MHKC

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Independent Review - Civil Aviation Authority

Review of the management systems, procedures and practices operating within the investigation and enforcement function, including the way in which expert evidence is obtained and managed and to identify any changes that may be required to the Authority's regulatory policies or practice.

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Executive Summary

1. The Civil Aviation Authority (**the Authority or CAA**) has a highly experienced, expert and passionate team who seek to perform their role and fulfil the Authority's objectives to the best of their ability. We do not question the individual capability within the Investigation and Response Unit (**IRU**) but complex investigations require much more than that. To us, the issue is with cohesion, culture and improving areas of investigative practice particularly around complex investigations.

2. Our interviews identified overwhelming support for some level of change as a result of this review.

3. We summarise our recommendations below.

Clarity and direction from leadership

4. The Director to clearly set out his expectations for the IRU within the Authority and the way in which he wishes it to operate. Some key concepts that come to our mind are:

    a. the regulatory role is given appropriate emphasis (recognition of its importance and a change from the current approach);

    b. consistency and transparency across investigations without unnecessary premature definition;

    c. firm but fair decision-making.

5. Senior Management to assist the Director to guide the organisation towards change, including:

    a. clarity of direction (written policies and procedures);

    b. hands on direction (facilitated workshop with IRU);

    c. training, mentoring and monitoring of performance.

IRU - a general investigation unit with multidisciplinary expertise, working collaboratively

6. Our recommendation is that IRU investigations commence as general investigations, coded as such, and remain so until there is sufficient clarity to close off any particular outcome. Investigations will produce safety learnings but not to the exclusion of the regulatory role. If the goal is to create safer skies, working together as one with a common purpose, accepted within the IRU and the Authority, will advance that. The aim is to avoid inconsistency in approach by different teams/investigators.

7. Comprehensive training for investigators on the initial fact gathering process including matters such as preserving chain of custody; asking the right questions of the right persons and cautions pursuant to the NZ Bill of Rights Act 1990 etc. Training around Part 12 of the Rules is also needed and, in particular, clarity around what the rules do and do not prevent in investigations.

8. We consider our recommendations require cultural, operational and policy changes. We do not make comment on whether structural change is required other than to say there are good arguments for and against that, and significant expertise exists within the unit to ensure changes are operationalised. The key is to maintain and build on existing expertise.

Investigation process

9. We see real benefit in appointing a multidisciplinary panel (or equivalent) at the outset of any "significant" investigation (discussed further) to assist it through to the end of the 12-month investigation period and to attend a final de-brief session. Less significant matters may be able to be triaged in the existing fashion.

10. The process to be adopted ought to be developed from within the IRU and workshopped with all relevant members. Some suggestions are as follows:

    a. The multidisciplinary panel could be a rotating rostered group including members of IRU, Legal and the relevant operational units. It would also be helpful to include an external expert in this panel as early as possible (their involvement however being more limited to preserve their independence).

    b. Set timeframes and milestones for each stage of the investigation.

    c. A co-ordinator or project manager be appointed within the multidisciplinary panel to manage the timelines and call milestone meetings.

    d. Robust and open discussion to occur around all relevant aspects of the file including the identified key issues, the information gathered to date, the direction the case should take, where the case sits in the regulatory priority (including likely regulatory tools), potential defences (if relevant) etc.

    e. Milestones such as those adopted by WorkSafe, with appropriate adjustment, be followed and reported against. For example, the end of the timeline could be that the IRU7 is completed by the 9-month mark and the IRU3 is sent to the Decision-Making Panel by 10 months (or similar). This should then give the Decision-Making Panel and external counsel enough time to take a considered view and ask any questions.

    f. The Decision-Making Panel to meet to discuss significant cases, rather than a simple email sign-off process as can occur currently (accepting the current process is often due to time constraints).

g. All significant meetings and decisions on investigations, even for no further action, to be documented in some form.

h. Early engagement of experts and well in advance of the completion of the IRU7.

i. A panel of external expert witnesses be developed and, for any complex case, external experts to be appointed. Internal experts continue to be utilised but without an expectation of appearing as a witness in adversarial proceedings.

j. A careful approach to be taken to Health and Safety at Work Act 2015 (**HSWA**) cases. Causation should only be alleged in clear cases and where there is external expert evidence to support it.

k. IRU to utilise the full range of regulatory tools available to it and be clear and consistent in terms of when which tools are used and why.

l. During an investigation, information to be requested from all relevant operational units and clear guidance to be given on what is required. This is emphasised as part of the investigative process.

m. Much greater clarity and guidance as to the role of in-house legal in the investigative process and their role in relation to external counsel.

Update policies and procedures

11. Policies and procedures to be updated to reflect the changes which arise from this Review and to reflect the post-Operational Design Review (**ODR**) structure. Alongside this, face-to-face training and guidance around the new processes.

12. An integrated document management system (which we understand is in process) to be prioritised to make the sharing of information between units more efficient and effective and ensure the Authority meets its criminal disclosure obligations. It is crucial that any document management system be used in a consistent manner by all staff across the Authority.

Facilitated Workshop

13. There are invariably cultural changes required to make a shift to a different way of working and to move to a more effective operational culture. The impact of the ODR, Covid and physical dislocation cannot be underestimated. We recommend that a mechanism for expressing, confronting and attempting to resolve cultural issues, in a safe way, be explored. There is plenty of available expertise to assist with this and we are happy to recommend the same as required.

Background to Review

14. On 16 June 2019, a fatal collision between two aircraft occurred at Hood Aerodrome in Masterton. Tragically, the pilots of each aircraft, Craig McBride and Joshua Christensen, lost their lives.

15. The Authority investigated and laid charges against Mr Christensen's employer, Sky Sports Limited (**SSL**) and its director under HSWA (referred to as the **Hood case**).

16. The charges centred on allegations that SSL and its owner had not done enough to ensure that its staff followed safe flying practices, and that SSL allowed Mr Christensen to deviate from local flight path rules. It was alleged that it was this deviation that caused the crash.

17. As part of the trial process, the defence commissioned expert evidence which was provided to the Authority approximately nine days before the commencement of the trial.

18. The defence expert evidence focussed on an alternative view of the key crash factors which put the Authority's position on causation in doubt. While the defence evidence was only received just prior to trial, alternative theories on causation could have been explored earlier.

19. The defence evidence also included email correspondence with business units within the Authority (other than IRU Team 1 that carried out the investigation) pertaining to, inter alia, requests in 2015 and 2017 to change the radio frequency at the Hood Aerodrome for safety reasons. These requests were not supported by the relevant Authority business unit, but another business unit had advised Hood Aerodrome management that the Authority was carrying out a review of the aerodrome operations.

20. The defence suggested that the evidence above, combined with evidence from past and present Authority staff, would show that the rule deviance was justified on safety grounds, despite being in opposition to the relevant Aeronautical Information Publication (**AIP**).

21. While this did not necessarily change the Authority's view as to the cause of the collision, the Authority considered upon review that the evidence was persuasive and could be accepted by the Court or at least raised reasonable doubts about the Authority's theory of the case.

22. The charges were withdrawn on the basis that it was no longer reasonable nor in the public interest to proceed with the trial.

23. A Transport Accident Investigation Committee (**TAIC**) report on the accident found that Mr Christensen had failed to give way but did not make any comment on the AIP compliance nor look at the health and safety issues arising from the accident.

24. The TAIC Report made several criticisms of the Authority's oversight of the aerodrome and made recommendations for the Authority to consider. The CAA intensified its safety at

uncontrolled aerodromes as a result and commenced a work programme to address these recommendations as appropriate.

25. This review has been informed by the Hood case but (as noted in the Terms of Reference) that case is not the focus of this report. We found that the issues arising from the Hood case are indicative of wider issues and are for general consideration.

Purpose and Scope of Review

26. The purpose of this review is to ensure the Authority's investigation and supporting functions are working in a cohesive, coherent and effective manner, meeting their strategic and regulatory obligations and goals.

27. The Review is a thorough examination of the investigation functions informed by the background of the Hood case, aimed at strengthening the operation of the investigative and enforcement functions and producing optimal outcomes for the Director, the Authority and the sector.

28. A copy of the Terms of Reference is attached at **Schedule 1**.

Methodology

29. This review has been conducted with the assistance of barristers, Erin McGill and Jane Barrow.

30. As part of the review, we interviewed:

    a. over 20 CAA employees across a range of different units (as per clause 9(a) - (e) of the Terms of Reference);

    b. two external Crown prosecutors that the Authority engages to carry out its Civil Aviation Act (**CA Act**) and HSWA prosecutions;

    c. two defence counsel who regularly defend prosecutions brought by the Authority; and

    d. the National Manager: Investigations at WorkSafe, the Director of Land Transport at Waka Kotahi and the General Manager of Investigations at Maritime NZ (to understand the approach of other agencies to investigations).

31. We have also considered numerous documents provided to us by the Review Steering Group and interviewees and examined aspects of other regulatory and enforcement processes both in New Zealand and internationally.

32. We wish to thank all those we interviewed for their informative insights and candid approach in discussing the issues.

33. We have conducted our review with reference to the Terms of Reference. We have however focussed this report on the key areas from the Terms of Reference where we see room for improvement and on our recommendations for change. This approach was discussed and agreed with the Steering Group in the course of the review. We remain able to include further detail as required.

Statutory Framework

CAA's Powers of Enforcement

34. An important part of the CAA's role is to take enforcement action, including prosecutions, to ensure and maintain the safety and security of New Zealand's civil aviation system.

35. The CAA is empowered to undertake enforcement actions under the Civil Aviation Act 2023 and HSWA.[1]

36. Simply put, these powers range from inspection and examination powers to powers to bring criminal proceedings or to seek injunctions from the Court. Under the CA Act, these powers must be exercised independently and without direction from any other person, including the Minister.[2]

37. These powers, both under the CA Act and HSWA, are set out in more detail in **Schedule 2**.

Findings

Current IRU process

38. Investigations are carried out by the Authority's IRU which is part of the broader Aviation Safety Group. IRU is made up of three teams:

    a. Team 1: Regulatory

1 The CAA is also an enforcement agency under the Hazardous Substances and New Organisms Act 1996 but we have not expressly considered its enforcement powers under that Act for the purposes of this review.

2 See section 32(3)(c) of the CA Act. The current director of the CAA is male and so is referred to as "him" or "he" throughout this report.

b. Team 2: Safety

c. Team 3: Aviation Related Concerns (**ARCs**)

39. We have been provided with the current structure of IRU and some statistics around investigations. A snapshot of the operation of the IRU and its predecessors is depicted below. This provides important context to our comments. Further details of the IRU are contained in **Schedule 3**.

Investigations opened and completed since the beginning of this financial year 01/07/2022 to today's date

Investigation Type	Investigations Opened	Investigations Completed
Aviation Related Concerns	417	404
Regulatory	14	20
Safety and Security	320	301
Section 15A	1	1
Total	752	726

Regulatory Enforcement Investigation outcomes over a 5-year period (financial years)

Outcome	2018 -2019	2019 -2020	2020 -2021	2021 -2022	2022 - present
Educational Letter	-	-	3	1	1
Infringement Notice	27	22	9	9	5
Improvement Notice	-	-	-	1	0
No Further Action Taken	3	7	3	9	3

No Offence Disclosed	-	-	-	5	1
Written Warning	8	16	20	4	4
Referred to Other Agency	-	2	-	-	2
Summary Prosecution	5	7	7	1	4
Total	**43**	**54**	**42**	**30**	**20**

Other investigations completed by IRU from 2018 - current date

Outcome	2018-2019	2019-2020	2020-2021	2021-2022	2022- present
Safety investigations	357	317	400	334	TBC
ARC investigations	728	662	578	549	404 (up to today's date)
15A investigations	5	3	0	0	1

40. We were provided with an outline of how it is intended that an investigation is commenced and then developed. In practice, these steps are not always being followed. We describe the current investigation process as best as we can below, noting that it is not being followed in all respects in all cases:

    a. When there is a serious harm or fatal aviation accident, the NZ Rescue Coordination Centre notifies the CAA Duty Investigator who then informs the CAA Duty Manager of the accident. Each month the IRU Manager, Team 1 manager, Team 2 manager and Team 3 manager each take turns being Duty Manager for a week.[3]

3 We note there are many different ways that investigations are triggered but we focus on the serious harm/fatal accident example here.

b. The Duty Investigator notifies TAIC of the accident and TAIC advises whether they will be opening an investigation into the accident. TAIC will open an investigation for most commercial aircraft accidents (which in turn means the requisite ICAO safety investigation is handled by an independent entity as per ICAO requirements). TAIC rarely investigates private aircraft accidents and notably focusses its attention on air transport and commercial operations (which corresponds with the Authority's regulatory priorities discussed below).

c. Team 2 then deploys to the accident scene and assists the Police/TAIC as appropriate or if there is no Police/TAIC investigation, Team 2 leads its own investigation at the accident scene.

d. There is a CAA team coordinator who works with the Duty Investigator to do the logistical planning for IRU (normally not at the scene) while the scene work is being carried out by Team 2. The logistical planning involves managing the logistics of deploying Team 2 to the scene including, for example, arranging flights, accommodation, or helicopters to remote accident scenes. Once Team 2 is deployed, the IRU Manager and Team 2 manager take over responsibility for the initial scene investigation and the Duty Investigator returns to their duty role. The relevant operational unit should also be involved at this stage to determine matters such as whether the company involved in the accident should continue to operate, if they need support etc. It appears however that in recent times, the operational units have not been involved at this stage as intended. We note that this involvement is a critical part of the process in our view.

e. If TAIC is investigating, IRU will still look at the relevant parties involved in the accident to determine whether there are areas that CAA should be looking into (e.g. is the operator still safe to continue operations; are there potential CA Act, rule or health and safety breaches to consider; or is further oversight required by CAA operational units such as audits, spot checks etc). IRU will discuss the issues with the relevant CAA operational unit manager who is responsible for the area of concern. This may result in the operational units (e.g. Certification, Monitoring or Inspection) considering other action depending on the circumstances.

f. The intention is that regular briefings occur which include persons such as the DCE Aviation Safety Group ("**DCE AS**"), IRU Manager, Team 2 investigator in charge, manager of the relevant operational unit/a team leader from this unit, and a member of the in-house legal team. These briefings are not always occurring however, or are not always including all of these units. The first briefing ideally occurs after the first week where the team meets to receive updates and make decisions on the appropriate response. The responses may include assigning investigators to roles (e.g., safety investigator for the scene, HSWA/Regulatory investigator, subject matter investigator) and other responses that may be required by other operational units within CAA.

g. For most significant investigations, the DCE AS will create a Terms of Reference for the investigation after the first briefing.[4] The IRU Manager usually completes a draft Terms of Reference for the DCE AS for expediency. The Terms of Reference follows a template and includes timelines, the investigation plan (including who across the Authority may be required to assist) and the information that the IRU investigators have at that stage of the investigation. The Terms of Reference is provided to the DCE AS for review, agreement and signing. Once signed, it is distributed to all involved in the investigation.

h. There should then be further briefing sessions after the second week and then every month thereafter where decisions are made as to which direction the matter should take. The Team Co-ordinator attends these sessions to take minutes and note action points. These further briefings are however not always occurring (again, we emphasise their importance).

i. If a decision is made that Team 1 should lead the investigation, the file is allocated to that team, the relevant work request opened by the Team Coordinator, and from that point on the assigned Investigator in Charge manages the process, with the Team 1 Leader overseeing. As the investigation progresses, the Investigator in Charge, Team 1 Leader, IRU Manager and the relevant operational unit manager will meet, be briefed and will decide which direction the investigation will take and how it is resourced. The operational unit with oversight of the matter should also be involved in the regular briefings and provide input into the direction of the investigation but this is not occurring in all cases at present. There do not appear to be structured milestones to be met as part of the investigative process (although it is obvious that there is a limitation period for any prosecution).

j. If a prosecution is to be commenced under the CA Act or HSWA, the CAA has 12 months from the date of the accident (or the date it becomes aware of the incident) to lay charge(s). The investigator prepares an investigation report prior to this 12-month period, known as an IRU7. That report is sent to the IRU Manager who then prepares an Investigation Action Cover Sheet, known as an IRU3, which makes a recommendation. The IRU3 is distributed to the DCE AS, Chief Legal Counsel and the Manager of the relevant operational unit for sign off (**Decision-Making Panel**). The three members of the Decision-Making Panel generally either confirm the recommended action by email, or they may ask further questions/request a discussion.

k. If it is agreed that charges are to be filed, the file is transferred to external prosecutors on contract to the CAA (currently two Crown Solicitor's offices). The external prosecutor may also have been engaged earlier in some cases. The external prosecutor assesses the file and provides advice on evidential sufficiency and, to a degree, public interest

4 Terms of Reference are also created for investigations commenced under section 15A of the CA Act.

factors. The DCE AS and the Chief Legal Counsel consider this advice along with the relevant public interest factors and determines whether to proceed with a prosecution.

Current policies and procedures

41. CAA is subject to policies and procedures, which set out its overall vision for itself and how it implements that vision. Notably, only two of the policies discussed below, the Prosecution Management Policy and the Regulatory Enforcement Policy, reflect the post-ODR structure. We understand there are resource and personnel reasons behind the delay in updating the relevant policies to reflect the new structure. This will naturally need to be attended to once this Review is concluded.

42. The policies form a hierarchy, beginning with the Statement of Intent and Statement of Performance Expectation, which set out the Authority's expectation for itself.

43. These Statements establish the CAA's overall vision and purpose - "A safe and secure aviation system – so people are safe, and feel safe, when they fly", its values and its overarching pathways for achieving this.[5] The Statement of Performance Expectation establishes the Authority's outputs or goals.[6]

44. The Authority's vision, values and pathway inform its regulatory strategy, which is set out in the Regulatory Safety and Security Strategy (the **Strategy**).[7] The Strategy provides an overview for CAA's regulatory practices, including its direction and intentions, the regulatory models it uses and how it delivers on its regulatory functions.

45. The Strategy supersedes and replaces the Use of Regulatory Tools Policy and Regulatory Operating Model (which we were originally advised remained operative). The regulatory decision-making model is designed to guide CAA personnel to deal with aviation safety and security risks with guiding principles. The guiding principles are (i) public safety and security are paramount; (ii) a safe and secure aviation system is a shared responsibility; and (iii) collective learning and continuous improvement are critical. The model proceeds in a series of stages leading from gathering information, assessing the relevant situation, determining and delivering a response, then assessing the impact.

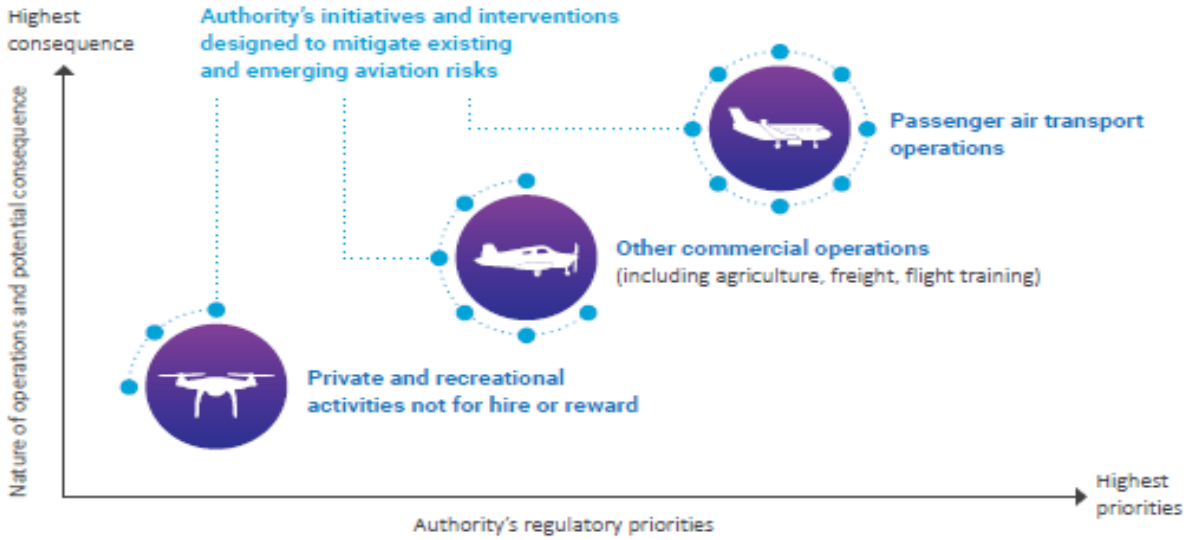
5 Its values are collaboration (me mahi tahi), transparency (me mahi pono), integrity (me mahi tika), respect (me manaaki) and professionalism (kia tu Rangatira ai). Its pathways are leadership and influence, active regulatory stewardship and professional regulatory practice.

6 The current Statement is for the period 2022/23 and contains outputs classes such as policy and regulatory strategy, outreach and certification and licencing.

7 Currently 2022-2027.

46. The regulatory priorities vary according to the nature of operations and activities, as demonstrated by the figure below from the Strategy:

Figure 3: Our regulatory priorities in relation to the nature of aviation operations and activities



47. The civil aviation system is essentially a closed system, with CAA responsible for controlling entry, providing assurance across the system and its participants, and for identifying and addressing situations of risk and non-compliance. Naturally, it is also responsible for controlling the exit of participants. The life cycle is demonstrated by the diagram below:

Figure 4: Life cycle of aviation documents

48. The regulatory decision-making model is designed to be intelligence-led, risk-based, with appropriate assessment of the relevant public interest factors. This generates a response which reflects the orthodox regulatory pyramid.[8] For example, where there is a poor understanding of risk and the requirements for minimising it, then advice and education to participants may be the best option. Where there is imminent exposure to harm, then administrative action to restrict privileges may be warranted. Where there has been repeated or reckless behaviour, enforcement action may follow.

49. Some of the critical considerations noted in the Strategy include direct operational involvement leading to intelligence as well as relying in large part upon high-quality reporting by participants. CAA prefers not to take enforcement action against those who fully report details of incidents and accidents, although that is tempered in situations of incomplete reporting or reckless or repeated unsafe behaviour.

50. Decisions regarding the choice of regulatory activities and interventions must be well-documented, capturing the evidence considered and the reasoning behind the decisions taken. This assists to ensure transparency, impartiality and fairness.

51. The core operational regulatory functions include investigation and administrative and judicial action. Investigation means CAA examines accidents and incidents to ascertain what happened and why, and to determine appropriate responses. CAA has a range of administrative and judicial actions available to address risk, to change behaviour, and to impose or seek penalties.

52. The Strategy notes three main purposes for carrying out investigations:

    a. To determine cause and to prevent a recurrence (**causal**);

    b. To determine the nature and extent of any safety or security risk involving a document holder (**administrative**);

    c. To determine if the law has been contravened (**enforcement**).

53. It is noted that following the conclusion of an investigation it might be appropriate to take administrative action and/or enforcement action. The management of these separate processes is noted as important to ensure the principles of natural justice are upheld and in the case of prosecutions, that the Solicitor-General's guidelines are adhered to.

54. There is nothing in the Strategy which suggests that investigations must be operationally separated depending on the intended purpose (and indeed that purpose may well develop, expand or contract).

8 See for example http://johnbraithwaite.com/responsive-regulation/

55. The Strategy sits above the Regulatory Enforcement Policy. This policy aims to provide clear guidelines for the application of the Director's enforcement powers. It outlines the principles used to determine whether an investigation should be triggered, how CAA conducts its investigations, approaches that should be considered when action is taken and responsibilities and roles of Authority staff within the decision-making process as it applies to actions. The policy goes into detail on matters such as the Search and Surveillance Act 2012, requests for information and the need for proportionality and consistency in enforcement decisions.

56. The Regulatory Enforcement Policy includes consideration of alleged breaches of HSWA and HASNO legislation and requires investigators to consider broader enforcement options such as improvement notices or prohibition notices. Other HSWA specific options such as enforceable undertakings are not considered and may need incorporation into the policy in due course. The more complex questions of interaction between offences under the CA Act and HSWA are not covered. We consider that these issues are likely to be very fact specific and are better dealt with in the context of the specific investigation with specialist advice.

57. Beneath the Regulatory Enforcement Policy are various specific policies including:

    a. Prosecution Management Policy – this policy sets out the role of staff within prosecution management, instruction of the Crown Solicitor, charges and management of the case as it progresses through the court system. This policy appears to be current.

    b. Infringement Notice Procedure – describes the enabling provisions (including unruly passenger offences) and process of infringement notices. This policy appears to be reasonably current.

    c. Warning policy – this appears to be a work in process, although the essence of it is contained within the Regulatory Enforcement Policy and a template warning letter, each consistent with the Solicitor-General's guidance on warnings in the criminal setting.[9]

    d. Investigation Management policy – this establishes the way that IRU effectively manages an investigation. Specifically, it allocates and assigns responsibility, record keeping, procedure, how to generate a file and timeframes. It also sets out the specific documents that should be logged and when, and the sign-off process. This policy needs to be updated to reflect the organisational changes, the Strategy, HSWA and other relevant changes (including to reflect any outcomes of this review).

    e. There is also an Investigation Planning document which sets out the procedure for how to plan an investigation.

9 https://www.crownlaw.govt.nz/assets/Uploads/GuidlinesProtocolsArticles/Solicitor-Generals-Guidelines-for-Warnings.PDF

58. Finally, CAA has developed an information and record keeping policy to ensure that regulatory, evidentiary and accountability standards are met in relation to information gathered, as well as a Use of Safety Information Policy, which defines how safety information gathered is used and protected.

59. It is noted that Team 2 (Safety investigators) have separate and detailed policies as to their operation when undertaking "safety investigations". For example, the Safety Investigator Responsibilities Policy (8 July 2009) and the Serious Incident and Non-Fatal Accident Report referral to the Operational Group (11 May 2012). These reinforce the current view that "safety investigations" are different in kind from regulatory or enforcement investigations, with the express aim being to report on the circumstances and causes of the event investigated, with a view to avoiding similar occurrences in the future (refer clause 6).

60. Safety investigators follow the process in ICAO Annex 13 and reach conclusions on the balance of probabilities (rather than a criminal standard). If, during the course of a safety investigation, it becomes evident that a certain threshold of conduct has been reached, the investigation is put on hold and the matter formally referred to the manager of the operational group. Such conduct includes carelessness, unnecessary danger, intentional non-compliance, recidivism and/or false or misleading information provided to the Authority.

61. Team 2 (Safety) and Team 3 (Aviation Related Concerns) have detailed guidance on their processes, timeframes and reporting requirements.

Investigation process, triaging of cases and timeframes

62. We are told that one of the goals of the ODR was that IRU would work more cohesively together as one unit. As part of this, IRU would look to undertake general investigations (i.e., not divided into safety or regulatory at an early stage) with multiple possible outcomes. Those outcomes could span from an investigation resulting in no further action, to a no-fault safety outcome, through to an educational approach, improvement notice, or prosecution at the most serious end. This is consistent with the Strategy outlined above.

63. Our interviews revealed however that the three IRU teams are continuing to largely work as they did pre-ODR with quite different aims and processes to each other. A common description of them is that they operate "in silos".

64. The siloed approach appears to be exacerbated by Covid occurring around the same time as the ODR. The CAA then had to move out of its premises which meant people were working across different buildings and from home. Currently, the flexible working environment means that it is difficult to meet in person or work alongside the team at any one time. Working remotely contributes to this issue.

65. Above we have described the process of commencing an investigation which involves both Teams 1 and 2 (and in some cases, Team 3). In theory, the teams work together, form a plan and then decide which track the case should go down (the safety track or regulatory track).

Although this is the intention of the Unit, this process does not work cohesively in practice and in our view is too binary (one or the other, rather than aspects of both). The process and decisions during this phase are not necessarily well documented or tend reinforce the siloed nature.[10]

66. The Regulatory Enforcement Policy describes the process:

> An investigation may be considered following the review of initial facts related to a reported breach, occurrence, or concern. The initiation of an investigation should not preclude the application of other regulatory tools. In particular, it should be noted that anything presenting an ongoing risk to safety should be addressed with priority and without waiting for the outcome of an investigation.

67. The policy notes the factors which will inform the commencement of an investigation and states:

> The CAA prefers not to take enforcement action against those who fully report details of accidents and incidents pursuant to Civil Aviation Rule Part 12. However, enforcement action is more likely to result when reporting is patently incomplete, or inaccurate, or reveals reckless or repetitive at-risk behaviour. Where it is identified that the participant is the subject of more than one intervention (e.g. audit or section 15A investigation), co-ordination of those investigations will be undertaken to ensure consistency.

68. Once it is decided that a case will proceed down the regulatory track (and this appears to be decided early on in an investigation), the case is then managed by Team 1, and Team 2 is engaged to assist as and when they are required. The impression some conveyed is that there appeared to be an element of predetermination that once a case is allocated to Team 1, it will progress towards enforcement action (and more likely prosecution). Historic numbers do not necessarily support that conclusion but the perception remains.

69. Other matters become (or remain as) Team 2 matters and those will be managed by that team and most result in no-fault safety recommendations. The perception of pre-determination in Team 2 matters exists as well – ordinarily once allocated, the investigation will progress towards a safety outcome (i.e., no accountability). If Team 2 ends up referring a matter to Team 1 by the process described above, Team 1 will then take over that matter and lead the investigation down a regulatory track. The existence of formal referrals within the same unit infers a lack of cohesion and rather siloed nature of investigating.

70. We have heard from a number of people that Team 2 "doesn't really seem to fit within IRU". This thinking seems to stem from the fact that Team 1 is seen as the enforcers and Team 2 is all about "just culture" and safety learnings. They both see themselves as having very different

10 Team 3 seems to have a clear process for how it manages the ARCs and its structure appears to work well. However, resourcing is an issue and more integration of those investigators with those of Teams 1 and 2 may assist with this.

roles and to the extent that IRU is considered a regulatory and enforcement arm of the Authority, then Team 2 with its current mandate is not seen to fit. The suggestion has been made that Team 2 should be moved out of IRU.

71. We do not agree. In our view the IRU personnel can and should work together effectively with the right direction, guidance, training and resource. There must obviously be clear direction and guidance as to how this "new way of working" is to be achieved so as to fulfil the Director's expectations. Consideration could be given to the ideal location and leadership of the IRU within the structure of CAA so as to ensure this occurs (we refrain from making any particular suggestion but note that historically the unit has worked with the legal team for example).

72. TAIC performs the role of the independent body required by ICAO to carry out investigations in line with Annex 13. We understand that CAA has, in part, been fulfilling that role to date. In our view, it does not need to do so.[11] Instead, it seems to us that ICAO-complying, no-fault investigations are the responsibility of TAIC, not the responsibility of CAA, which ensures an appropriate division of labour and separation of protected safety information.

73. CAA has a statutory notification duty to TAIC in relation to accidents and serious incidents (not non-serious incidents).[12] TAIC's legislative jurisdiction extends only to occurrences that may have significant implications for, or increase, transport safety. Noting that CAA's primary role is to carry out regulatory and enforcement investigations and it is not obliged to undertake a safety investigation (although in some cases it may choose to do so), we envisage that CAA will continue to receive notice of and review incidents where it considers appropriate. Regulatory and enforcement investigations may also include safety messages where relevant. We understand that this approach, if adopted, would change the way in which CAA has managed investigations to date.

74. It was also regularly cited to us that Team 2 cannot collaborate with Team 1 on investigations because of Part 12 of the Civil Aviation Rules which regulates the notification, investigation, and reporting of accidents and incidents. We doubt that Part 12 requires such a result.

75. Part 12 protects certain information from use during a prosecution. A person who reports an accident or incident in line with the formal requirements of Part 12 of the Rules would expect that the information submitted in the report would not be available for a prosecution investigation or enforcement unless the information reveals that an act or omission caused an unnecessary danger to another person or to property, the information was false or the Authority was obliged to release it pursuant to a statutory requirement or Court order.

76. The resounding reason given for the need to keep the units separate is that Team 2 needs to maintain good relationships with participants and if seen to be "enforcers", then participants will not report. However, participants are required to report under Part 12 regardless. We are

11 We have provided separate advice to CAA on this point.

12 And search and rescue operations – see section 50(2) of the CAA23, 27(2) of the CAA90.

also told that reporting levels are low in any event and we query whether this should be given as much weight as much as it is currently.[13]

77. We see opportunities for the IRU teams (with input from operational units) to work cohesively on investigations – to share expertise and to ensure the right regulatory or safety outcome. As investigations progress and facts are gathered, sometimes a different approach to that initially considered becomes appropriate and a multidisciplinary approach allows a change in direction more easily. A report from a participant under Part 12 does not preclude an investigation involving them in the normal way. It means certain information provided by them cannot be used against them in a prosecution. The Strategy notes a preference not to pursue those who fully report but it is not an immunity.

78. One possibility raised was that each significant investigation (criteria for which would need to be developed)[14] could be assisted by a multi-disciplinary panel or equivalent who stay involved in the case until a final decision is made as to a safety or regulatory outcome. For example, the multidisciplinary panel for any given significant case could come from IRU, Legal and the operational units (on a rotating basis as appropriate). There is a wealth of knowledge within CAA and we see real benefits in having a panel meet regularly to brainstorm ideas and debate the issues throughout the investigation process. The Authority will be best placed to determine who to include in such a panel but, to us, it would make sense to include representatives from Teams 1 and 2, an internal subject matter expert, Legal, relevant operational units etc. We would also recommend that an external expert be engaged early and included in the panel (their involvement however being more limited to preserve their independence). This multidisciplinary panel would act to ensure that a multidisciplinary approach was taken, with less risk of relevant information not being gathered or available. The panel would work to ensure that the regulatory outcome was consistent with the policies and regulatory tools of the Authority, whilst ensuring the operational units and others were supportive of their action. Once the IRU7 was finalised and sent to the IRU Manager, we would envisage that there would be limited need for full panel input from that point with the matter then being managed by Team 1, Legal and the external prosecutor. Obviously, if specific issues/questions arose later, the full panel or specific members could be consulted.

79. It may be that this would be most beneficial for those cases that are currently triaged down the HSWA prosecution track as those cases are the most complex and open to directional change. However, we see no harm in the same approach being taken to all significant investigations (those with fatalities, serious safety risks, or other significance – as defined by the process we suggest).

80. Waka Kotahi has a system monitoring function that carries out its work after any enforcement action is concluded and looks to whether safety can be improved and how. A similar approach

13 We were told that only around 20% of participants from the recreational sector who are required to report under Part 12 report as and when they are required.

14 We note that Accident and Serious Incident definitions appear in CAR Part 1 and could form a component of the criteria.

could still be carried out by Team 2 at CAA if and when any enforcement action is decided against or resolved. We note that safety recommendations arising from investigation findings can be made early in the investigation and should be made as soon as reasonably practicable.

81. As all investigations commence with a unified approach and an open mind as to where they may end up, it would be important to have clear processes for matters such as site investigations (that preserve evidence and chain of custody) and interviewing witnesses (with the correct Bill of Rights' cautions and range of questions) to ensure all possible regulatory pathways are preserved.

82. We see merit in treating the 12-month limitation period as a project management exercise with clear timelines and milestones around what needs to occur in the investigation and when (departures from that requiring suitable explanation). This is the approach WorkSafe takes to its investigations. We suggest further examination and consideration of WorkSafe's Investigation Milestone Review Guidance as an example. That guidance sets out timeframes in an Investigation Planning Document. We appreciate resourcing is an issue at CAA but the current practice of submitting IRU7s weeks or days out from the 12-month deadline has resulted in insufficient time to receive considered feedback from managers and rigorously test decisions made. For example, a 9-month (or so) deadline for IRU7s to be submitted would be preferable.

83. Other than the timeliness of when they are produced, the IRU7s we have reviewed are thorough, well drafted and clear - no material changes are suggested there.

84. Given there have been a number of CAA prosecutions in recent times for which lessons could arise, we suggest a formal de-brief session after the conclusion of each case would be beneficial. This could include external counsel, the multidisciplinary panel and anyone else internal that has a relevant interest. Discussions would focus on what went well, what went wrong and what improvements could be made next time. A set list of questions to cover at any de-brief session would be useful and a focus on open and honest feedback from all so as to get the most out of such a review.

Appointment of experts

85. The process for appointing experts for regulatory matters is not documented nor clear. We are not clear on what assessments are carried out (and at what stage) to determine who should be appointed expert; whether the expert should be internal or external or a mix of both and how resourcing decisions are made around this.

86. Team 2 investigators are commonly used as the expert witness(es) in the Authority's prosecutions. External experts are sometimes used (mainly in HSWA cases).

87. There has been an understandable desire to engage just one or two experts in a case. However, in some instances this has led to one in-house expert having to cover a large ambit

of subject matter, not all of which they feel equipped to address (particularly to the "beyond reasonable doubt" threshold).

88. Because Team 2 focusses their role so much on safety and learnings, an adversarial court room tends to be an uncomfortable space for Team 2 investigators. As discussed above, Team 2 investigators focus on probable or "most likely" causes and work on the balance of probabilities (the civil standard). As causation HSWA prosecutions require proof of causation beyond reasonable doubt, a higher level than "probable cause" is required which is often difficult to establish.

89. Team 2 also have not been given adequate training on what is expected of them in an adversarial environment and around the types of questions they may face in court. The additional role as expert witness also puts a resource strain of Team 2 which are already stretched. Taking all of this into account, the current practice of using internal experts is not working well. In our view, the Authority needs to move towards using external experts on all complex or significant cases including those involving causation issues and HSWA.

90. One suggestion is for the Authority to establish a panel of qualified external expert witnesses to call on when needed. Team 2 investigators could still give evidence in court on the scene examination, but complex or controversial issues such as in causation/HSWA cases could be left to the external expert (or at least supported by an external expert).

91. External experts are, of course, bound by the code of conduct found in schedule 4 of the High Court Rules 2016. Pursuant to that code, experts have an "overriding duty" to assist the court impartially on matters relating to their expertise. In other words, they are not advocates for their engaging party. The (actual and perceived) independence of an external expert would also an advantage at trial.

92. WorkSafe advise that they use external experts for all their prosecutions. Those experts are engaged early and assist WorkSafe to decide whether they have a prima facie case. Maritime NZ use both internal and external experts but their internal experts are comfortable giving evidence in the court environment.

93. Expert evidence should optimally be obtained earlier than it has been on some files. There seems to be a tendency (possibly resource driven) to file the charges and then find the evidence later. This is sub-optimal and is resulting in problems, such as the following three. First, is that it is difficult to see how the evidential sufficiency test can be fully assessed without the expert evidence. Second, if the expert evidence ends up different to that expected, then late changes need to be made in the case. Third, if the investigator has predetermined the outcome and then searches for an expert to support the case, then there is a risk of reliance on lower calibre experts and the case is made vulnerable to challenge.

94. The Court of Appeal case of *Talley's Group Limited v WorkSafe NZ* [2018] NZCA 587 stressed the importance of the prosecutor having fully particularised its case at the time charges are

filed. Expert evidence on all relevant areas therefore needs to be sought early (at least in summary) so that it can form part of the IRU7 upon which decisions are made.

95. Against this is that HSWA defendants are often funded by insurers. This means that there is likely to be high calibre legal counsel (and experts) for the defence. CAA needs to ensure it has expert witnesses that will stand up to both the quality and confidence of those giving evidence for the defence.[15]

96. Where a defendant to a criminal charge proposes to call an expert witness, they must disclose to the prosecutor a brief, or summary, of the witness's evidence at least 10 working days before the date fixed for trial.[16] Obviously, that does not leave much time for the prosecutor to assess it and test it with its own experts.

97. When defence expert evidence is received, it needs to be carefully considered and tested with the Authority's experts. If the right experts have been engaged early by CAA and there has been regular discussions around what might be raised by defence, we hope that in most cases the content of the defence evidence will not come as a surprise. It is not clear to us to what extent the defence theory of the case is tested with the expert(s) in a case prior to it being received. Even if the defence theory is unknown, usually various alternatives can be tested earlier.

Use of regulatory tools

98. We query whether enough consideration is currently being given to utilising the full range of regulatory tools available to the Authority. That was the feedback given to us.

99. The figures shown in the Table above at paragraph 39 suggest that the use of lesser alternatives such as warnings and infringement notices seem to have lessened. Further examination is required to understand the cause of that.

100. It is not clear whether the full suite of regulatory tools (across the full range of legislation) is being applied consistently across the unit. Further training is likely required to ensure consistency of approach.

101. While we did not gain significant insight into this issue, it appears there has been insufficient training and guidance given to investigators in terms of when to apply which CAA response from the toolkit (in particular the relatively new HSWA options).

102. There was a perception from some we interviewed that Team 1 matters tended to be directed at the top of the regulatory pyramid irrespective of whether a lower-level response could be appropriate. That is not obvious from the figures above (although lesser options seem to have

15 See section 25.

16 Criminal Disclosure Act 2008, s 23(1). Where only a summary is produced, the defendant must produce the brief as soon as possible after it becomes available.

declined in recent years) but it is a perception that is unhelpful. We consider that initially treating all investigations as general multidisciplinary investigations will assist with keeping investigator's mindsets open to a variety of responses. In terms of those participants that report their conduct to CAA under Part 12 (signifying accountability and honesty), that will be one factor for IRU to consider along with others in determining what level of regulatory response is appropriate.[17]

103. Along with specific training on HSWA and the tools available under that legislation, we see a need for a consistent and coherent approach to when which tools are applied. There should also be clear written procedure on this and training with it.

HSWA cases and causation

104. We have identified that the HSWA causation cases are the most difficult to prove for the Authority due to the variety of factors that can contribute to an aircraft accident. It is not therefore surprising that these are the cases that have caused CAA the most trouble in terms of a late change of tack/unsuccessful prosecution. Going forward, careful consideration should be given to alleging causation in these cases. There is no utility in choosing the most serious approach if there is a significant chance that it will not be sustainable at trial. This only creates mistrust in the Authority from participants.

105. Careful regard should be given to the Solicitor-General's Prosecution Guidelines to assess whether the evidential sufficiency and public interest tests for prosecution are met.[18] Further, given the difficulties with these cases even when these tests are assessed as being met, one option is to only allege causation in cases where the cause is very clear and where the defendant has engaged in wilful conduct or has a background of non-compliance. Regular engagement with the multidisciplinary panel as the investigation develops should assist to determine whether there is a clear case for prosecution in these cases (including matters such as chain of evidence, expert evidence, background of compliance of operator etc).

106. One argument commonly made for alleging causation is that causation is required to establish a basis for reparation for victims at sentencing. This may be resulting in borderline causation cases proceeding simply to leave this sentencing option open[19]. Our view is that there is too much focus on this at present in light of the difficulties of proving causation. WorkSafe advise that their more recent approach is not to focus on alleging causation unless it is very clear. They inform victims early on that they are not a compensation organisation. We tend to agree with this approach. While taking victims views into account is obviously necessary, it is only

17 The Regulatory Enforcement Policy sets out the framework for enforcement decisions (formal warning, infringement notice or prosecution). It includes HSWA enforcement powers but not other HSWA tools such as improvement notices etc. It is an up-to-date and helpful document to describe the Regulatory Enforcement Process. The impression we are left with is that the policy may be sound but the practice does not match it for the reasons we outline.

18 https://www.crownlaw.govt.nz/assets/Uploads/Prosecution-Guidelines/ProsecutionGuidelines2013.pdf

19 We were given anecdotal evidence of this being the case.

one consideration among many, and taking a borderline case to trial and having to withdraw is not victim-centric.

107. We also consider more thought needs to be given to the conduct rather than the outcome in assessing charges. Just because the outcome is serious (harm/fatality), does not mean it is the most serious breach or that in all cases a top-level regulatory response should be used. Similar to careless driving causing death cases, low level conduct can unfortunately result in the most tragic of outcomes.

108. Further HSWA training is needed across the unit (and potentially wider). We understand some internal HSWA training is being developed at present. Investigators need guidance on what regulatory tools within HSWA to utilise for which cases. HSWA is relatively new and very few people within CAA understand its scope and intricacies. CAA-wide HSWA training could help all units to understand how input from other units can assist and what information investigators may be looking for. While in CA Act or Rule breach cases it may be easy to spot relevant information, the issues are far more broad reaching in HSWA cases.

How recommendations from TAIC reports and other areas of the Authority are identified and considered by investigators

TAIC

109. TAIC's principal function is to investigate accidents and incidents.[20] It will do so if it believes that the circumstances of the accident or incident have, or are likely to have, implications for transport safety, or may allow it to establish findings or recommendations which may increase transport safety or it is directed to do so by the Minister.[21]

110. TAIC meets New Zealand's international obligations under the ICAO Convention to have an independent body responsible for safety investigations. TAIC does not carry out any enforcement functions, such as prosecution; those functions remain with CAA.

111. TAIC's practice is to issue reports in two stages. First, it issues a draft or preliminary report, which is subject to extensive internal peer review and consultation.[22]

112. The consultation process is subject to strict legislative requirements to protect natural justice and to enable people to make disclosures to TAIC without fear of prosecution.[23]

113. Where the preliminary report states or infers that a person's conduct contributed to the cause of an accident or incident that TAIC is investigating, TAIC shall give that person an opportunity

20 TAIC Act, s 8.

21 TAIC Act, s 13.

22 https://www.taic.org.nz/how-we-work/draft-report-and-consultation

23 These are set out in part 3 of the TAIC Act.

to be heard (in writing or by a hearing) and have regard to that person's statement and other evidence.[24]

114. After the consultation period, and any amendments (or redrafts) to the report, TAIC publishes the final report. Its practice is to give confidential advance notice to persons and organisations consulted, as well as to the Minister and Ministry of Transport, the appropriate regulator (for example CAA) and the Coroner if the accident resulted in a casualty.[25]

115. Where possible, victims and families of the deceased will be given an advance notice that the report is going to be published, a confidential advance copy and, in some circumstances, a briefing.

116. The report is then made public. Generally, the practice is for TAIC not to publish its report until any prosecution has concluded.

117. In the Hood case, unusually, the TAIC report was released prior to the conclusion of the prosecution.

118. We asked whether the TAIC findings were considered by the investigators when it was released as the report did make some findings that were not entirely consistent with the prosecution case. We are told the TAIC findings were considered but did not trigger any change in approach to the case. It is not clear to us if these considerations were documented. It may be that, in Hood, the TAIC report alone might not have changed the direction of the prosecution but if experts had been tested more thoroughly earlier and all the information from the operational units had been gathered, together it may have indicated an issue with the case.

119. Generally speaking, we would suggest that if a draft or final TAIC report is released prior to prosecution, then it should be carefully considered and tested by IRU against the prosecution case (noting the limitations around use of the report in court).

Other areas of the Authority

120. As already mentioned, the Authority has a wealth of knowledge amongst its people. Successful outcomes on prosecution cases will only occur when there is the right level of input from across the Authority. It is crucial that the investigators identify who within the Authority may have relevant information, explain to those units what is being requested and why, and that all information on file is gathered and assessed by the investigator. This cross-unit collaboration has been lacking due to the siloed approach of teams, geographical constraints and a lack of a unified approach towards enforcement. That requires determined effort to overcome.

24 TAIC Act, s 14(5).

25 https://www.taic.org.nz/how-we-work/final-report-and-publication

121. Aside from simply providing information, the operational units are full of subject matter experts who have important input to give on cases and so should be consulted and kept up to date as an investigation progresses (perhaps as part of a multidisciplinary panel as suggested above).

122. Issues arise when relevant emails from operational units within the Authority are not in the possession of the CAA investigator or prosecutor, nor disclosed to defence. This not only poses a risk of embarrassing the Authority when that information is provided from external sources, but it also risks the CAA failing in its criminal disclosure obligations under the Criminal Disclosure Act 2008.

123. It has been suggested to us that the investigator should request and review all material from the relevant operational units from the 10 years prior to the incident. This may be a reasonable timeframe to capture all potentially relevant information. It will be up to the investigator to identify which operational units to make approaches to and to ensure they are accessing all material. The onus is on the investigator to be diligent in seeking out the relevant information (whether inside the Authority or no). Operational units should also provide guidance as to what may be of most relevance and/or which other units should be consulted. The operational units can only fulfil this role though if they understand the nature of the investigation and what the issues are.

124. Further, a participant's history of engagement with the CAA and compliance or otherwise is a relevant factor in assessing which regulatory tool to apply when a breach occurs. Therefore, in our view, it is imperative that cross-unit coordination improves so that this information can be assessed and form part of the decision-making process.

125. The document management system has also been identified as being not as good as it could be. We understand there may be an upgrade to a new system underway. One unified system where all correspondence and documents are stored is essential to avoiding missing relevant information and meeting disclosure obligations. Further, for the system to work, it is essential that there is a requirement and commitment across the Authority for all staff to use it in a uniform way. The days of idiosyncratic investigator methods (which do not permit others to search, access and collaborate) are well and truly over.

126. As mentioned earlier, the units need further guidance from the Director and management as to how they are to support each other in their functions. Our interviews suggest that staff are happy to help IRU with information and feel they are doing their best to do this within the resources available. However, as this is not working well, specific guidance is required from management on how they are to interact and support each other (and at what stages).

Director's expectations and manager guidance

127. In our view, the first step towards implementing a change within IRU is for the Director to be clear what his expectations are. We suggest that staff could do well to be reminded that CAA

is a regulator first and foremost. While it is useful to have good relationships with, and within, the industry, they should not be at the cost of regulation, accountability and therefore safety.

128. If the Authority is able to demonstrate through consistent treatment of cases that it is firm but fair, the industry trust in the Authority should improve.

129. Guidance needs to be given by the Director and senior leadership as to how IRU is envisaged to operate including how the teams are to interact, how expertise is to be utilised, how a multidisciplinary team should operate to triage cases, the timeframes that must be met for each stage, which experts are to be engaged and when, etc.

130. The common view is that the ODR anticipated that IRU would work in a new way but little if any guidance was provided as to how the "new way" was to work in practice. There is a desire for more guidance and training around this. The three teams are continuing to work in the best way they can but are defaulting to how they have always worked.

131. The same issue arises with how Legal is to work with IRU. Better and clearer guidance is required on this so that both Legal and IRU understand their respective roles.[26] Input from Legal in investigations should follow a set procedure. At present there is not a clear line of instruction, and it is causing confusion for all as to what role Legal have in the process. We also understand that Legal formally instructs external counsel on some matters and not others (in those cases, the instructions come direct from IRU). A clear or consistent approach should be applied for instructions to external counsel. We recommend:

    a. Legal are involved in all significant investigations as part of the multidisciplinary panel.

    b. Chief Legal Counsel remains on the Decision-Making Panel as one of the signatories on the IRU3.

    c. Good practice appears to invariably recommend that the internal legal department instruct all external counsel and we recommend CAA adopt that practice.

    d. Once external counsel are instructed, the investigator and external counsel may liaise directly without input from Legal (but with Legal copied in).

    e. Legal is consulted on any significant prosecution decisions (e.g. alterations to charges and changes in prosecution direction) and as and when external counsel require Legal's input.

26 The Regulatory Enforcement Policy notes that the Chief Legal Counsel will assign a senior solicitor to provide legal advice where required. There does not appear to be sufficient guidance given to both the legal team and the IRU as to how/when they are expected to engage.

132. There are some huge champions throughout CAA and they are supportive of this review. They feel as though there are a lot of competing priorities and stretched resources. They want clear direction on where to put that resource and how to operate together most efficiently.

133. We suggest a good first step would be for a facilitated workshop process to be conducted where the relevant IRU staff and managers are able to contribute to the way in which these recommendations are given effect to.

Other relevant matters identified during the Review (outside of Terms of Reference)

134. Two further matters that became apparent in our interviews were those relating to IRU culture and industry capture.

Cultural issues

135. There will invariably be cultural shifts required to fully integrate the teams and to facilitate a common way of working and interaction between them. This is normal given the different roles and personalities in each team and the intention to work in a more multi-disciplined environment. A failure to make this shift can complicate matters and negatively impact the required collaborative culture. A clear commitment to make this work coupled with clear direction and expectations will facilitate this and a facilitated workshop format could assist here.

Earned Autonomy

136. The issue as to the appropriate level of regulatory oversight to be applied across the sector was raised with us on multiple occasions; namely the balance required between regulation and enforcement in relation to small operators in comparison to larger operators, which due to the size and sophistication of their operations are given greater autonomy. Larger operators are sometimes seen by the Authority as self-managing in terms of regulation. This is based on the concept of earned autonomy that through earned trust the Authority can feel confident that they are complying with their regulatory standards to a high level.

137. This does not mean that the Authority position should be to consistently step back and not engage directly on specific issues. To do so would give the impression that such an approach exists and would not fulfil our suggested goals of "consistency", "fairness" and "transparency".

138. There is a concern that a perceived "stand back" approach will negatively impact the Authority's reputation if a serious incident occurs within a large operator and if the Authority is found not to have been fulfilling its regulatory oversight function adequately.

139. An earned autonomy model must be balanced by ongoing regulatory oversight (trust and verification). When an issue arises, the Authority should address it directly. It must also be accompanied by ensuring that all participants are treated the same way in terms of expectations regarding information provided. The need to maintain good relationships to ensure the ongoing flow of information about incidents should not outweigh insistence that

all participants meet fully their reporting requirements. We suggest relationships can be maintained if the Authority is seen to act consistently and fairly across all of the industry, while still adhering to earned autonomy as appropriate. We understand this issue is under active consideration and leave these matters with the Authority to consider further.

Conclusion

140. As noted above, the Authority has a dedicated and highly experienced team who are generally performing well and fulfilling the Authority's objectives to the best of their ability.

141. The primary weaknesses in the current approach are highlighted in complex investigations. Our report focusses on improving the Authority's investigative function in order to deliver a consistent and fair approach across the industry (one which is supported within and outside of the Authority). This will involve cultural, operational and policy changes. We are happy to discuss any of our recommendations in more detail if that would assist.

Schedule 1: Terms of Reference

Terms of Reference for a Review of the Civil Aviation Authority management systems, procedures and practices operating within the investigation and enforcement function, including the way in which expert evidence is obtained and managed and to identify any changes that may be required to the Authority's regulatory policies or practice.

27 February 2023

Introduction

1. The Review is to provide advice to the Director of the Civil Aviation Authority of New Zealand (the Director) in accordance with these terms of reference.

2. This review is informed by, but not limited to, the circumstances arising from the Health and Safety at Work Act 2015 (HSWA) prosecution of Sky Sports Limited (SSL) and its director, Martin Lloyd (Owner).

Context

3. Enforcement decisions (such as criminal prosecutions or administrative actions) that may follow an investigation, are part of the Director's toolkit of actions that can be taken to regulate and promote aviation safety and security under the Civil Aviation Act 1990 (the Act), Civil Aviation Rules (Rules) and HSWA, within the Director's designation.

4. Administrative action and prosecution hold people to account for breaches of the Act, Rules and HSWA and promote aviation safety and security. Not all breaches result in administrative action or prosecution. The Director exercises a discretion as to whether in all the circumstances, action falling short of prosecution may be more appropriate, such as issuing an improvement notice under the HSWA or a warning or infringement under the Act.

5. Decisions to take enforcement action often adversely impact the lives and livelihood of those they are taken against, victims and those that are involved in them, such as witnesses. They are a call on Authority resources and often incur significant costs. When considering whether to take enforcement action, the Director and those who act under the Director's delegation, are required to exercise discretion, act judiciously and avoid the arbitrary exercise of their powers.

6. For this reason, processes and systems are put in place, underpinned by regulatory policies and practice, to ensure enforcement decisions and the management of them are well founded and sustainable. Enforcement actions are built on a robust process of evidence analysis in order to meet a high standard of proof. This means those in the Authority responsible for the conduct of enforcement actions, must constantly review actions underway and continuously ensure the Director is fairly discharging their responsibilities as a safety regulator. To help it

do so, the Director uses internal and external experts and external specialists, such as Crown prosecutors.

7. Other business areas of the Authority may have knowledge of the person or operators being investigated, be carrying out work related to that person or operator or responding to matters arising out of the incident being investigated, (for example another agency's investigation or actions being taken about the subject by other internal business units within the Authority). This information should help inform the investigation, as other parts of the business will have industry or other knowledge that should be considered.

Background

8. Following an investigation by the Authority into a fatal accident at the Hood aerodrome in Masterton in 2019, charges were laid by the Authority against SSL and its owner under the HSWA.

9. The Authority carried out a safety investigation along with an investigation by an Authority regulatory investigation team[27]. A report from an Authority expert and the conclusions and recommendations of the investigation were subject of an evidence sufficiency and public interest test (in accordance with the Solicitor-General prosecution guidelines) by one of the Authority's external prosecution service providers, Luke Cunningham Clere.

10. The charges centred on allegations that SSL and its owner had not done enough to ensure safe flying practices were followed, they allowed SSL's pilot to deviate from local flight path rules. These are set for each aerodrome in a pilot's flight guide known as an Aeronautical Information Publication or AIP. It was this deviance it was alleged that caused the crash.

11. As part of the trial process, the defence commissioned expert evidence which was provided to the Authority approximately nine days before the commencement of the trial. That evidence contained viable alternative explanations as to the possible causes of the collision. This evidence was carefully considered and tested, leading to the conclusion that it might be accepted by the Court or at the least raised reasonable doubts about the Authority's theory of the case. As a result, the charges were withdrawn, as it was no longer reasonable nor in the public interest to proceed with the trial.

12. The information provided by the defence included email correspondence with other business units within the Authority pertaining, inter-alia, to requests in 2015 and 2017 to change the radio frequency at the Hood Aerodrome for safety reasons (raised by defence experts as a possible contributing cause of the collision). The requests were not supported by staff from

27 The Authority has a safety investigation function and a regulatory investigation function. In the past, decisions were made early following an incident/accident as to whether to pursue a regulatory (rule based or HSWA) approach or a non-fault safety investigation. Recent approach is to initiate a broad investigation to establish facts about the situation; once this has been established a decision will then be made as to which investigation path should be followed. It is possible that both the regulatory and a safety investigation may continue in parallel.

the relevant Authority business unit. A business unit had advised Hood Aerodrome management that the Authority was carrying out a review of the aerodrome operations which might include spot audits, examination of different parts of the aerodrome safety and flight systems, including radio communications, flight paths and compliance with aerodrome procedures. The defence also intimated it would call as witnesses, past and present Authority staff whose evidence would be supportive of the defence case and in particular seek to show that the rule deviance was justified on safety grounds despite being in opposition to the AIP.

13. A Transport Accident Investigation Commission (TAIC) report on the accident in 2022 found that the pilot of the SSL aircraft had failed to give way, but did not comment on AIP compliance (central to the Authority's allegations) nor look at the Health and Safety issues the accident may represent, as it found this to be the role of the Authority.

14. The draft TAIC Report in mid-2022, made several criticisms of the Authority's oversight of the aerodrome and made recommendations for the Authority to consider. The Authority in its communications advised that it has intensified its safety activity at uncontrolled aerodromes.

Purpose of Review

15. The purpose of the Review is to ensure the Authority's investigation and supporting functions, such as legal and subject matter experts from across the Authority:

    a. are high performing, delivering their roles, duties, functions and powers efficiently and effectively, meeting current and future needs, and producing optimal outcomes for the Director, the Civil Aviation Authority and the aviation sector;

    b. are resilient and capable of adapting to the changing landscape of New Zealand's civil aviation system;

    c. have clarity of purpose and approach, sound governance and accountability arrangements;

    d. are committed to benchmarking and continuous improvement, and efficient and effective management systems and processes;

    e. investigations are well planned, conceived and widely consulted on to ensure the right areas of inquiry are identified;

    f. have high productivity and quality output coupled with well written reports based on sound examination and investigative disciplines;

    g. the system for planning, undertaking, completing and handing over investigation reports, recommendations and decisions is characterised by good management and good organisation;

h. sound management processes, procedures, guidance, templates, tools, policies, formal feedback mechanisms, internal, peer and external review, and quality control processes are in place;

i. investigation review reports are evidence based, easy to read and understand, and follow an approved style guide.

j. are recognised for their professional and robust culture; their openness, transparency and preparedness to engage and adapt in light of feedback and evidence; and

k. investigation staff are well connected and networked at all levels of the Authority.

Review

16. The Review will:

a. examine the way the investigation work programme is developed, the process undertaken to decide on resource applied to investigations and key recommendations and decisions on whether to take enforcement action, who is consulted; and how it is approved;

b. assess the current state of the functions' management procedures and practices, tools, guidance, allocation of work, the process for and appointment of expert evidence, quality review processes, structured feedback mechanisms, peer review procedures, and quality control processes to support the delivery of investigations and investigation reports of quality, depth and rigour against contemporary best practice, and make recommendations for improvement (if any);

c. comment on the current state of the function's approach to planning, work programme and investigation review reports and make recommendations (if any) for improvement;

d. comment on the existing arrangements, quality control, internal and peer review procedures, and advisory/reference group arrangements that are in place and make recommendations (if any) on how these can or should be strengthened;

e. provide advice on the management oversight arrangements to oversee the work of the function to ensure their programme and reports are well managed, meet quality and timeliness standards and meet the Director's expectations;

f. comment on the way expert evidence is obtained, when it should be obtained and the use of external experts; whether expert evidence should be considered and incorporated into investigation reports before a recommendation as to enforcement actions is made; how expert evidence provided by the defence should be considered and whether this should lead to changes in Authority policy, rules, guidance or practice;

g. comment on how recommendations, such as those arising from TAIC reports or work of other areas of the Authority concerning the persons or entities under investigation, are identified and considered by investigators when carrying out investigations;

h. comment on whether the function is (and if not, how it should be) connected to the work of other business units of the Authority;

i. provide advice on whether the arrangements be changed or strengthened to support the delivery of high quality, evidenced based investigation reports, that meet the requirements of evidential sufficiency and public interest tests, and the exercise of the Director's discretion;

j. make recommendations (if any) about changes to policies, procedures and practice; and

k. raise any other relevant matters identified in the course of the Review.

Scope and Approach

In scope

17. The Review is designed to ensure the staff of the Investigation function(s) are supported in their work by investigation procedures, tools, guidance, consultation and feedback procedures, peer review and quality control mechanisms that are benchmarked against contemporary best practice.

18. When undertaking the review, the Reviewer will:

    a. conduct the review openly and transparently;

    b. ensure members of investigation function(s) are given a reasonable opportunity to provide comment on the matters under review and, where appropriate, consider such feedback.

19. Interviews:

    a. The Reviewer will interview a range of Authority investigation managers and staff, and managers and staff from other relevant areas including the Legal Services Unit, operational teams and subject matter experts;

    b. The Director;

    c. The Deputy Chief Executives, Aviation Safety and Strategy, Governance, Risk and Assurance and the Chief Legal Counsel;

    d. Members of the Authority Leadership Team as relevant;

    e. Any additional Authority staff members identified through the process;

f. External counsel involved in Authority prosecution work, and any other external person who may assist the review.

20. Sponsor – the sponsor is the Director who will take decisions on Review recommendations.

21. Steering Group – a steering group comprising the Deputy Chief Executives, Aviation Safety and Strategy, Governance, Risk and Assurance and the Chief Legal Counsel, will oversee the review, provide comment on the draft review report and receive regular progress updates from the Reviewer.

Out of scope

22. The Review will not examine or comment on any individual's performance or any decisions taken (specifically [Hood aerodrome] or more generally).

23. The Review will not assess the evidence or decisions relating to the SSL and its owner prosecution. For the avoidance of doubt, the review will be informed by the circumstances arising from the HSWA prosecution of SSL and its owner.

24. The Review is not a review of structure. It is possible however the Review may suggest changes to tasks, or the way things are done.

Administrative support

25. The Deputy Chief Executive, Strategy, Governance, Risk and Assurance will arrange administrative support to the Reviewer to carry out the Review.

Key documents

26. In order to undertake this review, the Reviewer will be provided access to key documentation, including but not limited to:

    a. Investigation policies and procedure manuals;

    b. any investigation unit or relevant organisational documents, work programmes, Review reports, work plans, business plans, quality assurance reports, peer review and feedback reports, performance reports;

    c. Any other investigation unit documents that are, or become, relevant, including any current policies and procedures under review or development.

Draft review report

27. The review report is to be delivered in May 2023 or on such other date that may be agreed.

Note - changes to the proposed timeline will be agreed between the Steering group and the Reviewer.

The Reviewer is to provide oral updates to the Director/Sponsor as requested.

Schedule 2: Powers of Enforcement

Civil Aviation Act 2023

1. The Director has an independent function to carry out enforcement responsibilities conferred on him under the CA Act or any other Act.[28]

2. The Director is to exercise his enforcement powers independently and without direction from any other person, including the Minister.3

3. Set out in Part 9 of the CA Act, those powers are conferred on the Director or other persons and include powers:[29]

    a. Of entry and inspection conferred on inspectors to enter premises, carry out searches, take samples, conduct examinations and require specific persons to provide identifying information.[30] These powers can be carried out for various purposes including performing any function of the Director, the CAA or an inspector, for the Australia New Zealand Aviation mutual recognition agreements and to investigate whether an offence has been, is being or is likely to be committed.

    b. To issue improvement notices where an inspector reasonably believes that a person is, or is likely to, contravene a provision of civil aviation legislation and the improvement notice may prevent or remedy that contravention.[31]

    c. To issue non-disturbance notices to preserve, or prevent the disturbance of, a particular site.[32]

    d. To obtain search warrants to detain aircraft, seize aeronautical products and impose prohibitions and conditions in relation to aerodromes, aircraft, and aeronautical products. These powers are exercisable where the issuing officer has reasonable grounds to believe that the operation or use of an aerodrome, aircraft, aeronautical product or class of aircraft or aeronautical product may be used to endanger people or property or where prompt action is necessary to prevent danger.[33]

    e. To seize, detain or destroy aircraft where the constable or a response officer has reasonable grounds to believe that an aircraft designed to be operated without a pilot on board is being operated in commission of an offence under the Act, used in the

28 See section 32(3)(c) of the CA Act.

29 Subpart 8 of Part 9 also gives Airways powers of entry but these powers are not discussed in detail here.

30 Subpart 1.

31 Subpart 2.

32 Subpart 2.

33 Subpart 3.

commission of an imprisonable offence under any other Act or operated in a manner that may endanger people or property and it is necessary to take action to prevent the offending from being committed or continuing to be committed.[34]

f. To grant exemptions from compliance with regulations and rules where the Director thinks appropriate.[35] The exemption can relate to any one or more named, or any class of, aviation participants, aeronautical products, aircraft, aerodromes and/or aviation-related services.

g. To accept enforceable undertakings in relation to a contravention or an alleged contravention by the person of civil aviation legislation.[36]

h. To appoint any person as an inspector or response officer.[37]

i. To apply to the Court for an injunction to restrain a person from engaging in conduct that constitutes, or would constitute, a breach of civil aviation legislation or requiring a person to do an act or a thing if they have refused, or are refusing, to do so and that refusal or failure was, is or would be a breach of civil aviation legislation.[38]

j. To intervene on grounds of national security.[39] These powers, which include the power to direct that an application can be refused, restrictions or conditions be imposed on an aviation document, disqualify a person from holding a document, or prohibit a person from doing anything in respect of an aerodrome, aeronautical product or aviation-related service, can be exercised if the Minister is satisfied, on the advice of the intelligence and securities agencies, that the action is necessary in the interests of national security.

4. In addition:

a. Subpart 14 contains general offences including communicating false or misleading information, obstructing an inspector or other person authorised by the Director or Secretary, trespass, failure to maintain accurate records, breach of emergency rule, prohibition or condition and flight over foreign country without authority or for improper purpose.

34 Subpart 4.

35 Subpart 5.

36 Subpart 6.

37 Subpart 7.

38 Subpart 12.

39 Subpart 13.

b. There is an additional penalty under subpart 15 for specific offences carried out for commercial gain.

c. Powers relating to infringement offences are contained in subpart 16. An infringement offence are those things set down in regulations and the CAA23 as infringement offences and include, for example, operating a portable electronic device on board an aircraft in breach of the rules,[40] carrying or causing to be carried dangerous goods on an aircraft in breach of the rules,[41] and being present in a security area without being searched or authorised.[42]

d. Powers relating to charging documents are contained in subpart 17, which subpart includes limitation periods and burdens of proof. Evidence requirements are contained in subpart 18.

e. Unruly passenger offences are contained in subpart 20 and these relate to persons who behaviour in a variety of unruly ways whilst passengers on an aircraft, including by smoking, endangering safety and becoming intoxicated.

Health and Safety at Work Act 2015 (HSWA)

5. In addition to the CA Act, the CAA is a designated agency, and has enforcement powers, under the HSWA.[43]

6. HSWA applies to an aircraft in operation, wherever it may be, while the aircraft is operating a domestic flight or operating outside New Zealand with New Zealand employed or engaged workers on board.[44]

7. CAA is a designated agency for the purposes of performing functions and exercising powers under HSWA.[45]

8. CAA's designation is limited to:

   a. work to prepare an aircraft for imminent flight;

   b. work on board an aircraft for the purpose of imminent flight or while in operation; and

   c. aircraft as workplaces while in operation.

40 Section 400(2).

41 Section 403(2).

42 Section 167.

43 HSWA, s 191.

44 HSWA, s 9.

45 Health and Safety at Work (Civil Aviation Authority of New Zealand) Agency Designation 2015.

9. Under Part 4 of HSWA, CAA, as a designated agency, has various enforcement powers.

10. Some of these are similar to CAA's powers under the CA Act. They include:

    a. Powers to issue improvement notices requiring a person to remedy a contravention or likely contravention of HSWA, or prohibition notices requiring a person to cease a particular activity that may involve a serious risk to the health and safety of a person from an immediate or imminent exposure to a hazard.[46]

    b. Powers to issue non-disturbance notices requiring a person to preserve the site at which a notifiable event has occurred or prevent the disturbance of a particular site, in order to facilitate the exercise of his or her compliance powers.[47]

    c. Powers to take remedial action for failure to comply with a prohibition notice and civil proceeding compelling a person to comply with a notice.[48]

    d. Powers to accept enforceable undertakings in connection with a matter relating to a contravention or alleged contravention of HSWA or its regulations.[49]

    e. Powers to undertake enforcement action through criminal proceedings.[50]

11. As with its powers under the CA Act, CAA also has additional inspectors' powers to enable it to carry out its powers and functions under HSWA. These include, for example, powers to:

    a. Enter to undertake, among others, examinations, tests and inquiries, take photographs or require the PCBU to produce information relating to the work, the workplace or the workers and the PCBU's compliance with HSWA or other relevant health and safety legislation.[51]

    b. Seize, destroy or take any other action to reduce or remove the cause of imminent danger.[52]

    c. Take or remove any material, substance or things for analysis, or seize and retain any material, substance or thing for the purpose of monitoring conditions in the workplace, determining the nature of any material or substance in the workplace, determining

46 Sections 101 and 105.

47 Section 108.

48 Sections 119 and 122.

49 Section 123.

50 Part 4, subpart 7.

51 Section 168.

52 Section 170.

whether relevant health and safety legislation has been, is being or is likely to be complied with or gather evidence to support an enforcement action.[53]

d. Require a person to provide their name and residential address if the inspector finds, or reasonably suspects, the person is committing an offence against relevant health and safety legislation.[54]

12. A regulator such as CAA may appoint a health and safety medical practitioner who has powers of entry to undertake examinations, take photographs and require a PCBU to produce documents.[55]

13. Additionally, the health and safety medical practitioners may require workers to be medically examined and suspend workers where they suspect the worker/s have been exposed to a significant hazard at work.[56]

53 Section 172.

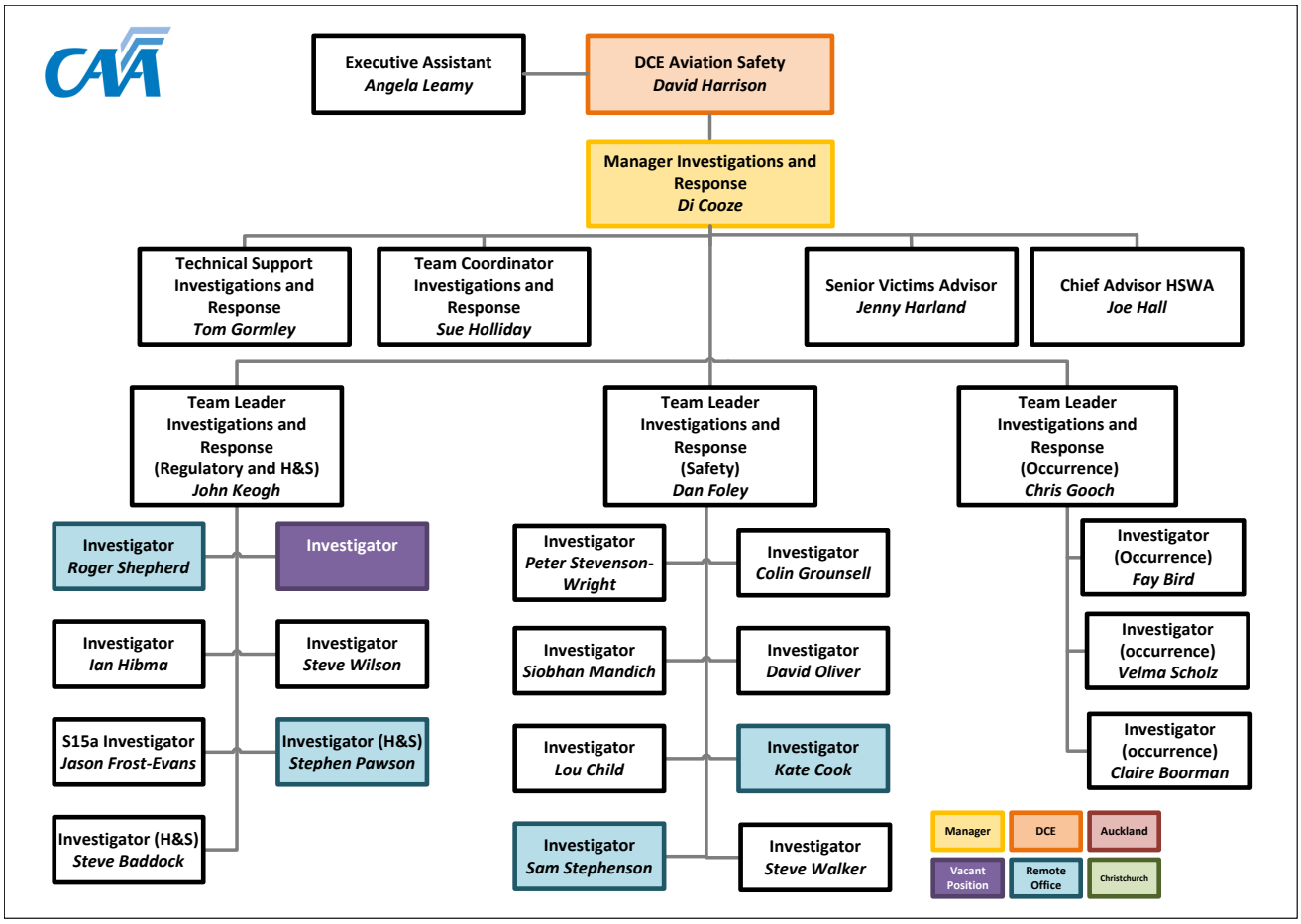
54 Section 175.

55 Section 183.

56 Sections 184 and 185.

Schedule 3 – IRU team structure and summary of activity

Current IRU Team Structure



Current Activity (as of 1 April 2023)

- No regulatory investigations opened in April 2023. IRU Team 1 have 7 open investigations assigned to them and 6 cases in the judicial system (2 under HSWA).
- 14 safety occurrences assigned to IRU Team 2 in April. There are currently 101 open investigations assigned to Team 2 and 12 fatal accident investigations currently open (9 assigned to Team 2 staff and 3 TAIC open enquiries that are assigned to Team 2 staff).

- This financial year, one member of Team 1 resigned. That number was added as an FTE position to Team 2 due to the workload of the safety team and the need to manage the on-call 24/7 roster sufficiently. The 15A investigator on Team 1 is currently being assigned regulatory investigations and ARCs as the number of 15A investigations has dropped post COVID/lockdown.

- There is currently a request for 2 more FTE in the budget bid for the 2023/24 financial year. These positions if obtained would be assigned to Teams 2 and 3 to assist with the volume of work both teams carry.