

11<sup>th</sup> July 2022

Penny Nelson,
Director General
Department of Conservation
Manners St
Wellington

Dear Penny,

## Wanaka Helicopter Crash

Following on from this tragic incident and the various reports that have been produced, you requested an independent review of:

- the PWC report and any other relevant documentation,
- the DoC responses to the PWC key findings and recommendations,

with the output being a report that outlines to you the levels of assurance that can be taken from the DoC response to the findings and recommendations.

The timeline for producing this report has been quite short and in order to meet the delivery date has had to be conducted through review of documents and phone/email. No physical verification of changes has been undertaken.

My findings are as follows:

The Wanaka tragedy led to considerable 'soul searching' within DoC to ensure that all relevant lessons could be learnt, and steps taken to prevent a recurrence. This learning took place at both a tactical and strategic level with different processes identifying issues related to helicopter operations generally and other at how risk in programme delivery were managed. A third piece of work tried to identify cultural factors that might influence behaviour.

The three pieces of work were somewhat disjointed in time, scope and management leading to some gaps, overlaps and inconsistency. Some staff felt disenfranchised by the process and that their perspectives had not been fully acknowledged.

Concerns about the sensitivity of the issues and people involved meant that there was sometimes a lack of transparency and some internal systems, for example for corrective action tracking, were not used, leading to a lack of formal close out of a few items. At least one of these relates to a long-term programme of work on critical risks, which includes, but was far wider than helicopter operations (and hence was not expected to have been completed within the same timeframe).

The management of the PWC report appears to have been contentious, although we consider its content and findings to be reasonable (but note some unresolved issues of disagreement). In our view it is appropriate for governance or senior executives to seek contestable advice in relation to complex issues, but to acknowledge that in seeking different opinions there may not be uniformity of

conclusion.

What is important is how those in senior roles use the insights to guide their path-rather than slavishly accepting and following all advice -or rejecting the whole report because they disagree with aspects of it. In this instance DoC's response indicates that it did accept all the findings (to a greater or lesser degree).

Much has changed since 2018 and there are now new investigation processes in place to provide direction and clarity around how to respond in challenging circumstances. One observation we make is that more use should be made of fully independent investigators who are both potentially more experienced, but also detached from DoC and the people involved. Investigating the deaths of longterm colleagues and your own organisation's processes puts a burden on internal staff that is perhaps unreasonable.

At a time when there are also regulatory investigations underway it may make sense to consider the use of legal privilege-not to hide anything, but to ensure that information in managed sensitively and appropriately. Again, using external investigators makes this easier.

One area that the PWC report has highlighted is the impact of the external context around the Tahr programme on its execution and how responding to rapidly evolving and conflicting political, stakeholder and media pressures disrupted the normal chain of command and decision-making processes. This appears to have still been evident in early 2019 when the programme was restarted.

You asked us to indicate the level of assurance that you can have that DoC has learnt lessons and responded appropriately to the findings and recommendations. Within the timeframe available (as noted above) we have only conducted a desk top review but, in our view, DoC has demonstrated organisational learning at management and operational level and has formally closed out the vast majority of recommendations at a system level. It is also embarking on a culture change programme to try and embed the right attitudes and behaviours to temper enthusiasm and commitment with structured dynamic risk assessment processes.

Ongoing monitoring of the effectiveness of these changes in practice will validate the extent to which they have become embedded in the DoC psyche. It will also be important to ensure that the reasons behind the modified systems and process are clearly articulated to new staff and reinforced during organisational restructuring.

Our conclusion is that you can have a *moderate to strong* level of assurance that change has occurred in the short to medium term, but, as the underlying inherent risk factors are still present, long-term controls assurance can only come from periodically testing and validating them in practice.

The tragedy that occurred at Wanaka in 2018 will have a lasting impact on DoC and all those involved. It is clear that the strategic context to the Tahr programme was far more complex and disruptive than was fully appreciated at the time. Lessons have been learnt and applied. External review, whilst painful, is an important part of seeking assurance and verifying that nothing has been missed.

From the information we have been provided with we consider that DoC has made considerable progress in its approach to these challenging programmes and is now devoting more, dedicated, senior management focus to them.

From a health and safety and risk management perspective there is a growing maturity of approachparticularly in the critical risk management space, and DoC is now leading the way (with other agencies) in setting and monitoring appropriate standards for helicopter operators engaged in high-



risk activities.

Thank you for engaging us to carry out this important review.

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