Department of Conservation's Organisational Response to PWC Report

Key Findings on Wanaka Helicopter Incident

22 September 2022

Department of Conservation
Te Papa Atawhai

Te Kāwanatanga o Aotearoa
New Zealand Government

This document sets out DOC's organisational response to the key findings in the PWC report 'Independent review for Department of Conservation of events leading up to the fatal accident at Wanaka in October 2018'.

Steps to address issues highlighted in the report have been implemented over the years following the accident.

The Health and safety of our staff, contractors and volunteers is a key priority for DOC, and a programme of review, evaluation and continuous improvement is driven by Leadership Team.

Organisational Response

PWC Key Finding 1: There are material relationship disconnects between senior management and operational staff, combined with inherent cultural traits within the Department that constrain an open and robust assessment of risks and appropriately acting on those risks.

PWC Key Finding 2: Known risks to operational staff were present immediately prior to the accident and were not adequately assessed and acted on.

DOC response

- DOC has continued to work on organisational and leadership culture. Our response has involved improving and updating systems to support a positive culture change. We have an ongoing commitment to build a stronger health and safety culture where people are listened to and managing health and safety risks is the number one priority.
- DOC's health, safety and risk governance framework has been fully revised to ensure senior leaders can govern safety as well as manage it.
- New systems are in place to empower staff at all levels to address safety issues:
    - 'Speak Up' – To encourage people to speak up when normal managerial leadership has failed.
    - 'Stop for Safety' – To empower staff to say stop. The system is proving highly effective, enabling staff to rapidly communicate safety issues to Director-level and halt work until safety concerns can be addressed.
    - 'Safe to Start'– Requiring active authorisation of work by every involved person.
- Work to remove all barriers to reporting incidents has progressed. We have piloted and implemented a smart phone app for all staff, and uptake is increasing.
- We have redesigned the Tahr programme to ensure clarity of accountability and authority at all levels.

PWC **Key Finding 3:** Assessment of Helicopter Safety is inadequate.

DOC response

- All DOC staff must complete a 'Helicopter Boarding Pass' critical risk control checklist before they are permitted to board a helicopter. This phone app requires staff to pause before boarding and check off that risk controls are in place e.g., a proper briefing from the pilot, no loose items inside the helicopter.
- Helicopter-related Standard Operating Procedures (SOPs) have been comprehensively reviewed and revised, with a strong focus on the Aerial Hunting SOP, Single-Skid/Toe-In Landing Procedure (STEP), Over-Water Flying and Aerial Seed Collection.
- Helicopter operators must meet the new FENZ/DOC Helicopter Operating Service Specifications (OSS) standard in order to work for DOC and FENZ.
    - This OSS addresses risks such as mountain flying, pod and door security and introduces new requirements such as mandatory in-cockpit cameras. It has an associated audit regime. The OSS is a requirement over and above the Civil Aviation Authority regulatory minimum.
- A Helicopter Capability Framework is under development to lift staff capability when working around helicopters.

PWC **Key Finding 4:** There is no formal criteria as to when ownership of a programme should be escalated to DOC's National Team.

DOC response

- The Tahr programme is now assigned to a single National Operations Director, who has clear (single point) accountability for assigning tasks at all levels across the programme.
- Other similar large-scale initiatives are delivered as national programmes e.g. national predator control programme.

PWC **Key Finding 5:** DOC has not funded or resourced tahr monitoring and control over an extended period.

DOC response

- Through Budget 2018 there has been a significant and sustained increase in funding for tahr monitoring and control.
- The programme is now assigned to a single Director using DOC's task assignment model. The accountable Director has full authority including access to all necessary human, technical and financial resources.
- Within the tahr programme, there is a focus on ensuring open communication within the team and that all members feel able to have a voice.

- We've introduced a training and competency framework for DOC staff undertaking aerial tahr hunting, which includes practical elements, delivered by an external provider, and theory. Once new aerial tahr shooters are formally assessed as competent, a structural progression plan will see them gradually take on greater responsibilities as their experience increases. This includes mentoring from experienced staff.
- An aerial hunter and helicopter safety verification process checks that safe processes are being used. This process covers both DOC staff and contractors.
- Regular contact is maintained with hunters throughout the year, including in the planning phases of operations and year-end reviews.
- The Tahr Plan Implementation Liaison Group, which includes hunting and conservation groups, has opportunities to provide comment and feedback on the development of the Tahr Control Operational Plan, which is revised annually. This includes a formal consultation process, which has been key to improving hunting sector and DOC relationships on the management of tahr.

PWC Key Finding 6: DOC's Incident Cause Analysis Method (ICAM) internal investigation into the Wanaka Helicopter Incident was inadequate.

PWC Key Finding 7: The significance of the risk factors was not fully addressed in the ICAM investigation.

PWC Key Finding 8: Not all risk factors were identified in the ICAM investigation.

DOC response

- The Incident Investigation System has been reviewed and updated. A key element of the updated system is a principle that all future ICAM investigations must be actively led and authored by at least a Tier 3 Director.
- Specific to the Wanaka Helicopter incident investigation, the risks associated with aerial hunting (including tahr hunting) have been addressed through the redevelopment of our internal Aerial Hunting SOP. Staff involved in aerial hunting, including those involved in the Tahr Control Programme, have been involved in the development of this SOP. Sitting below the Aerial Hunting SOP is the Safe Aerial Hunter System, which clearly maps the process to plan and deliver safe operations.
- A revised 'Incident Capture' system is being implemented. It includes the introduction of a smart-phone app to make it easier for all staff to report incidents.