

MRH90 Taipan Helicopter incident

Senate Standing Committees on Legal and Constitutional Affairs

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Introduction

I make this submission in relation to the Senate inquiry into the fatal July 2023 MRH90 Taipan Helicopter incident in the Whitsundays.

I do not make this submission as an aviation engineer, pilot or technical specialist. I make it as a former member of the Australian Defence Force who understands that service personnel operate inside a command system ordinary civilians do not experience. Rank, obedience, loyalty, operational pressure and institutional culture are not incidental matters in Defence. They shape what people report, what they tolerate, what they question, and what they feel able to challenge. I also make this submission as a citizen concerned with institutional accountability, Defence safety governance, public integrity, and the treatment of service personnel and their families when serious harm occurs inside a system controlled by the Commonwealth.

The terms of reference are broad. They include airworthiness assessments of the MRH90 platform and associated equipment, Army Aviation compliance with Defence Aviation Safety Regulations, Comcare's investigation, other investigations, the appropriateness of the decision not to prosecute, and any other related matters.

That breadth matters. This inquiry should not be reduced to a narrow technical question about the final moments of the flight. The committee should examine the wider institutional system that placed four service personnel in that aircraft, under those conditions, with that equipment, after that procurement history, within that chain of command, and then handled the investigation and accountability process after their deaths.

This includes the procurement and sustainment history of the platform. The MRH90 tragedy did not occur in isolation from the earlier decisions that selected, accepted, sustained, remediated, certified, operated and ultimately withdrew the aircraft. Those decisions do not prove the cause of the incident. But they are part of the institutional setting in which the incident occurred and in which later accountability must be tested.

Captain Danniell Lyon, Lieutenant Maxwell Nugent, Warrant Officer Class Two Joseph Laycock and Corporal Alexander Naggs died while serving the Commonwealth. Defence has released an aviation safety investigation report and has stated that the primary cause was an unrecognised loss of spatial orientation. Defence has also stated that aviation safety investigations do not seek to apportion blame or liability, and that the report identified 196 findings, indirect findings and observations, informing 46 recommendations.

That creates the central problem for this inquiry. A safety investigation may assist learning, but it must not become a substitute for accountability. The committee should ensure that a no blame safety process does not become a no accountability public outcome.

Good public purpose

This submission applies the filter of good public purpose.

In this context, good public purpose means a Defence aviation system that protects the lives of service personnel, identifies known risks early, allows personnel to report danger without fear, treats procurement failure honestly, preserves evidence, permits independent scrutiny, compensates families properly, and does not allow institutional reputation to outrank truth.

A Defence capability is not merely an aircraft, a contract, a platform, a squadron or an operational objective. It is also the people ordered to operate it. The first duty of public purpose is to ensure that those people are not treated as expendable instruments of capability.

The floor that must be built is a real safety floor beneath Defence personnel. The ceiling that must be regulated is institutional self-protection, including secrecy, procurement defensiveness, contractor dependence, command pressure, fragmented investigations, narrow legal explanations and the tendency of large systems to protect themselves after failure.

The danger of a narrow accident narrative

The committee should be cautious about any account that isolates the incident from its broader setting.

A cockpit focused explanation may be relevant. It may be accurate as to the immediate mechanism of the crash. But it cannot be allowed to become a complete explanation if earlier decisions materially increased the risk. The real question is not only what happened in the final moments. The real question is whether Defence had already allowed known or knowable risks to accumulate before those final moments occurred.

The public record already shows that the MRH90 program was not an ordinary, uncomplicated Defence asset. The Australian National Audit Office recorded that the program involved acquiring 47 helicopters and their support system at a budgeted cost of about \$4.013 billion. It later recorded that the program was running about four years behind schedule by March 2014, that substantial work remained to develop an adequate capability, that requirements definition was inadequate, that the acquisition and sustainment contracts did not contain adequate protections for the Commonwealth, and that the program had been listed as a Project of Concern.

The ANAO also recorded significant technical, commercial and sustainment problems, including aircraft delivered later than scheduled, reduced operational capability, temporary and permanent design waivers, ongoing design issues, low reliability and maintainability, suspension of aircraft acceptance because of persistent technical issues, and potential total acquisition and sustainment costs of about \$11.7 billion to 2040.

That history does not prove the cause of the fatal incident. But it does mean Parliament should not examine the incident as if the platform history is irrelevant. The MRH90 was a troubled capability. The committee should ask whether that troubled history affected airworthiness decisions, operational confidence, safety culture, equipment treatment, fatigue management, risk acceptance, maintenance pressure and the willingness of Defence to confront the full implications of failure.

Safety learning is not accountability

There is a legitimate place for aviation safety investigations that do not apportion blame. Such investigations can encourage candour and improve safety systems. But a no blame safety investigation cannot be allowed to produce a no accountability public outcome.

This distinction is critical. Defence has stated that the aviation safety investigation did not seek to apportion blame or liability. That may be appropriate for that investigation. It is not adequate for Parliament.

The committee should require a reconciled public account across all relevant processes, including the Defence aviation safety investigation, the Inspector General of the Australian Defence Force inquiry, Comcare material, any coronial process, and the

decision by the Commonwealth Director of Public Prosecutions not to commence a prosecution.

The IGADF material identifies the inquiry as led by former Justice Margaret McMurdo AC, assisted by senior aviation and legal personnel including a recently retired senior Air Force officer and a senior Army Reservist. Expertise may be necessary, but expertise is not the same thing as visible independence. Where retired or serving Defence personnel are involved in reviewing Defence systems, the public needs clear conflict disclosure and a clear explanation of how institutional assumptions, professional loyalties and prior involvement have been managed.

Michael Hodge QC, Counsel Assisting the Financial Services Royal Commission, made an important point about professional judgement when he spoke of the value of doubt and the need to recognise unconscious bias. The relevance here is not the financial services context. The relevance is the principle. Honest and capable professionals may still carry assumptions shaped by the institution in which they worked, the people they served with, the projects they defended, and the professional norms they absorbed.

That is why visible independence matters. It is not enough for Defence to say that reviewers, advisers or investigators intended to act properly. The committee should ask whether the structure of the process required them to doubt their own institutional assumptions. A process can be conducted by sincere people and still be weakened by institutional loyalty, professional familiarity, procurement defensiveness or unconscious bias. Public confidence requires more than good intention. It requires a structure that tests good intention against independence, disclosure and doubt.

Comcare and the decision not to prosecute

The decision not to prosecute is one of the most important issues before the committee.

Public reporting states that the CDPD advised in July 2025 that it did not consider there was sufficient evidence to commence a prosecution, after assessing a brief referred by Comcare. Public reporting on released documents also states that the Comcare report identified serious work health and safety breaches by Defence relating to fatigue and failure to minimise known risks relating to helmet mounted night vision devices.

The committee should not conclude that a prosecution must have been commenced. That is a legal decision. But the committee should not allow the phrase insufficient evidence to end the matter.

The harder question is why the evidence was insufficient. Was it insufficient because no breach occurred, or because the evidence was held inside a military and institutional system controlled by Defence? Was it insufficient because the relevant records, safety warnings, command decisions, fatigue evidence, equipment assessments,

airworthiness material or witness accounts were incomplete, unavailable, protected or difficult to use? Was it insufficient because the system created a practical barrier between known risk and prosecutable proof?

That distinction matters. If Defence controls the aircraft, the operation, the safety reporting system, the fatigue records, the equipment history, the airworthiness framework, the command pathway, the witnesses and the documents, then weak evidence should not automatically favour Defence. In some cases, weak evidence may itself be evidence of poor governance.

The committee should require a public explanation, to the maximum extent possible, of the gap between alleged serious safety failures and the decision not to prosecute. Families and the public do not need every protected operational detail. They do need to understand whether the accountability system is capable of dealing with Defence as a workplace when Defence itself controls so much of the evidence.

Chain of command and structural intimidation

The committee should examine whether Army Aviation had a genuine safety culture or merely a formal safety process.

In a military environment, intimidation does not need to take the form of an express threat. It can arise from rank, loyalty, posting prospects, career dependence, operational pressure, fear of reputational damage, unit culture and the expectation that personnel will press on unless danger is undeniable.

A safety system is not real merely because it exists on paper. It is real only if personnel can use it without fear.

This is directly relevant to fatigue, equipment concerns, airworthiness concerns, night flying risk, mission pressure and training intensity. If personnel believe that raising concerns will mark them as difficult, weak, disloyal or career limiting, then the safety system is already compromised.

The committee should therefore ask whether personnel had practical confidence to raise safety concerns outside the ordinary chain of command. It should ask whether concerns about the MRH90 platform, associated equipment, fatigue, night vision equipment, flying conditions, training conditions or safety compliance were previously raised. It should also ask whether the reporting pathways were genuinely independent, or whether they ultimately returned personnel to the same command culture that may have created the pressure.

Defence cannot demand obedience, control the workplace, control the aircraft, control the records and control the reporting culture, then later rely on silence or incomplete evidence as proof that the system was safe.

The F111 precedent

The F111 fuel tank matter is not a technical equivalent to the MRH90 tragedy. But it is an important institutional precedent.

The ANAO recorded that leaking fuel tanks and the F111 fuel storage system meant maintenance workers undertook repair work in hazardous occupational settings not previously experienced with other RAAF aircraft types. It also recorded formal deseal and reseal programs and ongoing repair work involving personnel entering tanks and physically removing sealant.

The relevance of F111 is not that the aircraft or risk was the same. The relevance is that Defence aviation work has previously produced serious harm through a combination of operational need, technical complexity, hazardous conditions, record problems, delayed recognition and long running disputes over responsibility.

That history should make the committee wary of institutional forgetting. Parliament has seen Defence related aviation harm before. It has seen how affected personnel can be left to fight over exposure, proof, records, recognition and compensation years after the Commonwealth should have known and acted.

The MRH90 inquiry should therefore ask whether the same pattern is reappearing in a new form. Known or knowable risks. Operational normalisation. Fragmented responsibility. Technical language. Delayed recognition. A burden of proof shifted onto families. No single institution carrying the whole moral and public accountability burden.

The Agent Orange precedent

Agent Orange is also not a technical equivalent to the MRH90 incident. It involved chemical exposure, contested medical consequences and delayed recognition after the Vietnam War. But its institutional lesson is relevant.

DVA's Anzac Portal records that Australian, United States and New Zealand soldiers were exposed to chemical agents during the Vietnam War, that many veterans believed exposure led to cancers, serious illnesses and risks to their children, and that intense debates continued about the effects of Agent Orange on veterans' lives. It also records that the Whitlam and Fraser governments denied Australian troops had been exposed to chemical defoliants, and that subsequent governments later retracted that position in the face of contrary evidence.

That is the institutional warning. Defence personnel serve under conditions controlled by the state. The state controls deployment, records, technical knowledge, medical pathways and later accountability processes. When harm emerges, the burden too often shifts back onto the individual, the veteran or the family.

The committee should reject that model in this case. The families should not be forced into an evidentiary contest against the institution that controlled the aircraft, the equipment, the operation, the records and the safety system.

Monetary incentives and institutional intransigence

The committee should also examine the monetary architecture that can sit behind institutional intransigence.

This is not a submission that Defence personnel were deliberately put at risk to save money. The problem is more subtle and more dangerous. Once a major Defence system fails, money becomes entangled with truth. Recognition of failure can expose procurement error, sustainment waste, contractor weakness, compensation liability, legal liability, ministerial embarrassment, career failure and precedent risk.

That creates an incentive to narrow the facts, fragment responsibility, delay recognition and shift the burden of proof onto the dead, the injured, the veteran or the family.

The MRH90 matter carries obvious monetary context. It was a multibillion-dollar capability with a long procurement, sustainment and remediation history. The aircraft were later permanently removed from flying operations before the planned withdrawal date of December 2024.

The committee should be alert to the possibility that a narrow narrative protects more than individuals. It may also protect procurement decisions, contractor relationships, sustainment choices, budget decisions, reputations and prior official assurances.

The Commonwealth's financial capacity should not be misunderstood. The Commonwealth is the issuer of the Australian dollar. The question is not whether Australia can afford to compensate families, support affected personnel, preserve evidence, run independent investigations or rebuild aviation safety systems. The real question is whether the Commonwealth is willing to accept the full consequences of its own institutional failures. Money should never decide how much truth families receive.

Compensation must not substitute for accountability

Any compensation paid to families should be treated as relevant, but not conclusive.

Compensation may assist dependants, meet immediate financial needs, recognise service or provide a measure of security. It does not answer whether Defence complied with aviation safety rules. It does not answer whether known risks were controlled. It does not answer whether fatigue was properly managed. It does not answer whether equipment concerns were escalated. It does not answer whether airworthiness decisions were sound. It does not answer whether the decision not to prosecute was properly explained.

Compensation can become an institutional pressure release valve. A payment can be made while liability is denied. A family can be supported while the public record remains incomplete. A statutory entitlement can be processed while command, procurement, sustainment, equipment and regulatory failures remain unresolved.

That is not justice. It is administrative containment.

The committee should not intrude into the private financial affairs of families. But it should ask structurally whether families were given full reasons, full access to relevant material, independent assistance and a process that recognised the Commonwealth's control of the evidence.

Money must not purchase silence, substitute for truth, or convert four deaths into an administrative file.

Contractor influence, procurement capture and conflict disclosure

This submission does not allege that kickbacks occurred in relation to the MRH90 incident. Serious allegations of corruption should not be made without evidence.

The issue is whether the committee can be satisfied that contractor influence, procurement history, sustainment pressure, procurement defensiveness, revolving door relationships, retired officer networks, serving officer loyalties and Defence reputation management played no improper role in the handling of airworthiness, equipment risk, safety escalation, investigation scope, public explanation or the decision not to prosecute.

That question is legitimate because the MRH90 tragedy did not occur in a vacuum. The aircraft was the product of procurement decisions, contract decisions, capability acceptance decisions, sustainment decisions, remediation decisions, waiver decisions, airworthiness decisions and operational risk decisions made over many years. The committee should not examine only the final flight. It should examine whether the earlier institutional and commercial decisions that kept the platform in service were properly made, properly tested, properly recorded and free from improper influence.

Defence procurement is structurally vulnerable to capture. Major platforms involve large sums, specialist information, limited external expertise, close contractor relationships, long sustainment tails, complex technical dependency and movement between public service, Defence service, consulting and industry. In that environment, procurement actors can become invested in defending the platform, defending the contract, defending earlier assurances and defending their own judgement. That may occur without criminal corruption. It may occur through ordinary institutional self-protection.

Recent public material shows that Defence contracting integrity risk is not theoretical. In November 2025, the NACC, AFP and Defence announced charges arising from alleged irregularities in Defence contracts valued at almost \$71 million, including an allegation that a Commonwealth employee exploited his position to influence contract allocation. That matter is separate from MRH90 and proves nothing about this incident. But it illustrates why Parliament should not treat procurement integrity as an abstract concern.

The committee should therefore require disclosure of relevant contractor relationships, consulting arrangements, gifts, hospitality, post service employment, procurement involvement, contract negotiation involvement, capability acceptance involvement, sustainment involvement, airworthiness involvement, waiver involvement, remediation involvement, advisory roles and prior MRH90 decision making roles held by any person materially involved in reviewing, investigating, explaining or defending the incident and its surrounding history.

That disclosure should not be limited to the immediate accident investigation. It should extend to those involved in the procurement, acceptance, sustainment, remediation, risk treatment, continued operation and withdrawal of the MRH90 platform where their prior involvement may bear upon the independence of later advice, evidence, review or public explanation.

The question is not only whether an actual conflict existed. The question is whether the families and the public can see that the process was independent of the Defence, contractor and procurement ecosystem whose decisions are under scrutiny. If the same institutional class that selected, accepted, sustained, defended or normalised the platform is later relied upon to explain its failure, the committee should require more than reassurance. It should require disclosure, separation and visible independence.

Recommendations

The committee should recommend a reconciled public account of the MRH90 tragedy. That account should bring together the Defence aviation safety investigation, the IGADF inquiry, Comcare material, any coronial process, the CDPP decision, the airworthiness history, the procurement history and the sustainment history. Parallel investigations should not be allowed to produce parallel fragments of truth.

The committee should recommend that the decision not to prosecute be explained publicly to the fullest extent possible. That explanation should address the evidentiary gap between alleged serious work health and safety failures and the conclusion that prosecution should not proceed. It should also address whether the evidentiary difficulty arose from absence of breach, absence of proof, protected material, incomplete records, weak documentation, military command structures, or the

practical limits of prosecuting a Commonwealth institution that controlled the relevant workplace and evidence.

The committee should recommend an independent review of the safety reporting culture inside Army Aviation. That review should examine fatigue, equipment concerns, airworthiness concerns, night flying risk, operational pressure, training pressure and whether personnel could raise concerns without fear of career damage, reputation damage or retaliation through the chain of command.

The committee should recommend a full conflict and influence disclosure process for all persons materially involved in reviewing, investigating, advising on, explaining or defending the incident and its surrounding history. That process should include serving officers, retired officers, Defence civilians, contractors, consultants, external advisers and any person with prior involvement in MRH90 procurement, contract negotiation, capability acceptance, sustainment, remediation, waiver decisions, airworthiness decisions, operational risk treatment, continued operation or withdrawal.

The committee should recommend that incomplete records, weak documentation or missing evidence not be treated as neutral where Defence controlled the system in which those records and evidence should have been created, preserved and disclosed. A failure of record keeping in a safety critical military aviation system should be treated as a governance failure, not as a shield for the institution.

The committee should recommend that family compensation processes be separated from accountability processes. Support for families must not be treated as closure, must not reduce the need for public truth, and must not be used to convert institutional failure into a private administrative matter.

The committee should recommend stronger independent safety reporting pathways for Defence personnel. Those pathways should allow personnel to raise concerns about fatigue, equipment, airworthiness, training pressure, command pressure, contractor issues and operational risk outside the ordinary chain of command, with protection against formal and informal retaliation.

The committee should recommend that Defence aviation safety be treated as a public capability question, not merely a compliance question. If safer operations require better equipment, better fatigue systems, more independent oversight, stronger reporting pathways, better training, better record systems, better procurement controls or more personnel, the Commonwealth has the financial capacity to fund those measures. The real constraint is not money. The real constraint is whether the Commonwealth is willing to organise the people, systems and institutions required to protect those who serve.

Conclusion

Four service personnel died while serving the Commonwealth. The committee should not allow their deaths to be absorbed into a technical report, a compensation process, a no blame safety culture, an unexplained prosecution decision or a fragmented set of institutional files.

The central question is not only why the aircraft entered the water. The central question is whether Defence built and enforced a safety system worthy of the people it ordered into the aircraft. That question necessarily includes the procurement, acceptance, sustainment, remediation, airworthiness and operational decisions that kept the MRH90 platform in service.

The F111 fuel tank scandal and the Agent Orange controversy show that Defence related harm can be denied, narrowed, delayed and contested for years when the state controls the records, the science, the workplace, the money and the process. The MRH90 inquiry is a chance to refuse that pattern.

Parliament should insist on a complete public account. It should test the airworthiness history, equipment history, fatigue evidence, chain of command, safety culture, investigation structure, conflict safeguards, contractor environment, procurement history, compensation framework and decision not to prosecute.

The families should not be left with fragments. The public should not be left with institutional reassurance. Defence personnel should not be left with a paper safety system that fails when most needed.

This submission does not ask the committee to assume corruption, criminality or individual misconduct without evidence. It asks the committee to test the structure that can conceal them, excuse them or make them unnecessary. Institutional failure does not always require a villain. Sometimes it is produced by procurement defensiveness, command pressure, contractor dependence, career protection, fragmented responsibility, weak records and a culture that treats operational continuation as more important than safety candour.

That is why this inquiry matters. The Commonwealth asks service personnel for obedience, courage and sacrifice. In return, it owes them more than ceremony after death. It owes them a safe system before harm occurs, truth after harm occurs, and accountability where the system failed.