the Engineering Investigation Team for the COI – 12 November 2010*

96. This report indicates that from 26 April until 5 May 2010 on-site field investigation was conducted with assistance of a CAA investigator. Engineering investigation included involvement of Bell (Iroquois manufacturer), Honeywell (engine manufacturer) and the Transport Accident Investigation Commission (**TAIC**) Inspector.

97. The report shows that the Engineering Investigation Team (**EIT**) utilised the resources of many different areas of expertise. In the end, the EIT was content that all avenues of investigation had been followed to a satisfactory end. There was review and consideration of the helicopter, including tear down and reconstruction.

*Exhibit FZ Impact Analysis Report for the COI (note exhibit FR superseded) – 24 November 2010*

98. Because of the content of other reports this report was limited to wreckage and impact information and survival and survivability aspects, including an assessment of equipment and other factors.

99. The report concluded that the forces likely to have been present at the final impact point were not survivable and noted that it is remarkable that one of Black 2's crewmen survived the accident. The fact that the Iroquois ELT was not 406.025 MHz and GPS capable was found to fail to fulfil RNZAF's obligation to provide an acceptable duty of care to aircraft passengers and crew.

100. The report makes a total of 49 detailed findings. Recommendations specific to the 406.025 MHz ELT and GPS were made. In addition, there is a recommendation relating to urgent inspection of all seat belts and restraints in service in RNZAF aircraft.

*Exhibit GA Air Accident Analysis Report – 24 November 2010*

101. The Air Accident Analysis (**AAA**) Report is another crucial piece of evidence. It discussed:
    a. Evidence of errors that may have been causal or related to the accident;
    b. Personal factors which could have been causal or relevant (further detailed in the HFR);
    c. Whether orders, instructions and SOPS were complied with and relevant;
    d. Decision-making and crew formation/interaction and the likely effect of each;
    e. Active and latent factors related to the accident (contributing factors and root causes);
    f. Organisational and supervisory situational factors; and
    g. Advice on additional equipment or revised processes that would have assisted survivability.

102. The AAA report made a vast array of conclusions. Primarily, it found that the accident was not related to technical failure, that the authorisation and oversight were not as robust as they ought to have been, and that the rules and training were also causally relevant. Issues to do with culture, RADALT use, training, and command were also found.

103. The AAA report's conclusions included:
    a. The accident was not related to any technical failure or unserviceability;
    b. The accident was not caused by other factors such as crew incapacitation, bird or lightning strike, turbulence or icing, or foreign object debris;
    c. The authorisation process failed to properly assess the numerous risks of the event;

d. Rules and regulations in place contributed to the accident;
e. SOPs and other 3SQN material in respect to IIMC procedure were inadequate and RNZAF did not adequately prepare the crews of Iroquois Black for the situation in which they found themselves;
f. RNZAF had largely not adopted ORM as a formal mechanism to identify flight safety risks to aircraft operations at a unit level; a formal ORM process would have identified the risks of each phase of flight and would have better identified and treated the risks in the transit phase;
g. There had been a lack of appropriate and timely engagement between 3SQN leadership and Black 2's pilot to properly manage his professional development;
h. Standing Orders, Temporary Orders and SOPs were inadequate and confusing in respect of a range of relevant matters, including qualifications, competency, low flying and NVG flying;
i. Audits conducted by 485WG had not been effective at ensuring timely and appropriate action was taken to rectify non-compliance issues. The audits did not appear to offer a real indication of the quality of the processes used to plan and execute operations;
j. RADALT equipment and procedures did not provide effective warning compared to modern systems;
k. The risks involved with the flypast and IIMC in particular had not been adequately analysed and treated; and
l. The operating culture of 3SQN prioritised task completion before adhering to orders. Command had been aware of the adverse operating culture and the lack of action indicated serious deficiencies in RNZAF's operational processes.

104. The report reviewed responses to earlier COIs and implementation of their findings and recommendations. COI recommendations into flight safety over the past ten years had resulted in completed remedial action only 47 percent of the time. Indeed, one of the findings noted in the AAA report is that the RNZAF did not have appropriate and effective operational processes to adequately and reliably ensure safe and effective military air operations. The Burleigh Evatt report (above) provides assurance that the same was not true following the Anzac day 2010 accident.

105. The report applied the Reason model and identified various active failures, failed defences and broader environmental, management and organisational issues (summarised above).

106. The final part of the report listed and repeated the findings. It is a very comprehensive analysis of the causes, fault and, to some extent, responsibility for the accident and the resulting fatalities.

107. The AAA report made 10 recommendations to address the causes of the accident, and a number of other observations and recommendations to address other issues identified.

## Private Prosecution of NZDF

*Sentencing notes of Judge W K Hastings – Wellington District Court – 18 July 2014*

108. The last of the key Documents I received related to the private prosecution of NZDF taken by Black 2's surviving crewman. This included the sentencing submissions of both parties, and the sentencing notes of Judge W K Hastings. The case was heard by the District Court at Wellington.

109. The notes on sentencing reflect NZDF's entry of a guilty plea on a charge of breaching sections 5 and 50(1)(a) of the HSE Act in that it failed to take all practicable steps to ensure the safety of its employees by failing to take all practicable steps to ensure that its employees were not exposed to hazards arising from the operation of helicopters while at work. The parties agreed that the level of culpability in the case was high.

110. The Judge identified six particular failings on the part of NZDF. None of those six failings reflect anything beyond the findings recorded in the COI report. The notes record NZDF's efforts at reparation before ordering further payments to the families of each of the deceased and to the surviving crewman. The judge referred to the Burleigh Evatt report and the steps taken by NZDF to address the failings. He recorded NZDF's unreserved apology to the victims, families, and people of NZ.

## Other materials

*Coroner's findings – Coroner Bell – 24 August 2016*

111. The Coroner's findings in respect of the causes of death of each of the deceased were also included in the key Documents that were provided to me.

112. I have reviewed the Coroner's reports, which confirmed that no further recommendations were required (given the extent of the COI process, SSC reports, and others). The Coroner was satisfied that issues raised by the families within her jurisdiction had been addressed, and that the deaths had been investigated by NZDF such that the matters required to be established under s 57 of the Coroners Act were established. She also made mention of the private prosecution against NZDF and of Mr McClelland QC's report.

*Exhibit DG – Inadvertent IMC Procedure (Confidential) – not required by the Court – returned to 3SQN*

113. I note briefly and for completeness that this exhibit has been omitted from the record of the COI; the COI report refers to it being a confidential SOP relating to IIMC procedures. I discussed the exhibit with NZDF and was informed that, in accordance with the Terms and the CAF's authority to release Documents for this review, the exhibit had not knowingly been withheld. Rather, it seems likely that it was omitted from the record of the COI sometime previously. Both the COI report and current NZDF personnel note that the SOP is not particularly confidential, although SOPs are restricted and not usually available for release. NZDF offered to make this exhibit available to me if possible under the COVID-19 restrictions. Having discussed the matter with NZDF and upon consideration of the COI record, I determined it was not necessary to view this exhibit.

# Conclusion

114. Charges against the pilots were considered by the Service Police, Defence Legal Services, the DMP (in respect of the pilots), and the relevant Commanding Officers. Charges were laid against the Authorising Officer and the Formation Leader. The Authorising Officer was convicted at first instance but that conviction was quashed by an appeal Judge. There were, therefore, at least four decision-makers involved (and likely more). Likewise, charges against the Formation Leader were variously considered by at least four decision makers.

115. In civilian life, this might be akin to having an accident investigated, examined and recommended for charge by a prosecutor, then being heard by a first instance judge and an appellate court. Put simply, liability of those with possible responsibility for the accident was examined thoroughly and exhaustively.

116. Consideration of the liability of superior command went through the Service Police and DLS (albeit there were two layers of DLS review). It was not passed, as far as I am aware, to the DMP. Limitation issues may have been the reason why there was no further consideration or review. I am advised that the then ACC considered the relevant Service Police reports and obtained advice upon them. I am also advised that the limitation issues had crystallised already in respect to the key commanding officer (before the final Service Police report was finished).

117. The apparent delay in providing DLS with a copy of the Service Police's third report (covering command responsibility) is possibly anomalous. DLS was tasked with considering the responsibility of the pilots and the Formation Leader for both AFDA breaches and criminal conduct after the Service Police reported on those issues. The Directorate of Legal Services advised on charges against the Authorising Officer after the Service Police delivered its interim report on liability at that level. The reason for the delay, and apparent lack of request, that preceded DLS's consideration of command responsibility is not explained in the Documents, particularly given that expiring limitation periods presented one (of several) factors that militated against pursuing command liability.

118. As noted, I am advised that the limitation issues existed well before the third report and DLS involvement. The then ACC advised that the liability of superior command was expressly considered and discussed with legal advisors (before DLS received the report). It would have been useful had the process (including any decisions not to take further action) been more fulsomely recorded in the Documents. That would have dealt with questions around expiring limitation periods.

119. That being said, the DLS consideration is thorough and well considered. NZDF and the Minister could, in my view, ask questions as to the process followed in reaching the decisions about prosecutions relating to command responsibility. On the Documents the differing process seems anomalous and the delay could give rise to a perception of letting matters drift. I am advised that was not in fact the position, but NZDF could provide the Minister reassurance on the process adopted.

120. Ultimately, NZDF took responsibility for the health and safety failings by way of its guilty plea and sentence in the District Court, in response to the private prosecution by the surviving crewman of Black 2.

121. As stated above, the Minister might seek to receive advice as to the completion of the recommendations made in the SSC review of the role of CAA and MBIE (item 18(e) above) in respect to responsibility for health and safety investigations in this context.

# Appendix 1 – Terms of Reference

**Terms of Reference**
**Desktop Review of Court of Inquiry and other Investigations into the RNZAF**
**Iroquois Helicopter Crash Anzac Day 2010**

To: Mr Michael Heron QC
You are requested to undertake a 'Desktop Review' of the following:

1. the Report of the Court of Inquiry Investigating the Accident involving Iroquois NZ3806 Near Pukerua Bay on 25 April 2010 assembled under section 200A of the Armed Forces Discipline Act and dated 2 December 2011;
2. the peer review of the Court of Inquiry by the Australian Defence Force Directorate of Defence Aviation and Air Force Safety dated 15 October 2010;
3. the advice of the Crown Law Office to:
    a. the New Zealand Defence Force's Director General of Defence Legal Services dated 10 August 2011; and
    b. the then Minister of Defence Hon Wayne Mapp dated 20 September 2011;
4. the Report prepared for the State Services Commission by Burleigh Evatt dated 6 December 2012 entitled "Review of the Implementation of the Court of Inquiry's Recommendations following the 2010 Anzac Day Iroquois Crash";
5. the State Services Commission and Ministry of Business, Innovation and Employment Review of Health and Safety Roles in the Military Context dated 10 December 2012;
6. Service Police Investigation into the ANZAC Day 201 O Iroquois Crash Reports dated 31 August 2011, 30 March 2012 and 11 April 2012.
7. The following legal advice:
    a. New Zealand Defence Force's internal legal advice dated 31 August 2011 concerning offences under the Armed Forces Discipline Act against the officer who authorised the flight on Anzac Day 2010;
    b. New Zealand Defence Force's internal legal advice dated 12 September 2012 to the Air Component Commander concerning whether the officer in charge of the flight should be charged with manslaughter;
    c. Peer review of the New Zealand Defence Force's internal legal advice by Tom Gilbert dated 12 September 2012;
    d. New Zealand Defence Force's internal legal advice dated 13 September 2012, 13 November 2012 and 12 December 2012 concerning offences under the Armed Forces Discipline Act against pilots and co-pilots of the other helicopters involved in the flying operation in which the Iroquois crashed on Anzac Day 2010;
    e. New Zealand Defence Force's internal legal advice dated 22 April 2013 and internal peer review dated 23 April 2013 concerning command responsibility for the 2010 Anzac Day Helicopter Crash.
8. Summary Appeal Court decision of Judge Dawson dated 15 December 2011 in respect of an appeal by [Squadron Leader];
9. Decision of Disciplinary Officer [Wing Commander] dated 16 April 2013 in relation to charge under section 73(1 )(c) of the Armed Forces Disciplinary Act against [Formation Leader];
10. Report by Matthew McClelland QC concerning the identification, notification and treatment of next-of-kin following the crash dated 20 March 2013;
11. The Findings of Coroner Bell in relation to the Inquiries into the [Black 2's deceased crewmen], all dated 24 August 2016;

12. Submissions by Counsel for [Black 2's surviving crewman] and Counsel for NZDF in … CRl-2014-085-007231 and the Notes of Judge W K Hastings on Sentencing dated 18 July 2014 in;

for the purpose of advising me whether the documents identified have comprehensively addressed the causes of and fault or responsibility for the Anzac Day crash and the deaths of [Black 2's deceased crewmen] and the serious harm injury to [Black 2's surviving crewman]; and

if not, what additional aspect of the causes of, fault or responsibility for the Anzac Day crash and the deaths or harm to those officers and airmen remains to be addressed and how that additional aspect could be addressed and by whom.

Any other matters you consider relevant.

In making your report:

a) you should assume that the report itself is likely to be made public;
b) all legal advice provided at 3. and 7. above in relation to the Anzac Day crash is released to you solely for the purpose of undertaking your report, in order to provide me with advice. However, the legal privilege applying to all the legal advice is required to be protected and therefore you are to complete your report in a way that does not quote or summarise the legal advice or refer to it in a way that might be inconsistent with the privilege attaching to the legal advice;
c) the names of all persons investigated by the RNZAF Police for, but not charged and tried with any offence, are to be kept confidential for reasons of privacy and therefore information which may identify an individual should not be included in your report;
d) note that the Chief of Air Force has authorised release of the Record of Proceedings under section 200T of the Armed Forces Discipline Act to you and any junior you have engaged to assist in this matter;
e) note the protections provided to individuals giving evidence to the Court of Inquiry in section 200N of the Armed Forces Discipline Act and the requirement for confidentiality of evidence submitted to the Court of Inquiry to be maintained in accordance with section 200S and T of the Armed Forces Discipline Act; and
f) note the requirement to comply with the principles of natural justice in relation to the procedure and conduct of your review, in the event you propose to make a finding that is adverse to any person, and ensure the person is aware of the matters on which the proposed finding is based and has had an opportunity in the course of your review to respond to those matters.
g) Your completed report should be submitted to me no later than 31 May 2020.

Should you wish to provide privileged legal advice based on any material provided to you, in relation to any matter covered by your report, this should be dealt with in a separate letter which is subject to legal professional privilege.

If, due to unforeseen circumstances, you cannot meet the date for submitting your report to me you may seek an extension from me explaining those circumstances. In the event you require technical assistance with military aviation matters, Squadron Leader David Woodhouse, Royal New Zealand Air Force is available. You may contact him on [redacted] or at: [redacted].

Mr Nigel Lucie-Smith, Manager Resources Law, New Zealand Defence Force, is available [redacted] or at: [redacted] should you require any liaison assistance, or need to notify any person to ensure natural justice principles are complied with.

Dated at Wellington this 4th day of December 2019
Hon Ron Mark
Minister of Defence